MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 3, 2019
9:23 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SUSAN THOMPSON, MS, RN
PAT WANG, JD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

AGENDA PAGE

P R O C E E D I N G S

[9:23 a.m.]

DR. CROSSON: Okay. I think we can reconvene.

It's a good thing the infectious diseases physicians are in town because I think an illness has just infected the -- oh, here come the rest of our Commissioners.

Okay. Let me first welcome our guests to the October MedPAC meeting. We are beginning this morning's session with our continuing work on Medicare Part D, and Rachel and Shinobu are here to present, and Shinobu is going to begin. You have the microphone.

MS. SUZUKI: Good morning. Today we will continue our discussion from the last cycle about potential changes to Part D.

Based on Commissioners' feedback at the April meeting, the discussion today will focus on the options to restructure the Part D benefit that builds on the Commission's 2016 recommendations.

Depending on your interest, we plan to work towards recommendations in the spring and are looking to you for guidance on policy direction.

In this presentation, we'll provide a brief background on Part D and the changes that have taken place since the program began in 2006.

We'll recap the issues the Commission has been concerned about which are the impetus for today's discussion. Finally, we'll go over in some detail an approach to restructuring Part D.

Your discussion will inform us of the direction of our work for next spring, and we plan to put this material into a chapter in the next June report to Congress.

Part D was created with the goal of expanding beneficiary access to prescription drugs using a market-based approach. The idea was to rely on competing plans and allow beneficiaries to choose among a wide range of plan options.

Plan sponsors, competing for those beneficiaries, would have financial incentive and some of the commercial tools to manage benefit spending.

Part D was structured to include Medicare's subsidies, risk sharing, and late enrollment penalties to encourage the creation of a new market for stand-alone

prescription drug plans and broad enrollment.

So what has changed since 2006?

Plans were successful at switching enrollees to generics for many of the widely prevalent conditions like high cholesterol.

By 2010, manufacturers had shifted focus on specialty drugs that treat conditions with smaller patient populations, such as rheumatoid arthritis and cancer. These newer therapies are often very expensive.

Part D's benefit changed, eliminating the coverage gap for some beneficiaries. Manufacturer discounts were part of that change, and this discount distorts market incentives and is one of the primary key reasons we need to restructure Part D. And we'll come back to this in a minute.

Another change is the expanded role of Medicare's reinsurance, which is a cost-based reimbursement to plans for 80 percent of the costs above the out-of-pocket threshold.

On the right you can see the rapid growth in costs above the out-of-pocket threshold, shown in orange.

In 2018, over 40 percent of spending was in the

catastrophic phase, paid mostly by Medicare. That's more than double the amount in 2010, when only 20 percent of spending was in the catastrophic phase. The pipeline shift, Part D benefit change, and the misaligned incentives have all contributed to this trend.

Turning to why Part D benefit needs to restructured, the Commission's 2016 recommendations addressed some of the same concerns we just talked about. They would: strengthen financial incentives to manage benefits; give plan sponsors greater flexibility to use formulary tools; modify LIS cost sharing to encourage generic use. But benefit design change and specialty spending have worsened plan incentives, reducing incentives to manage spending, and in some cases, encouraging preferential formulary treatment of high-price, high-rebate drugs, which increases both program costs and beneficiary premiums. The focus on rebates may have affected some manufacturers' pricing decisions.

The misaligned incentives work differently for LIS and non-LIS benefits. I'll start with the non-LIS benefit on the left. The figure reflects benefit for brand-name drugs and biologics. The focus here will be the

coverage gap in the catastrophic phase above the out-of-pocket threshold.

The coverage gap is the phase between the initial coverage limit and the out-of-pocket threshold. As you can see, the plan liability, shown in blue, is much lower once a beneficiary reaches the ICL: 5 percent in the coverage gap and 15 percent in the catastrophic phase.

Another thing to note is that the 70 percent manufacturer discount applies only to brand-name drugs. So for generics, plans are liable for a higher amount, 63 percent this year and 75 percent thereafter. This effectively lowers brand prices relative to generics, distorting the price signal which is at the core of a market-based system.

LIS benefit, on the other hand, still has the coverage gap as originally structured.

For LIS beneficiaries, Medicare picks up nearly all of the cost sharing, including the entire costs in the coverage gap. So plans have zero liability in the coverage gap and just 15 percent in the catastrophic phase.

Based on CMS data, rebates on brand-name drugs average about 30 percent. That means for some brand-name

drugs and biologics, the value of rebates exceeds plans' costs for spending above the ICL.

In addition, as noted earlier, Medicare's reinsurance pays for 80 percent of the costs above the out-of-pocket threshold.

What this shows is that the current structure clearly fails to provide strong incentives to push back on high prices or to manage spending for high-cost beneficiaries.

While the coverage gap discount does provide some financial relief to those who use brand-name drugs and biologics, it affects only a small share of spending for high-cost drugs and biologics placed on specialty tiers. As you may recall, plans are allowed to use specialty tiers only for the most expensive products.

This table shows the differential impact coverage gap discount has on specialty tier drugs, shown on the top, and non-specialty tier drugs in the lower panel. These are all major drug products with Medicare spending of at least $1 billion in 2018.

The second column shows the discount paid for each product as a percent of total spending.

You can see that for specialty tier drugs, coverage gap discount accounted for about 2 percent or less, and this is because the discount applies to a limited range of spending, as we saw earlier, between the ICL and the out-of-pocket threshold, and it is also because the bulk of the costs for specialty drugs are in the catastrophic phase. This is shown in the last column.

In contrast, coverage gap discount for other drugs accounted for a higher share for the selected drugs shown, more than 6 percent to nearly 11 percent.

Another reason for low coverage gap discounts among specialty tier drugs is that they don't apply to LIS enrollees, but LIS enrollees, as you may recall, are the majority of the beneficiaries who incur high costs.

What all of this shows is that, in addition to distorting price signals, coverage gap discount is not an effective way to offset rising prices and spending.

So here's the broad outline of policy ideas we are continuing to explore to restructure Part D.

The first idea we'll discuss is eliminating the coverage gap discount.

The second idea would equalize the basic benefit

for enrollees with and without the low-income subsidy.

The third set of ideas would restructure the catastrophic benefit by adding: a new manufacturer discount, cap on beneficiaries' out-of-pocket spending, increased plan liability, and lower Medicare reinsurance.

To summarize the key points, we currently have two separate benefit for LIS and non-LIS beneficiaries, and that includes very little to no plan liability in the coverage gap and only 15 percent above the out-of-pocket threshold.

The restructure would eliminate the coverage gap and make plans liable for a consistent 75 percent of the benefit up to the out-of-pocket threshold for both LIS and non-LIS beneficiaries.

Medicare would provide lower reinsurance in the catastrophic phase, and the remainder would be a mix of plan liability, which would be financed through higher direct subsidy, and a new manufacturer discount.

We'll now go through the individual components of the restructured benefit.

The first piece is eliminating the coverage gap discount. This would increase the plan liability for

brand-name drugs filled by non-LIS beneficiaries from 5 percent to 75 percent and make plans responsible for a consistent 75 percent of the benefits between the deductible and the out-of-pocket threshold.

The policy would remove the price distortions between brand and generic drugs in the coverage gap, which in turn would improve plans' formulary incentives. And it would also simplify the benefit structure.

However, this change would eliminate manufacturers' contribution toward Part D's benefit costs. The gap discount in 2018 totaled about $6.9 billion. With a 70 percent discount rate beginning this year, the amount would be even higher.

DR. SCHMIDT: A second major part of the restructuring would be to use the same benefit design for enrollees with and without the low-income subsidy. If an LIS enrollee had spending high enough to reach what's now the coverage gap, their Part D plan would become responsible for 75 percent of benefits, the enrollee would continue to pay the nominal co-pays that are set in law, and Medicare's low-income cost-sharing subsidy would pay the difference between 25 percent and the co-pays. Plan

liability would increase in that phase of the benefit from no liability to 75 percent, and Medicare's low-income cost-sharing subsidy would decrease from 100 percent to a bit under 25 percent.

We think this change would improve plan incentives, particularly with respect to the decisions they make about their formulary structure. Plans would have stronger incentives to manage the spending of their LIS enrollees. However, plan sponsors would take on additional benefit spending to cover 75 percent of coverage gap benefits for LIS enrollees. Medicare would subsidize about three-quarters of that amount, and premiums for all enrollees would increase to cover the remainder.

At the same time, spending for Medicare's LICS would decrease and would more than offset the increase in Medicare's premium subsidy. So as we equalize the LIS benefit, Medicare program spending would actually go down on net, and all Part D enrollees would pay somewhat higher premiums. As plans become responsible for more of the LIS benefit, they also would need more tools. Part of the Commission's 2016 recommendation was to modify LIS co-pays so that enrollees would have a greater financial incentive

to use lower-cost drugs when available.

A third major part of the restructured benefit would be a new brand manufacturer discount in the catastrophic phase of the benefit. This would apply to all enrollees whether they receive the low-income subsidy or not. That's a change from current policy.

One approach might be to set the new discount rate so that the aggregate amount of revenue at least offsets the amount that manufacturers have been paying in coverage gap discounts. An alternative approach would set the new discount higher to offset other costs of the restructuring or to try to provide some drag on manufacturer price increases.

This approach would offset the cost of eliminating the coverage gap discount, and the cap discount would apply much more directly to specialty drugs that have the highest prices. Because the new discount would be open-ended in the catastrophic phase, it would introduce a new consideration that manufacturers would have to bear in mind as they made decisions about price increases and launch price.

Consistent with the Commission's 2016

recommendations, a restructured Part D could cap beneficiaries' out-of-pocket spending. Today enrollees who reach the catastrophic phase pay 5 percent coinsurance indefinitely. Under a restructured design, Part D's basic benefit would cover the 5 percent. So, for example, the million or so beneficiaries who don't receive the low-income subsidy and reach the out-of-pocket threshold today would no longer pay any cost sharing for prescriptions in the catastrophic phase. Nearly 3 million LIS enrollees also reach the out-of-pocket threshold today, and they currently don't pay co-payments in that phase. Instead, Medicare's low-income cost-sharing subsidy pays the 5 percent on their behalf. Under a restructured Part D, the basic benefit would cover what's now covered by Medicare's extra help with cost sharing.

This change would provide all enrollees with more complete insurance protection. But the flip side is that benefit spending would be higher. Medicare's premium subsidies and enrollee premiums would increase to cover the new benefit. But as with Slide 12, spending for Medicare's low-income cost-sharing subsidy would decrease, offsetting part of the increase in Medicare's premium subsidy. On

net, program spending would increase, but not by as much as you might expect because premiums of all Part D enrollees would help to pay for the new benefit.

Consistent with the Commission's 2016 recommendations, under a restructured benefit Medicare would provide less reinsurance, and plans would finance more of the catastrophic spending. For example, the Commission previously recommended lowering Medicare reinsurance from the current 80 percent to 20 percent and increasing what plans pay from 15 percent to 80 percent.

At the same time, Medicare's capitated payments to plans would increase so that the program would continue to provide the same overall premium subsidy. The program would keep Part D's risk corridors in place, at least during a transition period, to keep financial protections for plans. And CMS would recalibrate the risk adjusters it uses for capitated payments to reflect plans' higher level of liability.

If plans were responsible for more catastrophic spending, that may affect their formulary decisions. Plans may be less inclined to prefer certain drugs with high prices and high rebates. If more of Medicare's payments

were capitated instead of cost-based, plan sponsors would face more financial risk. Among stand-alone plans, most enrollees are in PDPs offered by very large plan sponsors, and in interviews we conducted, consulting actuaries told us they thought PDP sponsors have enough capital to reinsure themselves. However, among MA-PDs, there are smaller regional plan sponsors that may need to purchase private reinsurance, which could lead to higher administrative costs and premiums. It could also affect whether some plan sponsors choose to enter or stay in certain markets. As both large and smaller plan sponsors take on more financial risk, they would also need more flexibility to use formulary tools to manage benefits.

One question to consider is whether Medicare reinsurance is still necessary. At the start of Part D, this form of risk sharing helped encourage plans to enter a new market. Today that market is well established, but reinsurance has grown in an unintended direction.

To think about whether Medicare's reinsurance is still necessary, we took a look at how variation in Part D spending per person has changed over time compared with fee-for-service medical spending. Between 2011 and 2017,

we found that the variation in medical benefits per person remained flat, but that variation in pharmacy benefits grew significantly. Median Part D spending fell nearly in half over the period. At the same time, the introduction of extremely high-priced drugs drove up mean spending. This might suggest a continued need for some Medicare reinsurance.

However, another thing to consider is what role Medicare's reinsurance plays. When health plans purchase private reinsurance, those contracts provide protection against unpredictable risk that the plan will have extremely high claims. Medicare's reinsurance is structured very differently.

First, Medicare reinsures about 8 percent of Part D enrollees compared to 1 to 2 percent of health plan members under private reinsurance contracts.

Second, most Part D spending in the catastrophic phase is predictable. In recent years, about 80 percent of Part D catastrophic spending is attributable to enrollees who also had catastrophic spending in the previous year. Medicare's reinsurance is not protecting against unpredictable high claims. It's providing cost-based

reimbursement for high-cost enrollees. In this sense, it may be countering selection incentives. But CMS already has risk adjusters for that purpose, and Part D also has risk corridors to help protect plans from unanticipated losses.

In order to help ensure a successful transition to a restructured benefit, we would need other changes. Changing from the status quo would have a lot of moving parts, and policymakers may want to phase in changes over time. Plan sponsors would need more formulary flexibility to manage the higher plan liability. When we ask plan sponsors what they think they would need, they often bring up current restrictions such as having to cover all protected-class drugs, not being able to limit their network of specialty pharmacies, and how LIS enrollees have weak financial incentives to use generics and preferred drugs.

Under a restructured benefit, it would be especially important for CMS to recalibrate risk adjusters because more of Medicare's premium subsidies would be capitated. There may be other ways in which to improve the Part D risk adjusters.

In addition to reinsurance, Part D also has risk corridors that protect plans at an aggregate level from unanticipated losses. We may want to consider changes to the risk corridors, at least on a transitional basis. One option is to tighten the corridors during the transition to a new benefit, giving plan sponsors more protection against the risk of overall losses. Similarly, the shares of unexpected losses and profits borne by plan sponsors and Medicare in the corridors could be changed so that Medicare bears more risk temporarily.

Now we'd like your questions and comments about this general approach. We would also appreciate hearing your perspectives about redistributing responsibility for financing Part D's catastrophic phase among beneficiaries, Medicare reinsurance, brand manufacturers, and plan sponsors.

In November, Eric Rollins will bring you more information about plan sponsors that have larger percentages of members with the low-income subsidy and their experiences in trying to manage LIS benefit spending.

DR. CROSSON: Well, I just want to thank you for that exquisite analysis and reformulation.

We will start with clarifying questions from the Commissioners.

Paul?

DR. PAUL GINSBURG: Yes. I thought that the paper was really terrific.

I had a question. You concluded that the net effect financially of all these changes would be a small increase in program spending and beneficiary premiums?

DR. SCHMIDT: We weren't providing a cost estimate of everything altogether. Each slide was kind of discussing the puts and takes of how program spending was with respect to each of the component we were going to on the slide.

DR. PAUL GINSBURG: The reason I wanted to bring up the question is I presume that there are so many parameters that can be varied, such as the discount percentage, the reinsurance percentage, to protect the classes, that some version of this could be made budget neutral or premium neutral if policymakers wanted to. Is that correct?

DR. SCHMIDT: Yes, that's correct.

DR. CROSSON: Okay. Kathy?

MS. BUTO: Thanks a lot for this, not just the chapter, but the concept, which I think is incredibly elegant.

I had a couple questions. One is whether you did an impact analysis or sort of a sensitivity or some kind of analysis that the impact of beneficiaries reaching the catastrophic cap, or would it be similar to the other proposal that we discussed where the manufacturer discount would no longer count toward reaching the cap? It feels like it would be very similar to that, but I just wondered if you had done that, that analysis of beneficiary impact.

DR. SCHMIDT: So in the 2016 recommendations, we were changing the treatment of the manufacturer discount so it no longer counted towards the true out-of-pocket threshold.

MS. BUTO: Right.

DR. SCHMIDT: And remember it was an overall package that had some things that people liked and some things that people did not like, and the fact that people would stay in the coverage gap longer was something that folks did not particularly like but was part of the overall package and something that we thought was necessary at the

time.

The nice thing about this redesign is that treatment, that change in the treatment is no longer really relevant.

MS. BUTO: Relevant, right.

DR. SCHMIDT: And the 25 percent cost sharing is really consistent with current law. So the only question is at what level the out-of-pocket cap is. Do you want it to be kind of the same as what beneficiaries essentially would pay under current law if you don't consider what manufacturers are contributing in the coverage gap or something else?

MS. BUTO: Okay. So, obviously, it's one variable that could be -- and the other, the other question I had was whether in the catastrophic cap phase whether the manufacturer discount would apply to generic manufacturers as well as brand name or just brand name. Had you thought about that?

MS. SUZUKI: We only looked up brand-name drugs partly because we were trying to replace the elimination of coverage gap discount with a cap discount, and so we were talking about the same entities.

MS. BUTO: Okay. Good. Thank you very much. That helps.

DR. CROSSON: Okay. Dana, Jonathan, Pat.

DR. SAFRAN: Yeah. Just adding my voice to the thanks for this really impressive piece of work.

I have two questions. One is about premium increases that you'd expect. You said a little bit about it here and a little bit about it in the chapter, but I just wonder if you could expand a bit on what you think are the likely consequences for beneficiaries in terms of premium increases that might be faced as the plans start to face the increased cost that you tell us are going to happen because of this and that are intended here and also whether there is any backstop possibilities to that in terms of a cap on increases allowed with respect to premiums.

And then I'll go to my second question.

MS. SUZUKI: So there are a lot of moving pieces. We explicitly did not provide the overall impact because it would depend on the parameters that are chosen.

Although one thing to note is that reinsurance is already part of the premium calculation for the plans. So

right now, essentially, 95 percent of the cost above the out-of-pocket threshold is already reflected in the premium amount. So changing that distribution will not necessarily lead to higher cost because I think we're now considering a cap discount to pay for some of that cost.

The big question is, What do you do with the out-of-pocket threshold, moving up or down, relative to current law would affect the premium amount? Because you have 75 percent coverage below the threshold but a higher -- potentially a higher coverage above the threshold, and then the low-income cost-sharing subsidy is one of the things that would lead to higher premium. But we think there are different ways to offset that, some of that cost, if that's the policy goal.

DR. SAFRAN: That was very helpful.

My second question is also about asking you what you thought about in terms of the behavioral economics here, which are quite complex, will play out.

Early in the chapter, you highlight that manufacturers had a notable shift toward specialty and orphan drugs. I wonder if you've thought about whether this policy shift would incentivize another type of

manufacturing shift, and if so, what do you hypothesize that could look like?

DR. SCHMIDT: We'd really be speculating. There are so many other factors that go into what manufacturers decide to put into their pipeline and take to the market. So it's the whole length of exclusivity, patent law, all of those things, and obviously, reimbursement policy is one important element of it. But it's just a small component.

But the fact that there would be this open-ended discount that manufacturers would have to provide may affect pricing decisions.

DR. SAFRAN: Thank you.

DR. CROSSON: Jim wants to get in.

DR. MATHEWS: So to go back to your first question with respect to beneficiary premium increases and consequences of those increases, as Shinobu said, the magnitude of those increases are going to depend on the parameters chosen for this redesign, but I also wanted to point out that there is a longitudinal element here, that a lot of the changes that we are discussing are designed to get at manufacturer's pricing behavior and to increase the incentives for plans to make formulary decisions over time

that ideally would have the impact of decreasing price growth over time.

So to the extent that the Commission has been concerned about the growth of high-price specialty drugs, the growth of Medicare reinsurance spending, part of what we were discussing here are changing incentives to get at those rates over the long term.

DR. CROSSON: Okay. Jonathan?

DR. JAFFERY: Yeah. Thanks.

My question actually is along the lines of Dana's second question about manufacturers' behaviors and their incentives, but I'll be a little more -- I'll home in on something.

You talk about the manufacturer's financial contribution being -- let me put a number on it -- 6.9 billion in 2018. So is it accurate that as we're estimating their contribution, that's going to be very dependent on their own pricing strategies? So if they double their prices, it suggests or we will calculate that they're actually contributing twice as much?

DR. SCHMIDT: Yeah. Right, pretty much. The 6.9 percent was looking at claims data for 2018 and looking at

the value of what's described as "manufacturer discount" on those claims in that year. So that was a year where it was 50 percent, and it's subsequently gone up to 70 percent discount. So that's how we came up with the amount of revenue.

But, yes, you're right. They have control over prices.

DR. JAFFERY: There's something analogous here to discounts that providers offer to insurance companies and whatnot. We'll have to think, I guess, about how we calculate different sectors' contributions based on that, because that's very different than, say, what a beneficiary premium is, which is an actual dollar amount.

All right. Okay, thanks.

DR. CROSSON: Okay. Pat and then Kathy.

MS. WANG: I wondered if you could talk a little bit more about the elimination of the manufacturer discount in the coverage gap. Assume that it no longer counts towards the out-of-pocket threshold, and so this acceleration of people reaching the reinsurance layer is gone.

There's statements in the paper as well as in the

slides around the discount and the coverage gap created price distortion between brand and generic. Is that a statement that is made, I assume, only for brands that have a generic equivalent? Because what about specialty, single source? I was wondering because it still feels like manufacturer discount at several layers of the benefit makes sense to try to get maximum incentives running in the correct direction.

So I wonder if you could explore that a little bit more.

MS. SUZUKI: So I think you're correct that, generally, the brand generic price distortion would be brands with generic, but I would add that sometimes there are therapeutic generic substitutions that are available to beneficiaries. And plans may have stronger incentive without the coverage gap discount to encourage more of those brand substitutions that are more based on therapeutic class, not just the direct generic substitution, which I think plans already do.

MS. WANG: Do you have any sense of relative proportion of those phenomena inside of the coverage gap? Would a continued coverage gap discount that did not count

towards the out-of-pocket net be better and more productive in terms of continuing to dampen price escalation than the phenomenon you're describing?

MS. SUZUKI: I think that's a really difficult question to answer, partly because some portion of those brands used are probably driven by clinical needs. Some portion may be due to the fact that they have hit the coverage gap, and from maybe their experience, they know that they're going to reach the catastrophic phase. In that case, your out-of-pocket liability would be minimized using the brand version of the drug.

So there are a mixture of things that happens in the coverage gap, but we think that if there are generic substitution that's available, then we want to ensure that that incentive is aligned.

MS. WANG: Does your thinking on that change if there was a manufacturer discount on generics?

DR. SCHMIDT: I think Kathy has raised that issue in past discussions about this, and I think we had some concern. This isn't true for all generic drugs, but we've seen declining numbers of manufacturers for certain generics. And so there was concern about if you add on top

of that a discount that they have to provide about the viability of maintaining generic competition.

MS. WANG: I think that the question really is more focused, not generics, generically, but there are certain generics where price escalation has been just as dramatic as on the brand side.

DR. CROSSON: Kathy?

MS. BUTO: I just wanted to go back to -- I guess it was something somebody, maybe Dana, raised that caused me to think this.

With a manufacturer discount that's sort of unlimited in the catastrophic phase, isn't that likely to stimulate higher pricing in sort of brand-name drugs; in other words, similar to our recommendation of keeping prices below sort of inflation, so that we would cap Medicare's payment rates?

If you're going to require a certain discount, then it seems to me the introduction prices would be -- there would be an incentive to really go high on those. I mean, I just wonder if you've thought about that.

The structure, I love getting rid of the coverage gap, but the structure also suggests that if there's no

skin in the game, then you've got, by manufacturers, before the catastrophic limit that you're going to have, again, more of a likelihood of high introduction prices. I just wondered if you all had thought about that.

DR. SCHMIDT: We have talked about that internally, and we've talked to other experts in the field. And there's just a lot of uncertainty.

We hear both sides of that argument, and I'm not sure that anyone knows precisely what happened. I think it's going to vary from drug class to drug class, dependent on competition in that class and so forth.

DR. CROSSON: You know, I think inherent in this -- and I almost hesitate to say this -- is that there is a perception that there's going to be a limit eventually to how much manufacturers can keep increasing their prices.

Now, I think people have been saying that for a long time, which is why I hesitate to say it, but I do think that given the level of public outcry, one might construe that while manufacturers might have an incentive in the face of this change in their liability outside in the catastrophic coverage arena, that they would reflexively do that. But I do think there could be other

forces pushing against that.

Jon, Bruce, Amol.

DR. PERLIN: Well, let me add to the chorus of thanks for a really thoughtful, superb chapter, and discussion.

I have really three questions for you. The first is the premise is that there's formulary management, but that implies that there are substantutes. Has there been any source sensitivity analysis about the degree of substitutability where the costs reside if you actually parse the pie of the Part D expenditures and to those things with and without substitute and what that magnitude is?

MS. SUZUKI: So CBO has looked at this a couple years back, looking at selected therapeutic classes to see how much Medicare could save if there were therapeutic generic substitutions. My recollection is those were pretty common classes of drugs.

And we've also independently looked at generic use rate within some broad classes where we think there is some mixture of direct generic substitution, therapeutic generic substitution available; for example, high

cholesterol is one of them. High blood pressure is another. Those classes where when we look at LIS enrollees compared to non-LIS enrollees who do see cost-sharing differential, we do see a difference in generic use rate. And some of it, we have argued that are due to financial incentives and due to clinical need differences.

DR. PERLIN: The reason I am asking that question is the notion of formulary management requires, by definition, formulary choices, and where those choices are constrained, that limits the overall pull.

If I am understanding correctly, the savings where there is substitution is what helps to rein in the cost against entities where there's a single drug or specialty drug in class.

With that in mind, it strikes that the points that were just made about the potential risk of the escalation of launch price is problematic, and I'll just tee this up for the second phase of conversation. But our definitions of what is a substitute, appropriate substitute for a specialty drug may be particularly important. Apropos of this, while certain things may be related to behavior in terms of pricing, some of the specialty

therapies involve new technologies that may be inherently more expensive. I just wonder how we get an estimate on any of that to really understand how this operates.

DR. CROSSON: Okay. I've got Bruce and Amol, and then we're going to, I think, move on to the discussion please.

Bruce?

MR. PYENSON: Actually, to pick up on Jonathan Perlin's comment, I opened up the June 2019 report. Table 2.2 has a list of the top specialty drugs, and you can actually go down the list of those drugs. Many of them have clear substitutes.

So I think that the analysis that you suggested is something we could do, and in looking at that list, some of these are also drugs that are probably off patent already. I think the proposal would address that issue by changing the plan liability in catastrophic.

My question, to pick up on Dana's question about behavioral impacts, I think there's some wonderfully complex behavioral issues here, the behavior of beneficiaries, the behavior of manufacturers, but I'd like to ask about the behavior of plans in response to a change

in structure.

I think you've identified some of those from a formulary management standpoint. I'm wondering if there's any lessons from the past on how plan behavior changes? We've talked about that a little bit from what happened with sequestration and Part B drugs, and I'm wondering if there's any lessons from that, that might be worth looking at, or other kinds of plan responses to changes in the environment.

DR. SCHMIDT: I don't know about the example of sequestration, but one thing that comes to mind is, you know, there was this gradual phase-out of the coverage gap, which partly was paid for by the manufacturer discount but also, at least for a while, plans had increasing viability that was going on. And I think one of the responses is in kind of recalculating what sort of benefits to include in their packages. So they previously provided more coverage in the coverage gap and among enhanced benefits, and that was no longer necessary and so they kind of re-evaluated whether to provide that or not, you know, in addition to kind of looking at the market competition to see what niche to fill.

So there would be some response that way, I suppose. I mean, I have to think through it exactly, what that response would be, but I think they might envision kind of changing not only what is on their -- well, primarily what is on their formularies. I think that is going to be the primary response. But I need to think about that more, I should say.

DR. CROSSON: Amol.

DR. NAVATHE: I would also like to echo the thanks for a great paper and I think some really nice thinking about the design here.

I want to switch gears from what seemed like a number of challenging questions to hopefully a softie. You mentioned, toward the end of the presentation, that you had talked to some plan sponsors and they had articulated this challenge with, I guess, the incentive to move away from generics at the beneficiary level for the non-LIS benes.

And so what I was wondering is, are they referencing the cost-sharing -- the fact that there is insurance itself and so there is a subsidy, in some sense -- or is there some other aspect of the benefit that they are referencing that is driving benes away from generics.

I wasn't sure what exactly was referenced by the plan sponsors there.

DR. SCHMIDT: I think I am a little perplexed about what exactly you interpreted. I think I was the one talking about conversation with plan sponsors, and the things that they mentioned to us were having to cover all the protected class drugs, some concerns about LIS cost-sharing and having the copay set in law and not being able to move beneficiaries towards generics and preferred drugs for that reason. But I am not quite following what exactly else you thought I said.

DR. NAVATHE: So I only took note, and maybe this was subsequent to that in the context of the bullet points that you guys had on Slide 17, on greater flexibility in formulary management. I think there was a comment that you made about specifically for non-LIS beneficiaries and an incentive away from generics. So that's what I was referencing, but maybe I took that out of context.

MS. SUZUKI: One thing we were concerned about is having brand-name drugs receive the gap discount and that counting toward the catastrophic threshold, your out-of-pocket threshold, may, at the margin, allow beneficiaries

to decide that taking the brand version of the drug would reduce my overall out-of-pocket spending. That's one possibility.

I think having a very low plan liability may affect plans' formulary decisions and may not put as much financial pressure on people who take brand-name version of the drug.

DR. NAVATHE: Okay. Thank you.

DR. CROSSON: Okay. I think we are going to proceed with the discussion phase now. I just have to make this point and say, you know, this is a big deal. This is, in many ways, to me, as important as, you know, the original design and passage of Part D, in the sense that if this and other changes that we have recommended, and that are under discussion at the moment, take place, I think we would have a reformulated and much, much better benefit for beneficiaries and a better financial approach for the Medicare program. So thank you again for the work.

I think what I'd like to do is have a discussion now, point to the last slide. I would add one thing to the second sub-bullet point about Medicare reinsurance and that's the question that was brought up about whether we

want to keep reinsurance at all. I think that is legitimately on the table. And so we will start with Bruce.

MR. PYENSON: Thank you very much, and I want to echo the compliments that Jay stated in the importance here. I was struck by how, Shinobu, how you began the discussion with a focus on the high price -- the issue of high-price drugs and catastrophic, and that really flows through so much of the work here, and appropriately so.

And I think the solution, in the direction that you've outlined, would really address that issue in many ways, the relief from what could be -- is often unaffordable co-insurance at the 5 percent level in the catastrophic zone for beneficiaries, as well as the incentives for higher-priced, higher drugs to be encouraged in the formulary, which is often there to, partly, to reduce premium rates and enhance competitiveness among plans. So I think that both of those are well addressed in the proposal and I really am very happy to see those developed and promoted.

I think there is another very important issue to address in catastrophic, which is the issue of the failure

of biosimilars to launch in the United States. Looking at the list of high-priced drugs, the billions of dollars that are being covered by Part D in that area, many of those drugs are considered biosimilars in other countries and are being widely prescribed and widely encouraged in many countries around the world but not in the U.S. And changing the structure of catastrophic would be only one of the solutions needed to have the U.S. come up to the level of other countries.

I think that the issue is very important because in the history of Part D, which, by and large, has been a very successful program, a big part of that success has been the growth of generic drugs over the last 10 years. And if we are going to have room for the expensive new therapies that are emerging in catastrophic we have to make that shift from old, very expensive drugs, to much less expensive biosimilar or biogenerics.

So I think some of those barriers are, I believe, clearly in the kinds of work that MedPAC can do. Perhaps patent law is not our area of expertise, but there are a number of other issues, such as correcting the misinformation about originator versus biosimilar safety

and efficacy for both clinicians and beneficiaries is an example. The issues of even nomenclature of how drugs are called and labeled. There are issues where it's a misunderstanding of the shifting, even within originator drugs over time, so that we ought to think about originator drugs as being biosimilar to themselves. The issue of international reference, where the reference for a biosimilar can't be some other country's originator drug.

There is a whole series of issues like that that are obstacles, and I think those are things we can identify and quantify, to some extent, because I think it is really the tip of the iceberg to a potential cost savings to beneficiaries and to the Medicare program to look at the existing biosimilars that are not being prescribed because of the catastrophic structure. The bigger portion of the iceberg is a wave of new biosimilars that can reduce spending.

But I really want to compliment you on the solid work and laying this out very systematically. I think this is really key to the future of Part D.

DR. CROSSON: Thank you, Bruce. Paul.

DR. PAUL GINSBURG: Yes. I wanted to first make

some comments about the context of this. We got Part D as a result of a longstanding debate whether Medicare drug coverage should follow the single payer model, the rest of Medicare, or whether it should use private plans and compensation, and the decision was made to use private plans and compensation. But a combination of the evolution of a drug market, where so much more of the money has moved into very high-cost drugs and some, perhaps, not-so-wise decisions about taking additional contributions from pharmaceutical companies for the ACA and then the Bipartisan Budget Act of 2018, in the form of coverage gap discounts, as opposed to some other place, have, for the most part, you know, blunted, removed a lot of the incentives that presumably the country was looking for in going for private plans, to run the Medicare drug benefit.

So, in a sense, it is nothing that anyone did particularly intentionally, but I think we are at a bit of a crisis where we have really disarmed our private competitive market-oriented mechanism and it can't do its job anymore. So that is just the context. I think it's consistent with everything you've done.

I'm very enthusiastic about the course you have

charted out for us, and I would be very intrigued in doing more on reinsurance. In other words, a quick first step would be taking it down from 80 percent to 20 percent. That is clearly a desirable change. But I think you mentioned, Rachel, that this co-insurance does not resemble typical reinsurance in insurance, which is usually focused on the costs of individuals who have extremely high spending as opposed to a broad part of the population that gets into this catastrophic range. And it might be useful to think about an idea, some ideas to put in real reinsurance in this program instead of what goes under the name of reinsurance that have now, or might have in the future.

DR. CROSSON: Thank you. Okay. So I see Dana, Jon, David, Pat, Jaewon, and Kathy.

DR. SAFRAN: Thanks. Just two thoughts to add into this conversation. So the first one is back on what we were talking about in the last round, which is there is tremendous complexity to the behavioral economics here, and, you know, I couldn't help being struck as I was reading the chapter at some of what you were laying out as the perverse incentives that have played out, as, why

didn't we think of that?

So what I want to suggest is it would add to this chapter if we had some kind of table that explicitly lays out, for manufacturers, for plans, and for beneficiaries, what do we think each of the main changes that you are proposed create in terms of behavioral incentives. And maybe even what would be the unintended consequences that ought to be monitored for.

My second comment relates to the question I asked in the question round, about premiums and increases there. It does strike me, from my time in a commercial plan, that it might be useful to consider one additional element here, and that is to have some threshold on the allowed percent increase in premiums from year to year. And, you know, in Massachusetts, this was done through a policy level at the state level, and to around drugs but around health care costs overall, and it was placed -- the state GDP was used as the percent allowed growth, and every provider and every plan was held accountable to growth no more than that. And it was and is a quite interesting and effective lever.

And I can't help but think of that as a potentially important lever here, because of the pipeline

and the prices attached to that pipeline as something that, you know, we were concerned about, all of us concerned about, read about every day. And it strikes me that plans ought to be playing the role of deciding what gets in and at what price. And by having some limit on how much overall costs can grow and premium growth caps would represent a pretty important part of that limit, we might put plans in a role of needing to be a really thoughtful gatekeeper about what new therapies get in at what price. Thanks.

DR. CROSSON: Thank you. Jon.

DR. PERLIN: Thanks. I am exceptionally aligned with Dana's first point, and on page 23 you write that because manufacturers would be able to estimate effects of the gaps discount on the net revenues, they may still increase prices to compensate for the cap discount liability. And I couldn't agree more with the idea of tables. In fact, my point is, just taken to its extreme, I was wondering if a manufacturer would ever withhold from this marketplace a particular drug so as not to be limited. So some of the incentives I think maybe could be played out to their logical conclusions, just as, you know, on a

simple financial basis. Thanks.

DR. CROSSON: Okay. David and then Pat.

DR. GRABOWSKI: Great. Thanks. And let me just agree with you, Jay. This is a really big deal. And I really believe it is a first step, it is a necessary step, but I don't believe it's sufficient. I think you do a really nice job in the chapter and in the presentation about if we are going to ask plans to take on more risk, we really need to give them more tools to manage that risk.

And so I really like the idea of greater flexibility in formulary management, and, indeed, if there is going to be kind of more risk for plans, and Dana mentioned unintended consequences, but we really need to guard against risk selection in this kind of model.

And so you mentioned the idea of further recalibration of the risk adjustment model, and there are probably other steps we might think about in future meetings around if we are going to ask these plans to take on more of that risk then I'm really worried about kind of increased incentives around risk selection. But I really like the direction this is headed.

I wanted to touch on the questions you asked

around the catastrophic phase. Paul already touched on this, but I would love to see us move towards a reinsurance model that looks more like what's seen in the commercial and employer health plans. It has never made sense to me -- maybe it did in the early stages of Part D, how we do reinsurance here -- but as the model has evolved, and you made a really good case, both in the reading and in the presentation, why we might want to rethink this. And I am very much on board of trying to move towards much more of a reinsurance model that looks like the private side. Thanks.

DR. CROSSON: On this?

DR. PAUL GINSBURG: Yeah, on this. I just wanted to make mention that when Part D was legislated there was a lot of worry about what if we do this and nobody shows up, meaning no plans show up. So a lot of things were done to make sure that plans showed up, and, in fact, tons of them showed up and have stayed.

DR. CROSSON: Pat.

MS. WANG: So I also want to compliment you and echo the other Commissioners on just how thoughtful and how much care is obvious in how you've kind of furthered the

discussion around here.

As context, I want to really endorse Bruce's comments around biosimilars because I think that the work here, which I agree with David wholeheartedly needs to continue to evolve, is very elegant in shifting risk among the current parties. The frustration is that we hope that through behavioral economics it will have some impact on actual prices. And I think it's speculative how much that will actually happen, and so I think that Bruce's comment about Medicare's role in sort of stimulating additional competition on the manufacturer side is critically important and will have long-range consequences for, you know, the viability of the Medicare Part D benefit. I think it's squarely in Medicare's playbook to sort of be active here. So anything that we can do in that area is important.

You know, one of the concerns that I want to add to the questions about, you know, unforeseen consequences and incentives and impacts is with the shift in risk. I do have concerns about smaller plans -- okay? -- and that may be a consequence that the country will deal with, that everything will migrate into the dominant eight to ten that

are now dominating the MA market as well as the Part D market. But I think we should have eyes wide open about that. And that is why, to echo, I appreciate very much the inclusion or the underlining of the importance of both risk adjustment and, I would add, SES adjustment to that. Even within the LIS population, there's different gradations of LISness.

Specifically on the questions and the content of the paper, I still would like to at least explore continuing the manufacturer discount in the coverage gap. And, Shinobu, I heard your concern about wanting to encourage in particular therapeutic substitutions where appropriate. I'm just not sure at the end of the day, again, the new benefit of what outweighs what, and my instinct would lean towards keeping manufacturers' skin in the game at all levels of the benefit design, and certainly there are many brands and increasing numbers of single-source and orphan drugs for which there are no generic substitutions. And it just feels like letting them out of the coverage gap is -- it just doesn't seem right.

I'd also like to explore applying the manufacturer discount to high-cost generics. It is

definitely -- there is a subset of generics that price escalation is incredible, and they rival the cost of brands, and sort of not somehow figuring out a way to put them into the mix seems like a miss.

In terms of the cap on beneficiary spending as well as Medicare's reinsurance, starting with Medicare's reinsurance, the thing that concerns -- I think it's worth exploring seeing whether there's a reinsurance model that is similar to the commercial. You know, reinsurance for drug prices is like dollar for dollar. There is no, like, insurance deal when it comes to drug pricing. So I'm not sure how great a solution that is actually going to prove to be, and Medicare's reinsurance, which I think has to stay at a minimum of 20 percent, is realistic for, I think, what it would cost in the private market. It's pretty much a cost pass-through.

I also candidly think it's important for Medicare to have skin in the game so that it continues to push for bigger solutions on the problem of drug pricing for beneficiaries as well. I mean, I think there are pros and cons that you have mentioned in the paper in terms of removing beneficiary incentives, basically the problems

that we see with the LIS population and indifference to the price of the drugs that people are taking. For good reason they don't have money to pay differential co-pays, but, like, beware that phenomenon when you remove price sensitivity.

We talked about risk adjustment, and, again, I really thank you for emphasizing that, and I'd throw SES in there.

The final thing that I would say -- and, again, I appreciate very much that you are going to have a separate look, Eric is, on the LIS population specifically. And I guess I would just as a threshold question ask whether it is an automatic thing that we should be seeking to standardize the non-LIS and the LIS benefit. The LIS population is just different. There's zero cost sharing to a couple of bucks. I mean, it's true, it's really a problem. It's the same cost sharing for, you know, a $100,000 brand drug and a $10 generic, zero, a dollar. The problem is that, you know, for the population obviously it's not like you can vary cost-sharing amounts, which for the more middle-class, more affluent populations, absolutely something that will happen. If this type of

proposal goes through, plans will seek ways to tier the benefit, change formularies, and try to bring the beneficiary into the equation more actively about which drugs they choose. Those tools are completely lacking for the LIS population, for good reason, and, you know, if you raise their co-pays, they're just going to stop taking the drug.

So I think that it is -- and I can tell you that this is absolutely true because I know from experience. It's really a dilemma, and so I would urge us maybe to step back from the assumption -- like going down this pathway for the restructure of Part D, it is one thing for the non-LIS population. But for the LIS population, it doesn't feel quite satisfying to me to sort of say let's just treat it exactly the same and the plans take on all the liability, because you can't give plans enough tools in the world to be able to deal with the issue of the lack of flexibility for the LIS population.

Thank you.

DR. CROSSON: Yeah, I just want to make one comment. So, Pat, just on the point you made about retaining some sort of manufacturer discount in the

coverage gap, I just want to be -- I think what you were saying was not keep it overall, but keep one -- keep some sort of one and focus it on drugs were there's no generic substitution, no generic available, no commonly used therapeutic substitution, and no biosimilar. Is that right?

MS. WANG: I think that's a very fine needle to thread, you know, maybe in an ideal world, but absent being able to, you know, sort of cut it that fine, I would just say keep it. Don't count it towards the out-of-pocket threshold. It's just get the manufacturers to split the cost somehow with the plans in that layer.

You know, I know that the theme here is you want to encourage -- that it sends the wrong pricing signals and so forth, but there really are a lot of single-source brands that are either clinician preference or have no generic substitution that are going to be at an increased initial coverage limit. I just feel like the manufacturers should continue to have skin in the game at every level.

DR. CROSSON: Okay. I just want to be clear what you're saying. Amol, on this? And then Paul on the same.

DR. NAVATHE: Yeah, so I just wanted to pick up

on the last point that you made, Pat, where you -- Pat was making the point that we should be mindful of sort of normalizing the benefit design across LIS and non-LIS beneficiaries. And the point I wanted to make there I think is just worth us looking further into is at different income strata we might see differential responses to increases in premium versus increases in cost sharing, you know, conditional participation. And if we're thinking about this from the perspective of access and then, you know, actual choices around filling medications, there's a layer there that might actually defer quite a bit. And so while I think philosophically I agree with the idea that you're advancing, which is we want -- you know, regardless of LIS or non-LIS, we want people to make cost-conscious and cost-efficient decisions, and that would improve the sustainability of the program in general. I think whether a unified benefit structure actually makes sense across those two strata is to me still an open question, and we might want to be careful about those design elements, particularly if we're going to end up raising premiums across the board.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: I just want to follow up on a different Pat comment, the one she made in response to you, Jay, it's that as far as where to be placing the manufacturers' discounts. And, clearly, you know, the set of drugs that are mostly in the coverage gaps and those mostly in the catastrophic are different drugs. You know, the catastrophic is a lot of the rare disease drugs; in the coverage gap, a lot more of the chronic disease management drugs. And it certainly does warrant some thought as to, you know, maybe it's been imbalanced and we need to shift towards more of a tax on the rare disease drugs because they've been given so many advantages in the approval process, et cetera. But we should be just very aware of the fact that these are different drugs.

DR. CROSSON: Okay. So we've got Jaewon, Kathy, and Larry, and Karen and -- yeah, I got you. Sorry. Jaewon, then Kathy, Larry, and Karen.

DR. RYU: Yeah, so I think the concepts I would agree with as well. I think the design is a good one. To Pat's point on keeping the manufacturers somewhat involved or engaged in that coverage gap, I think that resonates with me.

One of the comments I put down was, you know, my observation seems like part of the complexity of how this program was created created some gamesmanship around different tranches have different splits of who bears risk. And the more -- just from a high-level philosophy standpoint, it feels like the more we can keep consistency across -- and maybe percentages themselves don't have to be exactly the same, but all the actors, I think we might be better off if they all have some skin in the game at each tranche. And I think that kind of goes with Pat's comment around the manufacturers still playing in that coverage gap space if there's a way to architect it that way.

The second comment I had was around concentration in the health plan market. In the readings, there's a comment around PDP market, extremely concentrated; MA-PD market, still concentrated but not as much. And I think you had said that 74.5 percent would be the subsidy, but now we'd convey it through capitation. I think if you follow that through -- and I'm not sure, but I think it's worth looking at -- that would mean the smaller plans are bearing greater risk, and just sheerly from a mechanics standpoint with risk-based capital requirements at

different state regulatory environments, there's a good chance you're pushing out a lot of smaller plans simply because they don't have the capital structure to support staying in the business of Medicare Advantage, which I think would not be a good thing. It also wouldn't be consistent with other discussions we've had in this group from the last cycle around how we look at five star and quality measurements and the bigger multistate plans being able to consolidate contracts and somewhat game the five star model. And we decided that that wasn't in the best interest, and this feels like a similar path we're down on.

And so however we could assess whether or not there truly would be an unintended consequence that would further concentrate the marketplace, I think that's got to be part of the analysis.

DR. CROSSON: Okay. Kathy.

MS. BUTO: So I heartily support the general approach, and I think beneficiaries would really welcome having a simplified benefit. Right now it's very complicated and hard for individuals to understand, and it's certainly hard to modify their behavior to meet the structure.

One thing I am puzzled about is I don't think there is a coverage gap anymore under this proposal. Am I correct in that?

DR. SCHMIDT: Under the proposal, correct.

MS. BUTO: So when people say continue the discount in the coverage gap, I think they mean start the discount from the very beginning all the way through the catastrophic phase, which I think that's what you're talking about. I think that actually is going to lead to higher prices, launch prices throughout.

The other thing I'm not sure about -- we really need Amy for this -- is to understand the dynamics of what that does to the interaction between the drug plans and manufacturers around rebates and their own discounts. So I think it sounds right, but, on the other hand, I'm almost 100 percent sure it would lead to higher prices. And, two, I don't know how that undermines whatever the dynamic is now between manufacturers and drug plans. So I think we just have to be aware of those things.

The other thing I would really ask that we be concerned about is when we go to look at setting the threshold or thinking about a threshold for the

catastrophic part of the benefit kicking in, that we try to factor in for the non-LIS where we think drug costs are really so burdensome that they really need to be attended to. So we need to look at that I would say almost before we do all these other calculations to figure out where just logically there should be a threshold for beneficiaries having to bear 25 percent of the cost, and -- because that was the point of the catastrophic threshold, is to protect beneficiaries.

I think the other policy that I agree with Pat on is we should look at, at least for high-cost generics, some policy there. Since the manufacturer discount in the catastrophic phase is unlimited, again, we could maybe address our concern about pricing by looking at those that meet some threshold or where the prices seem to escalate. I mean, there might be some factors we'd want to think about for modifying or having different manufacturer discounts depending on certain behaviors, pricing behaviors that we think are important.

I don't know what those are, but I just feel like we ought to, for restructuring the benefit, which I think we are, that we ought to look at a number of factors like

that. But I would start with where should the threshold be for beneficiaries and try to figure out what a reasonable tradeoff of liability is below the threshold and above among the different actors.

DR. CROSSON: Thank you, Kathy. Larry.

DR. CASALINO: Yeah, just one quick comment about the use of the word "reinsurance," and this goes back to what Paul said at the very beginning, and David, and you mentioned, Rachel, at one point that it's not really reinsurance. It's cost-based reimbursement. So I think that really matters. The word "reinsurance" is used in the presentation here today in two ways. In the last slide here, it's used really kind of in the cost-based reimbursement sense, which is kind of a novel sense, really, for the word "reinsurance." And then on Slide 15, for example, I think it's used more in the traditional sense of, you know, reinsurance for high-cost beneficiaries, say, rather than for all your cost, which is cost-based reimbursement.

So I think it's generally -- I think you should do what you can -- you're very aware of this issue, I'm sure -- I know, and that the more you can do to clarify

that in what you do I think will really be important. First of all, it's never good to use the same word for two very different things. But, secondly, by doing that and by using the word "reinsurance" as a synonym for cost-based reimbursement, I think it really changes what the nature of the debate will be, and it's giving away a lot, right? Because it's like reinsurance good, cost-based reimbursement bad. Right?

And so I think I would really try to separate those two explicitly. I know the term "reinsurance" has been used -- not by chance, I don't think, historically -- to mean really cost-based reimbursement. But this is an opportunity to try to push at that a bit. I'd really encourage you to try to do that and not use the same word for two different things.

DR. CROSSON: Karen.

DR. DeSALVO: Thank you. This really was an excellent chapter, and I found it to be very responsive to some of our prior questions, so thank you for that. I also want to thank you for clarifying some areas really nicely like the cost-based reimbursement, reinsurance, and some of the implications.

I want to quadruple down on Dana's point about the importance of having clarify around the consequences, including the unintended consequences. As I read this, I did see that there was going to be likely market consolidation and the implications of that for beneficiaries and on drug pricing, just it would be helpful to think that through.

The second point I wanted to raise for you all in terms of tools as you start to think about formulary management tools, in addition to maybe some that we've had historically, we have technology available to us, particularly the Office of National Coordinator and CMS interoperability rules that are still not finalized, but that were proposed, provide additional opportunity for more seamless interface to do point-of-care decisionmaking about formulary, cost of drug, not only for the clinician but also for the consumer. And so as a policy matter, CMS is pushing to leverage technology a number of ways, but that could be an additional opportunity for the private plan.

DR. CROSSON: Okay. Thank you. Very good comments. Excellent presentation. Again, we look forward to your coming back to us with additional work, and we will

move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. So for the second item of this morning, we're going to be taking a look at some potential changes to Medicare reimbursement for dialysis facilities, and Nancy and Andy are here. Nancy has got the microphone.

MS. RAY: Good morning. During today's session, Andy and I will be building on work from our April 2019 presentation in which we discussed how the ESRD prospective payment system, the PPS, pays facilities that are low volume and rural and an alternative approach that may better target low-volume and isolated facilities that are necessary to ensure beneficiaries' access to care.

We seek comments from Commissioners on the material presented today. This analysis is part of our work to help improve the accuracy of the ESRD PPS.

So several factors motivated our work to develop an alternative to the current low-volume and rural payment adjusters.

First, last December and January, Commissioners raised concerns about the disparity between urban and rural

facilities' financial performance under Medicare. What really influences the Medicare margin is treatment volume. The Medicare margin is decidedly lower for facilities in the lowest volume quintile than facilities in the top volume quintile.

Second, the current low-volume payment adjustment, the LVPA, and rural payment adjustments do not always target low-volume and isolated facilities, which are critical for beneficiaries' access.

Lastly, the design of both adjustments does not meet the Commission's principles on payments to rural providers.

Since 2011, the ESRD PPS payment bundle includes drugs and laboratory services that were previously paid separately by Medicare

For each covered treatment that a facility furnishes, its base payment rate is increased using the patient-level and facility-level factors listed on the slide. The current payments that are added onto the adjusted base rate are also listed on the slide.

Today we are discussing issues with the two separate facility-level adjustments for low volume and

rural location. Over the next year, we expect to come back to you to discuss other concerns with the PPS.

Guiding our analysis is the very strong correlation between a dialysis facility's total treatment and Medicare average costs. This figure shows the 2015, 2016, and 2017 cost per treatment, adjusted for differences in the cost of labor.

Facilities on the left-hand side of the figure furnishing under 6,000 treatments have much higher costs per treatments than facilities on the right-hand side of the figure. Since 2011, when the ESRD PPS was implemented, we have consistently found that cost per treatment decreases as the number of treatments a facility furnishes increases.

In 2017, about 5 percent of facilities of the roughly 7,000 dialysis facilities in 2017 received the LVPA, which increased facilities' base payment rate substantially by 23.9 percent.

Eligible low-volume facilities are those that furnished 4,000 treatments in each of the three years before the payment year in question. The LVPA only factors in the distance to the next facility if both facilities are

owned by the same parent organization and within five miles from one another.

We have a couple of concerns about the LVPA's design. First, some facilities are receiving the payment adjustment even though they are not isolated. In 2017, 40 percent of LVPA facilities were located with five miles of the nearest facility. An LVPA facility can be located next door to another facility that could be big or small as long as they are owned by different parent organizations.

A second concern with the low-volume adjustment is that it uses only one volume threshold of 4,000 treatments. This so-called "cliff effect" might be encouraging some facilities to limit services. And the current low-volume adjustment does not address the higher cost of facilities with volumes of between 4,000 and 6000 treatments per year that I showed you on the previous slide.

So, in this figure, the blue bars are the freestanding dialysis facilities that received the low-volume payment adjustment in 2017. These facilities furnished fewer than 4,000 treatments in 2014, 2015, and 2016.

The two blue bars on the left show the facilities getting the adjustment that were within 5 miles of the closest facilities, demonstrating that the LVPA does not always target facilities necessary for ensuring access.

The red bars are facilities that furnished under 6,000 treatments in 2014, 2015, and 2016. Some of these facilities, the red bar facilities, received the LVPA. However, some did not qualify for the adjustment. Recall the prior graph showing that facilities with 4,000 to 6,000 treatments have relatively high average cost per treatment.

So please focus on the facilities in the yellow rectangle. These are both low-volume and isolated that is more than 5 miles to the closest facility. Note that two-thirds of facilities providing less than 6,000 treatments in this yellow rectangle did not receive the LVPA. This is the difference between the red and the blue bars in the yellow box.

Moving to the 0.8 percent rural adjustment, this is applied to the base rate of all facilities located in rural areas. About 18 of all facilities received this adjustment. Our concern here is the targeting of this adjuster.

In 2017, about 30 percent of rural facilities were located within five miles of another facility, and in 2017, about half of all rural facilities were higher-volume facilities, furnishing more than 6,000 treatments, and had lower adjusted cost per treatment than low-volume facilities located in rural areas.

As we evaluated the ESRD low-volume and rural payment adjustments and considered alternative approaches, we were guided by the principles that the Commission developed to evaluate rural special payments over the course of several meetings and published in 2012.

The Commission stated that payments should be targeted toward low-volume isolated providers, that the magnitude of payment adjustments should be empirically justified, and that the adjustments should encourage provider efficiency.

DR. JOHNSON: Now we're going to review the low-volume and isolated, or LVI, policy option that we introduced in April. The LVI incorporates the Commission's principle that the rural payment adjustments be targeted to facilities that are both low-volume and isolated. The LVI is a single adjustment that would replace the current low-

volume and rural payment adjustments.

To be eligible, first, facilities must be farther than five miles from the nearest facility to be considered isolated. Second, facilities must consistently exhibit a low volume of treatments during each of the preceding three years.

The LVI would expand the definition of low volume to three categories. This expansion would mitigate the cliff effect of the current low-volume adjustment and would better account for the higher cost of relatively low-volume facilities. Facilities eligible for the LVI would provide fewer than 4-, 5-, or 6,000 treatments in each of the three preceding years and would be assigned to the lowest category for which they are eligible.

The next slide shows how the LVI adjustment does a better job of targeting facilities that are low volume and isolated and, therefore, important for maintaining access to dialysis.

This figure shows the number of facilities eligible for the current low-volume adjustment in blue and the current rural adjustment in red, grouped by the number of dialysis treatments provided in 2017.

Some facilities providing more than 4,000 treatments in 2017 received a low-volume adjustment because eligibility is based on the three preceding years. These facilities would not be eligible in the following payment year.

The tallest red bar on the right shows that the majority of facilities receiving the rural adjustment were not low volume.

The green bars show the number of facilities that would have been eligible for the LVI adjustment. In the lowest treatment category, the isolation requirement would have resulted in slightly fewer facilities being eligible for the LVI than the current low-volume adjustment.

In the 4- to 5- and 5- to 6,000 treatment categories, the expanded definition of low volume would have resulted in more facilities being eligible for the LVI than the current low-volume adjustment.

Among rural facilities, the LVI adjustment would concentrate payments in those facilities that are low volume and isolated.

To estimate the size of LVI category adjustment factors, we conducted a regression analysis of the average

treatment cost in freestanding dialysis facilities. Our method differs from CMS's approach which splits total treatment cost across two equations -- one at the facility level and one at the patient level. The text box in your mailing material discusses our concern with using a two-equation approach.

Our method uses a single facility-level regression equation and included explanatory variables, similar to those used in the ESRD PPS model; however, the key difference is that replaced the current low-volume and rural variables with the LVI category variables.

This table shows our estimate of the payment adjustment factors for each LVI category. All estimates are statistically significant.

The LVI Category 1 adjustment factor would increase the Medicare base rate by about 31 percent. The size of this adjustment is similar to our estimate of the current low-volume adjustment factor, which has the same volume criterion.

For facilities that are newly eligible for the low-volume adjustment, those in LVI Category 2 or 3, the Medicare base rate would increase by 27 and 19 percent,

respectively. These results demonstrate that there would be a benefit to expanding the definition of low volume for facilities that are isolated.

We know that the relative size of the three LVI coefficients aligns with the cost and volume relationship that Nancy showed you earlier. That figure is repeated here.

In this version of the figure, the gray column covers facilities that are eligible for the current low-volume adjustment. However, as Nancy noted, 40 percent of these facilities are located within five miles of another facility and would not be eligible for the LVI adjustment.

The LVI adjustment would expand the definition of low volume to cover additional facilities with relatively low volume, as shown in the green column, as long as those facilities are located farther than five miles from the nearest facility.

We also estimated how average Medicare payment rates would change for freestanding facilities by replacing the LVPA and rural adjustments with the LVI category adjustments. Payment rate changes depend on the facility's eligibility for each of the adjustments.

For about 180 facilities that are eligible for Category 1 LVI adjustment, payments would remain roughly the same, as this adjustment would basically replace the current low-volume adjustment.

For about 280 facilities that are eligible for LVI Categories 2 and 3, payments would increase by about 18 percent, as these facilities are newly eligible for a low-volume adjustment.

For about 260 facilities that are currently low volume, these facilities are located within five miles of another facility. Such facilities would not be eligible for a low-volume adjustment and would see a payment decrease of about 20 percent.

The current low-volume adjustment subsidizes low-volume facilities that are near other facilities. One goal of the LVI adjustment is to improve the value of Medicare spending by supporting only low-volume facilities that are essential to maintain access to dialysis care.

In summary, based on the Commission's rural payment adjustment principles, we are concerned that the current low-volume and rural adjustments poorly target facilities that are both low volume and isolated.

We have discussed replacing the current low-volume and rural adjustments with a single-payment adjustment for facilities that are both low volume and isolated.

Second, the LVI payment adjustment would consider a facility's proximity to any other facility, not just those under common ownership. Some facilities receiving the current low-volume adjustment would not receive the LVI adjustment, as they are located near other facilities.

Finally, the LVI adjustment would expand the definition of low volume. The proposed three categories are designed to mitigate the cliff effect and to account for the higher treatment costs of facilities providing between 4- and 6,000 treatments per year.

We would appreciate feedback on aspects of the LVI adjustment such as whether five miles is an appropriate definition for isolated facilities and whether additional LVI categories are necessary.

Based on Commission feedback, we can develop a recommendation for December that would replace current low volume and rural adjustments with an LVI adjustment in the ESRD PPS.

In the spring, we will turn out focus to other aspects of the ESRD PPS, which include modeling alternatives to the current patient-level adjustment factors and revising the method used to estimate those factors.

We look forward to your comments, and I'll turn it back to Jay.

DR. CROSSON: Thank you, Nancy and Andy.

I'd like to start with one question myself. One possible ramification of adopting the LVI recommendation would be consolidation of certain facilities, let's say, within five miles who don't qualify for the low-volume adjustment. You could imagine market dynamic leading to consolidation of those facilities.

This presentation is not focused on quality, but could you remind me? Do we have --and what is our thoughts about the relationship between -- the number of dialysis procedures and quality?

MS. RAY: Oh, I'm sorry. The volume and quality?

DR. CROSSON: No, I'm sorry. Volume and quality.

MS. RAY: Okay. I did not quite follow that. Thank you for the clarification.

I would have to get back. That's a very good question.

DR. CROSSON: Okay. I'm sorry. It's not part of the presentation.

MS. RAY: But let me just say this. In terms of -- I'm just trying to triage my thoughts here. In terms of CMS's Quality Incentive Program, because of the sample size needed to be part of the QIP, the ESRP QIP, we may not have some of the quality data for those facilities.

What I can do is get back to you and look at the availability of QIP data and look at the availability of dialysis, facility star data, to answer that question.

DR. CROSSON: Right. So the point I was getting at is if there's going to be consolidation, good, bad, what's the tradeoff? Anyway, to the certain extent we can look at that, it would be great. If we can't, we can't.

Larry, did you want to make a point on this?

DR. CASALINO: Yes. It would be interesting to know, I think, of the low-volume facilities that are close to another facility, what is their quality? Pretty much what Jay is just asking, I think.

But then, also, it would be interesting to know

the low-volume facilities that are within five miles of another facility, who owns them? There are really two big dialysis providers in the U.S., and we may or may not think that them getting even bigger is a good thing.

One possibility, these are sitting near little mom-and-pop dialysis facilities that have low quality, and they'll disappear. And the industry will be more consolidated. We may not like that, but we may think okay.

By the way, to really try to understand the consequences of this, I think we would need to know both what is the quality and also what's the ownership distribution.

Other than that, this is a very, very lucid presentation and elegant and simple solution. The complexity of this seems so much less than what we were just talking about. I like this one.

[Laughter.]

DR. CROSSON: Right. This is a positive comment, by the way.

Karen, did you want to comment on this as well?

DR. DeSALVO: I do have something on implications, but I have another point.

DR. CROSSON: Go ahead.

DR. DeSALVO: I went pretty micro on you guys on this on the question of consolidation, and I wondered about impact on beneficiaries who live near a state line and if there are implications for closure, particularly if they were dually eligible or if there are some other payment considerations. And I just don't have enough knowledge to know what that might mean, but maybe it's only a handful. But perhaps that's an exception to the rule kind of situation.

The other question I had, do we have any idea, by the way? Do we know? Do you have a map of what we think the --

MS. RAY: No, we don't, but we will.

DR. DeSALVO: Okay. And my other questions was about benefits that are offered by dialysis units. So five miles, I would appreciate you all getting more narrow on the radius, but the question was, Do dialysis units offer transportation to folks who don't have it otherwise? Because in rural communities, there's unlikely to be public transportation. They may not have a car or gas money or even a bicycle.

MS. RAY: Right. So some dialysis facilities do provide transportation to beneficiaries, yes. And we were mindful of, you know, well, should it be 5 miles? Should it be 10 miles? And given that, you know, a majority of patients right now do go to the facility three times a week, over time -- you know, there's the expectation that home dialysis will increase, but there still will be a population of incenter patients. And there is literature, you know, showing that at least for certain patient populations that dialysis adherence is affected by the travel distance to the facility.

So current CMS uses that 5-mile in its low-volume adjustment, and we thought it was a good starting point.

DR. CROSSON: Okay. Let's see. I've got -- Larry, we already got you. So we've got David next, and then let's go Jaewon, Sue, Dana, Marge. Got it.

DR. GRABOWSKI: Nancy, I think you already started to answer my question. I was going to ask you about this 5-mile cutoff, and I know that is what CMS has used. But I just was wondering if there was more empirical support for why 5 miles. And, 25, to your point, strikes me as too wide. I have no reason to think 5 miles is the

right or wrong cutoff. I'm just curious, have we, as a Commission, thought about sort of looking at variation around that, in travel distance, and whether 5 miles is the right number?

MS. RAY: Again, internally, the discussion was balancing the need to be consistent with the Commission's principles on focusing on low volume and isolated facilities, and also on patients' travel time to and from the dialysis facility. We certainly could model other, you know, distance thresholds, just to show the effect.

I can also go back and include some of the literature on patient adherence and travel time in our next go-around.

DR. GRABOWSKI: And this is just a quick -- oh, I was just going to -- go ahead. Sorry.

DR. CROSSON: Yeah, I was just going to comment. I mean, this has come up before, the issue of distance versus travel time, and obviously travel time in a rural setting, you know, with a highway available, versus travel time in Manhattan at rush hour, those are two different things.

I think the general -- and recognizing that, I

think the general thought we have had, as we have discussed this previously, on this and different issues, is while, you know, that's a valid consideration, actually trying to craft that into some kind of law would be very difficult, because travel time varies by the time of day, et cetera, et cetera. So it's hard to do.

DR. GRABOWSKI: That makes sense that a fixed road mile cutoff would be the right approach.

I guess the other thought -- and maybe I've taken too much economics -- is there any thought that the industry is going to adjust to this, in terms of their decisions about how to locate and where they sort of place themselves, vis-à-vis competitors, or is that something that is just sort of they're fixed, or you can just sort of tell me I've taken too much economics, and that's fine.

MS. RAY: Right. I mean, it's a complicated question, and I know some of the earlier questions about the potential for consolidation under the LVI. I mean, I think it's a multifaceted decision about, you know, if the LVI was implemented what would providers' reaction be? I mean, for example, on the one hand there is a movement towards more home dialysis, and we have heard a couple of

the larger providers announce that they may be opening fewer de novo facilities in the next several years.

Another reaction might be for the facility getting the LVPA right now, who would no longer, under this policy, that facility may decide to expand their treatment volume. I mean, they could be one of those providers that may be limiting.

I think another factor in terms of really nitty-gritty issues is sort of the real estate. You know, do they own? Do they lease? When does the lease come due?

So I think it's a very multifaceted decision.

DR. CROSSON: Okay. Marge.

MS. MARJORIE GINSBURG: Thank you for this report. It was clear, I could understand it all. I appreciate that.

Just a couple of very quick questions. Have many facilities closed due to insufficient payments? That's question one. And sort of linked to that is, are there any commercial patients? I mean, by the time people have end-stage renal disease are they virtually all on Medicare, and therefore there is no role for commercial insurance and what they may be paying for the services, for their

members? So I was just curious whether there's any role for commercials.

And then the last question is -- and this is kind of related to the quality issue -- has there been any evidence of inaccurate upcoding of patients? And I realize this was not about the quality of the information that we're getting and the legitimacy of payments, but I was curious whether, in your work, you've also been looking at the issue of upcoding. Thank you.

DR. JOHNSON: I'll address the last one and then Nancy will address the first two. We haven't found issues of inaccurate upcoding but there is a related diagnostic coding issue, which we're going to get to in the spring, the comorbid conditions that are part of the patient level factors. So that's something we will come back to, but it's not the same situation as what we've heard of as upcoding in other sectors, like MA or PEC.

MS. RAY: Okay. In terms of your first two questions, are patients all on Medicare? No. There are some commercial patients. And the percent of commercial patients, that will vary across facilities. And that would probably be another factor in a facility's decision, that

is getting the LVPA, who wouldn't under this policy, whether or not -- you know, what they would do.

In terms of closures, we report on that every year in our adequacy analysis. That's upcoming in December. We see few closures from year to year, and there has been a net increase of facilities in each year.

DR. CROSSON: Yeah, I would add one thing, and my understanding is that commercial payment rates are generally in the range of four times what Medicare reimburses. So while the number is small, for some facilities the impact is significant.

MS. MARJORIE GINSBURG: [Off microphone.]

DR. CROSSON: Jaewon.

DR. RYU: Yeah. I just had a quick question around, is it contemplated that this approach would be done in a budget-neutral way, and if not, what is the anticipated net-net impact to the program?

DR. JOHNSON: We would anticipate it being done budget-neutral, as all updates to the ESRD PPS are conducted. I think it's hard to say exactly what the impact would be from this change. Roughly, the amount of money going to the two current adjustments and the three

adjustments as we have proposed, are in the same ballpark. But it also might depend on if we consider other changes to the patient-level factors. All of those factors are estimated jointly in one regression model, so we think that it would be a small impact if it was on its own, but that is sort of a counterfactual. It is not necessarily what the case would be if CMS were to estimate this through their own process.

DR. MATHEWS: But the intent here, to be clear, is that this would be done in a budget-neutral manner.

DR. CROSSON: Sue.

MS. THOMPSON: Back to page 10, in the fourth set of data there, what do we know about the characteristics of those facilities that would be obviously negatively impacted by this set of recommendations? And specifically, kind of building on that question, how many of these facilities are hospital-based? I mean, we assume that these two big players in this business are, you know, the predominant players, but how many of them, particularly in rural locations, are running out of critical access hospitals and are hospital-based facilities? Do we know?

DR. CASALINO: [Off microphone.]

MS. THOMPSON: I am asking, in this population of all of these facilities, how many of them are hospital based?

DR. JOHNSON: In our analysis we have looked only at the freestanding facilities. We can provide more information about the hospital-based facilities.

MS. THOMPSON: Okay.

MS. RAY: Also keep in mind that hospital-based facilities represent 6 percent of all facilities and only 5 percent of all Medicare treatments.

MS. THOMPSON: Of all?

MS. RAY: Yeah, of all Medicare treatments, that's correct, and that this share has been generally going down over time.

MS. THOMPSON: And do we think that those percentages play in this subset as well, in this low-volume and rural set of facilities?

MS. RAY: Again, we will come back with you and address that.

DR. CROSSON: Okay. Dana.

DR. SAFRAN: Thanks. I have a couple of questions that are in the realm of trying to understand

home versus center-based dialysis. Is home-based dialysis volume included in the volume for the centers that you're describing here?

MS. RAY: Yes, and certain centers can just be home-only facilities.

DR. SAFRAN: Okay.

MS. RAY: Correct.

DR. SAFRAN: Okay. And do we know anything about the differences in the cost profile, you know, cost per treatment for home versus center-based?

MS. RAY: No, we don't, and I think -- looking at the data on the cost reports and trying to compare in-center and home is a little bit tricky, because of the relatively -- at least, you know, up until this point, small sample sizes, small number of facilities that furnish high enough volumes of home dialysis to, you know, utilize their cost data.

DR. SAFRAN: Okay. So let me ask it this way. Is there something that you think that is included in the proposed approach to the policy revision that would be wind in the sails of a moment toward more home-based dialysis?

DR. JOHNSON: Not specifically for home-based

dialysis. I guess if there was a reason for a facility to locate itself farther than 5 miles from a currently existing facility, there might be some benefit there, but that wouldn't be specific to a home-based facility.

DR. SAFRAN: Okay.

DR. CROSSON: Jon, on this point?

DR. PERLIN: On this point -- and this may be something that Jonathan Jaffery, as a nephrologist, can illuminate. Obviously there are certain benefits for home dialysis. Patient complexity and their frailty mitigates against those aspirations. But I am wondering how you considered the impact potentially of changing technology. So, for example, there are emerging technologies that use small volumes of dialysate as opposed to, you know, a constant stream of purified water, et cetera, and these technologies are inherently more mobile.

I am reminded of, you know, Clay Christensen's work on innovation. Do you see this potentially inviting additional development of that purposefully low-volume and isolated centers by virtue of changing technology?

DR. JOHNSON: I don't think that's something we've gotten into yet, but we can consider that further.

And are you thinking specifically for home dialysis being mobile type technologies, or another facility-based alternative?

DR. PERLIN: You know, small-volume facility-based, because the technology is inherently less complex. The patients are equally complex, but the ability to distribute, you know, it's kind of like the micromole analogy that Christensen writes about, where you may be able to distribute -- still manage the frailties of patients in a way that you can't do at home, yet disperse the technology in a way that the historical approach has not allowed.

DR. DeSALVO: Just on this point, one model of this might be to have dialysis available in a tractor trailer that is moved around from location to location. And that would beg the question of, what does 5 miles mean if you're moving from one big box store to another, to do dialysis, or whatever that's going to be, one faith-based organization on the weekend to do dialysis, and how does the 5 miles, et cetera, get into that?

I think you're probably, not right away -- this is not a near-term issue, but if we're going to fix the

policy it might make sense to think about some of the innovations that are being thought of to help reach hard-to-reach populations.

DR. CROSSON: Okay. We're going to move on to the discussion. Oh, sorry. Larry.

DR. CASALINO: So I understand that there needs to be a hard cutoff for what low-volume means, because you have to be low-volume and isolated. And when I first read it I thought three categories of low-volume makes sense. But then thinking about this some more, you have to have the hard cutoff, like 6,000, whatever, for low-volume, but below that, do you think it's better to make two categories below that, two more categories, or use a continuous standard for pay?

I ask that because I remember years ago being at a major medical center interviewing some of the top executives, and it was a time when a lot of attention was being paid to leapfrog volume standards for cardiac surgery. And they were joking that -- this was in February, and they were joking in December of the previous year, they were just one short of the volume standard for cardiac surgery. And the CEO nodded to another director

and said, "You know, Dr. So-and-So here volunteered to have his chest cracked open so we could hit the standard."

So the less of that, the better, it seems to me. So is there a reason it couldn't be done continuous below the hard cap at the top?

DR. JOHNSON: So we heard this comment last time as well, and I think where we got to in this time, you know, we spent a lot of time getting our data together to run some models, but I think the current requirement is to identify consistently low-volume facilities, and the easiest way to do that is to apply a cap in each year. If you were to conduct a continuous adjustment, I think you would have to contemplate some averaging across years, or a total volume across the three years.

And we looked at some of the low-volume facilities and saw some new facilities who had low volumes, still sort of low-volume, and then really high volume. And those facilities would have met an averaging criteria but they fall out in our criteria. And those types of facilities are not the ones that we are trying to target here.

So I think there is room for some more discussion

but we just didn't quite go straight to considering a continuous function, but we would certainly welcome more comments on that.

DR. CASALINO: To be clear, there would be one cutoff. If you were below X, 6,000, you would be in the low-volume, but then below that there's the way you get paid, instead of having two categories it would be continuous. And I was just asking if that would be possible or if you think it would be better.

DR. JOHNSON: We can certainly think about that.

DR. CROSSON: Okay. We'll move on to the discussion. Jonathan?

DR. JAFFERY: Yeah. Thanks, Jay, and thanks to both of you. This was a great presentation and great chapter, and I think, you know, despite some of the conversation earlier that, you know, this seems so simple compared to the previous one. I think as we get into this clearly there is more and more complexity.

And I really appreciate, this is a unique, complex patient population, right? They have an intensive therapy that is ongoing, that requires, at least in in-center hemodialysis, three times a week, half-a-day

treatment. It's 7 percent of the Medicare budget, or something along those lines. So it continues to be an important topic.

I wanted to spend just a couple of seconds giving everyone a little bit of context thinking about how treatments have changed over time. There was a point, decades ago, where there was more home dialysis, particularly peritoneal dialysis, and this starts to speak to changes in technology that allow other opportunities.

Over time, various drivers -- economic, demographic, educational -- resulted in more dialysis units opening up, and then that created an opportunity for more in-center hemodialysis. And then, over time, that becomes a bit of a cycle, where fellows are less experienced with -- again, this was traditionally more peritoneal dialysis, but home dialysis overall, which then makes them more comfortable with offering patients preferentially in-center hemodialysis. And now you have a cycle where it's mainly in-center hemodialysis.

So I think, you know, Nancy, you said this several times and others have commented about the changes that we're seeing that maybe incenting more home dialysis,

whether that is through payment policy or complex technologies like home dialysis units, or home dialysis technologies that get simpler to use, or maybe even simple technologies like how do we have mobile dialysis units, which I know some places have actually tried to look at.

So I think regardless, we're going to need to keep paying attention to this. Some of the things that we're talking about here, that people have mentioned, feel like they're somewhat arbitrary, in terms of 5 miles versus 10 miles, even if directionally they make sense, but I think we are really going to have to keep an eye on things as they evolve, as they inevitably will, because of all these changing factors.

So that said, I think that adding simplicity to this and targeting it towards the places where we think the policy adjustments or the payment adjustments were intended is laudable, and so I really support trying to move in this direction of a more targeted and simple payment approach.

I think the idea of thinking about proximity to all facilities rather than just the ones that are individually owned aligns with our goals and incentives as well.

In terms of the five-mile thing, again, probably a little bit perhaps arbitrary. I think not changing the current standard makes sense. And I do agree with what others have said that the 25 miles may not seem like a far distance for certain things, but when we think about what people have to do to travel three times a week, you know -- so I've taken care of dialysis patients for a couple decades now in both Vermont and Wisconsin, and people may recall that sometimes there's snow in those places, and at least one of those places has mountains. So it can be pretty hard for people to get through winding mountainous roads in the snow. And we do get into -- it's not impossible to get into some emergency situations that people can't get to treatment sometimes. So making that easier makes some sense.

And then, finally, I think avoiding cliffs is a good idea, not only for the reason that you mentioned about incentives for facilities to do things that might limit beneficiary access with that cliff, but also, as you've shown, there's evidence that facilities greater than 4,000 treatments a year have some -- are not covering their facility costs with their per treatment cost, and I think

it just aligns with our goals of private pay providers adequately.

Thanks.

DR. CROSSON: Thank you, Jonathan. Further discussion? I see Kathy and Dana and Amol.

MS. BUTO: I want to support the recommendations and moving in this direction, but Jonathan and Dana's comments just prompted me to want to mention one thing from history, and that is, there was a time when there was a real spike in the use of home dialysis, and the reason for the spike, it turned out, is we were paying reasonable charges for home dialysis that were so high -- I don't know if it was twice as high as the in-facility rate, but it was pretty high -- to the point where the home dialysis provider was able to offer free medical assistance to come to your home and help you with home dialysis.

We proceeded to try to put a cap at the in-facility rate and found ourselves in court. I think eventually what happened, I think we lost that case. I testified, and I remember the judge was not too sympathetic because these patients are very sick, and if you can keep them at home with an assistant, you know, it sounded very

appealing to him. But we got a change in the law.

So I'm just saying as we look at the issue of how do you promote more home dialysis, I think it bears more work to look at, you know, what are the obstacles and what might we do from a policy perspective that won't really distort the incentives in a way that promotes more home dialysis where possible.

DR. CROSSON: Thank you. Dana.

DR. SAFRAN: Yeah, I'm fully supportive of the direction that you're moving here. I really like it. And I have three comments to offer.

One is building on this issue of home dialysis and Jonathan's add to that around just innovation. I'd like us to really think about how we can structure this in ways that promote innovations and doing the very best for quality of life for beneficiaries who need dialysis. This is just a monumental impact to people's quality of life, and so whatever we can do to promote home dialysis where that's safe and, you know, can be done effectively without huge cost implications seems really important.

Second is that I was thinking on similar lines to what Larry suggested, which is I love that you're trying to

address the cliff, but I fear that we've now got three. So I'd love to see a smoothing of that to incentives, and I hear your point that, you know, you don't want to average across three years and then, you know, be paying for low volume when you don't actually have low volume anymore. So I do take that point and recognize we have to address that. But let's think about an approach that won't give us three cliffs rather than one.

And then the last is I know you mentioned that there actually is a quality incentive program for this field and that you're going to come back and be talking about that later. So I don't think I've learned about that program yet and will be interested in it and think it will be really important to think about it again with respect to home- versus center-based dialysis and how we can learn, if we don't already know, the differences in quality but also just making sure that we are building into that quality program the same kind of principles that we've been systematically building into all of the quality programs that we touch. So I'm looking forward to seeing what the proposals will be there.

Thanks.

DR. CROSSON: Thank you, Dana. Amol.

DR. NAVATHE: Thanks for this great work, and I certainly echo a lot of the comments made before.

I think in some sense I feel like it's helpful to take a step back as we're thinking about why we have this program in the first place around isolated, low-volume facilities. I think it's framed in some sense around the additional costs of providing dialysis services in lower-volume facilities.

If we take a step further back from that, I think it's about access, and in some sense you can think about an analogy here being kind of like the critical access hospital. And so what struck me is we might want to be thinking quite carefully about this access pieces or perhaps a little bit more deliberately about the access piece. Again, in some sense, you know, our goal here is to match supply with demand or try to induce a matching of supply with demand such that we're getting to the right point from an access perspective. And while we do -- and I think I would certainly endorse this approach over what we have now. I think it's a step in the right direction. We do want to try to address some pieces of, you know, sort of

gaming that could happen where facilities could be shopping up essentially to get access to these subsidies in essence.

I think it's worth trying to understand how, you know, the sort of five-mile radius piece, but kind of what is the market, local market for ESRD services. How do patients actually flow? And, you know, we used MedPAC markets as part of the analysis. I think it might be worth taking a step back and understanding how that sort of natural structure of ESRD services looks from a geographic perspective. And then in that context, either in those markets or the other markets that we're using here, MSAs, MedPAC markets, otherwise, thinking about other metrics of access. So, you know, ESRD patients to, quote, ESRD beds, you know, in some sense, or other capacity to utilization type of metrics. Because one thing that struck me is there was kind of an assumption, I think, made. On page 10 of the paper, we had Figure 2 shows that some LVPA facilities were located near other facilities, suggesting that they may not have been essential for ensuring access to care. And I think sort of borrowing David's point about having learned some economics, I think we would assume to some extent that suppliers are responding to the need and,

therefore, are locating themselves where there is volume. That may not be perfectly the case when you have these regulated prices, and so there may be some distortions. But I think we should directly look at access metrics as a way to ensure that what we're doing is actually creating greater alignment around access.

DR. CROSSON: Thank you, Amol. Larry.

DR. CASALINO: So, again I'm generally very supportive and I like the clarity of what you've done. Just one more question about the low volume but close to another facility. We talked earlier about possible effects on consolidation and asked what's the quality of the low volume but not isolated, because you imply in what you wrote that if they're low volume but not isolated, they should just merge maybe. And if they're low quality, the low volume and not isolated, that might be a good solution.

But I do think we need to think about the effects on competition and hat that can mean for access, quality, transportation. So let's suppose there's a low volume not isolated that's just kind of okay for quality, and then there's a high-volume corporate place nearby, and the little guy goes out of business. What effect will that

have, for example, on the offering of transportation, for example, from the big facility that's the only place left? Because I think that is a decision point or a point of competition that families and the dialysis patients care about. Is there transportation available? For emergencies, as Jonathan was -- my mother was on dialysis for ten years, so I kind of got to see this in action. So, on the one hand, there's the emergency, my God, the person can't get dialyzed at all. But there's also the driving home from dialysis. You don't really feel so good after dialysis, and if there's not someone to drive you home, you're driving yourself, you know, that matters. And some people might prefer if there's transportation.

My sense is -- and, Jonathan, you probably know better -- that most places do offer transportation in some way or another, but it's not that great if you have to wait three hours after your dialysis to get the transportation. So I'm just asking, think about if we cut competition, there's only one left, does that matter or not? And I don't have the answer to that.

DR. CROSSON: Kathy.

MS. BUTO: Nancy or Jonathan, I don't know if you

know, but I think the U.S. is the only country that deals with dialysis as an industry the way we do, with a lot of in-center facilities versus other options. And I wondered, as we look at this broader question of access, whether there's some work that could be done to look at what other at least OECD countries are doing in that regard. And I assume you know already. But my understanding is that we are the only country that has this extensive network of in-center dialysis. Maybe I'm wrong.

DR. JAFFERY: Well, I haven't looked at this in a while, and maybe you guys know more. But I don't know how they're distributed in other countries, but most other countries, as I recall -- and, again, it's been a while since I looked at it -- were more in-center than not, with a few exceptions. I think Mexico stands out as a place that always did a lot of peritoneal dialysis, but --

MS. BUTO: Yeah, I was thinking of other alternatives like mobile units and so on. But --

DR. JAFFERY: I don't know about things like mobile units.

DR. CROSSON: Okay. I wasn't sure what you were saying. I thought you were implying that in many countries

it's done in acute-care hospitals or outpatient --

MS. BUTO: I think that's also true.

DR. CROSSON: Yeah.

MS. BUTO: In other words, I think we're -- I could be wrong, but I think we're the only one that has a big for-profit industry like this, and that others have smaller community-based and other options, and I thought some mobile units as well, more home dialysis, et cetera.

DR. JAFFERY: You know, I think there are a number of dynamics in other countries where you don't have -- it's not as common for people as they get older with multiple complex chronic conditions to necessarily either be offered or receive dialysis, and it's a different dynamic than we have here, of course. And I just don't know exactly, but what I do know, though, is that one of the two large dialysis organizations is based in another country, in Europe, so that suggests that there's some market there for it.

Can I make one other comment?

DR. CROSSON: Yeah.

DR. JAFFERY: I think it would be really interesting to come back to this quality discussion, and I

know that's not for today, but, you know, thinking about certainly wanting to have the quality measures line up with our overall philosophy and be consistent with what we do in other areas and other sectors that Medicare pays for, but also thinking about some of the unique factors that might not be captured here, I'm thinking about -- especially with these shifts towards home dialysis, I'm thinking about what that really means for quality of life for people in terms of traveling, not just transportation to individual units, but, you know, we're talking a lot about this population as being very fragile and frail, and certainly we want to be considerate of that. But I think we also want to remember that there are a lot of people who still work and still travel and want to be able to do those things. And a lot of time and effort has gone into trying to facilitate travel for people on in-center dialysis, which may be something that is easier to do if you're doing it yourself and you can get the supplies appropriately, there's ways to do it.

So I think we want to think a lot about what those quality metrics mean in terms of not only outcomes and cost but really patients' quality of life.

DR. CROSSON: Okay. Thank you for this excellent work, and I think we have supplied you with some additional food for thought, and we'll be seeing you again.

That ends this topic, and we now have time for a public comment period. If there are any of our guests who wish to make a comment on the matters before the Commission this morning, please come forward to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until 1:45.

[Whereupon, at 11:56 a.m., the meeting was recessed, to reconvene at 1:45 p.m. this same day.]

AFTERNOON SESSION

[1:46 p.m.]

DR. CROSSON: Okay. Let's reconvene.

I'd like to welcome our guests to the afternoon session at our October MedPAC meeting. We're having two presentations this afternoon. First one will be focused on Medicare payments for physicians and other providers. Brian, Kevin, and Carolyn are here.

Who's starting? Brian.

MR. O'DONNELL: Good afternoon. I this session, we'll discuss two updates to the methods the Commission annually uses to assess the adequacy of physician fee schedule payment rates.

In particular, we'll discuss planned changes to how we count primary care physicians and changes to our volume analysis.

This work responds to Commissioner feedback over the last cycle. In particular, Karen, you asked us about the effects of the increasing number of internal medicine residents choosing to become hospitalists.

Jaewon, you asked for more information –

[Laughter.]

MR. O'DONNELL: I'm just going to go down the row.

Jaewon, you asked for more information regarding the decline in primary care physicians' billing.

And, Bruce, you provided several suggestions to improve our volume analysis.

Before we get into these topics, Carolyn will provide some context on how these changes fit into our payment adequacy framework.

MS. SAN SOUCIE: Today's presentation is regarding updates to the methods used to assess the adequacy of Medicare payments for physicians and other health professional services.

The updates you see today will be included in our December presentation. Every year, we use the following factors to assess payment adequacy for physicians and other health professionals: beneficiaries' access to care, quality, and Medicare payments and providers' costs.

Today we will be presenting updates to our methods of calculating the first factor: beneficiaries' access to care. Although there are additional indicators of beneficiaries' access to care, including the

Commission's annual beneficiary access survey, we have updates on two indicators in this presentation. First, we will discuss the supply of providers. Second, we will update our analysis of volume of services.

Regarding supply of providers, we have an updated estimate of the number of hospitalists billing the Medicare program.

To begin, I will define the hospitalist specialty as well as give its role today. Then I will contextualize trends we see in the number of hospitalists with trends related to primary care within the Medicare program.

Hospitalists are physicians whose primary focus is the general medical care of hospitalized patients.

The first program utilizing a hospitalist model of care in the United States was implemented in Minnesota in the 1990s. Several factors influenced the creation of the program, including previously inefficient use of physician time and delays in discharging patients.

The model departs from the historical practice of primary care physicians, or PCPs, rounding in hospitals. Instead, it relies on hospitalists to monitor the progress and tend to the needs of hospital inpatients, while primary

care physicians focus on office-based care. The use of hospitalists quickly spread throughout the country, and they now serve a prominent role in inpatient care.

Many factors may influence residents' or physicians' decisions to become hospitalists. Namely, hospitalists' training, salary, and schedule may be influential in that decision-making.

Regarding training, most hospitalists are board-certified in internal medicine, and no additional sub-specialization is necessary to practice hospital medicine.

Concerning salary, hospitalists earn substantially more than primary care physicians on average. One survey found that in 2018, hospitalists earned about $36,000 more per year than PCPs. Median compensation is about 243,000 dollars for PCPs and 278,000 dollars for hospitalists.

Lastly, hospitalists' schedules often consists of working for several consecutive days and then having the same amount of time off. For example, one common schedule is to work 12-hour shifts for seven consecutive days and then have seven days off. This type of scheduling, which does not involve being on call, may be attractive to many

new physicians. Young physicians may increasingly choose to become hospitalists because doing so requires no extra medical education, increases their salaries, and may provide a more favorable work-life balance.

However, this is a potential cause for concern because hospitalists are drawn from the same physician specialty that constitutes a large share of the primary care supply: internal medicine.

Indeed, recent data from a survey of third-year internal medicine residents suggest that the share of residents who plan on practicing general internal medicine has declined substantially over time.

Meanwhile, the share who plan on becoming a hospitalist has increased. Because general internal medicine physicians constitute a substantial share of primary care physicians, a shift away from general internal medicine could affect the supply of PCPs.

From 2002 to 2018, the share of third-year internal medicine residents who plan on practicing in general internal medicine declined from 23 to 11 percent, while the share who plan on becoming hospitalists increased from 9 to 19 percent. The share who planned to

subspecialize remained relatively flat in comparison.

I'd like to also note that although it is not reflected in the figure, the percentage of respondents who were unsure of what they wanted to practice increased during this time as well.

In its annual assessment of payment adequacy, the Commission tracks the number of clinicians who bill the fee schedule as an indirect measure of access to care. Historically, the Commission has tracked the number of physicians who bill the fee schedule in two groups -- primary care physicians and other specialties.

The Commission defines PCPs as those who billed a plurality of their fee schedule-allowed charges under one of four specialties -- internal medicine, family practice, geriatrics, or pediatrics -- and includes all other physicians in the "other specialties" category.

Because CMS had not established a specialty code for hospitalists prior to 2017 and most hospitalists are board- certified in internal medicine, the Commission counted nearly all hospitalists in its count of PCPs because they self-designated as internal medicine.

Including hospitalists in the count of primary

care physicians could be problematic because the services they furnish do not meet the criteria that are commonly used to define primary care.

Beginning in the second quarter of 2017, CMS introduced a separate specialty code for hospitalists. Before then, hospitalists self-identified under other specialties.

Because of concerns about how the increasing number of hospitalists affects the supply of primary care physicians, we sought to better understand the number of hospitalists who bill Medicare and the services they bill.

We used the introduction of the hospitalist specialty code in 2017 to more fully understand the billing patterns of hospitalists and to establish a methodology to retrospectively identify hospitalists in claims data.

We used that information to separate our estimate of hospitalists from our PCP count going back through 2010.

We developed the methodology, as explained in your mailing materials, and are happy to answer any questions you may have afterwards.

Using the billing patterns of self-identified hospitalists in 2017, we estimated the number of

hospitalists over several years. From 2010 to 2017, the number of hospitalists who billed Medicare grew from about 32,000 to 48,000.

We found that the number of hospitalists who billed the fee schedule increased steadily over the last several years. Specifically, there was an average growth rate of 5.9 percent per year.

Now Brian will go over how this estimate of hospitalists affects our count of PCPs used for payment adequacy.

MR. O'DONNELL: So this next figure shows the effect of excluding hospitalists from our annual counts of PCPs.

The dotted blue line represents the counts we've published in our annual March reports.

The solid green line shows the count of PCPs after excluding hospitalists.

From 2010 to 2017, we estimate that about one in five physicians the Commission has historically considered to be a PCP were actually hospitalists.

While the data from the previous slide suggests that a smaller number of PCPs billed Medicare than we

previously estimated, it does not change our past conclusions that beneficiaries maintained adequate access to care.

For example, the Commission's annual beneficiary survey has found that beneficiaries have been less likely to wait longer than they wanted for routine care compared to those with private insurance.

The survey has also not indicated large changes in the share of beneficiaries who had trouble accessing PCPs, and beneficiary access to PCPs has remained as good as or better than individuals aged 55 to 64 with private insurance.

While the absolute differences in PCP counts does not indicate an access issue, the slower growth in PCPs after excluding hospitalists underscores the Commission's concern about the future supply of PCPs.

To demonstrate this, we will now look at the same data we've been discussing in the last two slides, but now we'll focus on growth rates and not absolute levels.

The blue bars in this figure represent the annual percent change in the number of PCPs that we've published in our annual March reports.

The green bars show how the annual percent in the number of PCPs change after we excluded hospitalists.

As you can see, after excluding hospitalists, the growth in the number of PCPs billing the fee schedule is much slower, with a flat or declining trend in recent years.

The staff will return to you in November with an update on our ongoing work on the pipeline of PCPs.

Switching gears a bit, I'll now discuss the updates we plan to make to the Commission's fee schedule volume analysis, and just a reminder of how this all fits together, the volume analysis is another way in which we measure access to care.

The Commission's traditional volume analysis took into account the number of services beneficiaries received and their complexity, as measured by relative value units, or RVUs.

We used volume trends to measure access to care, with increasing volume suggesting sufficient access.

We've also used volume trends to help determine the drivers of spending increases.

However, our volume measure was sensitive to

shifts in the site of service. This means that our measure of volume could go up or down based simply on where services were performed. For example, shifts from physician offices to hospital outpatient departments, HOPDs, have resulted in negative volume trends because RVUs disappear from our volume analysis when such shifts occur.

These negative volume trends do not indicate access issues but are instead an artifact of technical differences in how Medicare accounts for practice expense costs across settings.

This slide gives an example of how RVUs disappear from our volume analysis when they shift and a site of service occurs.

The left-hand bar represents a CT scan that is performed in a physician office.

The right-hand bar represents a CT scan performed in an HOPD.

As you can see, the number of RVUs that would be included in our volume analysis declines by about 60 percent when the same service is performed in an HOPD instead of a physician office, nearly all of which is due to a decline in practice expense RVUs, the green bars.

To address the site of service problem, we will replace our traditional volume analysis with two new analyses. The first new analysis will measure access to care and is the number of beneficiary encounters with clinicians.

Encounters do not take into account the number or complexity of services per encounter and are less sensitive to shifts in the site of service. For example, we would count an office visit as one encounter, regardless of where it was performed.

The second new analysis measures spending and relies on allowed charges, which are the payment amounts specified under the fee schedule. Total allowed charges are a function of the number of services billed, the RVUs for those services, and other factors, such as the conversion factor.

The Commission tracks a similar metric for HOPD spending. Using similar metrics for both fee schedule and HOPD spending could allow us to better understand global spending trends for clinician services, as clinician services continue to shift to the HOPD.

I'll now walk through two examples of our new

measures of access and spending.

This table shows the number encounters per beneficiary, stratified by type of clinician. From 2013 to 2017, the number of encounters per beneficiary increased modestly from 20.4 to 21.1, suggesting stable access to care.

However, the patterns by type of clinician suggest shifts occurred beneath these top line numbers. For example, the number of encounters per beneficiary with PCPs fell by about 3 percent per year, while encounters with APRNs and PAs grew dramatically, by about 13 percent per year.

The decline for PCPs occurred across a broad range of services, is consistent with previous Commission analyses, and suggests that APRNs and PAs could be billing many services once billed by PCPs.

This next slide is an example of the type of analysis we plan on including for allowed charges. We will continue to examine growth rates by type of service, as we have done in the past, only now it will be growth in allowed charges per beneficiary. For example, allowed charges grew by an overall average of 1.6 percent from 2016

to 2017, but growth rates varied between different service categories.

Differences between categories reflect a number of factors that we will discuss in the update chapter, such as differential growth rates in service use and policy changes.

In the March chapter, we plan on updating this analysis with 2018 data and including the table from your mailing materials that breaks down allowed charges by the more granular type of service categories.

This last slide reiterates a few of the topics we covered today. While we now estimate that a smaller number of PCPs billed Medicare than we previously thought, this does not change past conclusions that beneficiaries maintained adequate access to care.

However, because the number of hospitalists has grown rapidly, netting them out of our count of PCPs reveals a flat or declining trend in PCPs in recent years. This trend reinforces the Commission's concern about the future pipeline of PCPs.

The staff is also seeking feedback on all the planned methodological changes we discussed today, and on

the policy front, staff will return to you in November with an update on our ongoing work on the pipeline of PCPs.

With that, I look forward to your comments, and I turn it back to Jay.

DR. CROSSON: Okay. Thank you, Brian, Kevin, Carolyn.

We are now open for clarifying questions.

Sue?

MS. THOMPSON: Thank you.

Yeah, it's Table 9 in our reading. It was just the previous slide. One more. Who are the other practitioners?

MR. O'DONNELL: So the biggest group amongst that is PTs, so PTs, OTs, are the two biggest groups in the other practitioners category.

MS. THOMPSON: So back to the APRNs and PAs -- and we've had this conversation in other discussions around primary care and what's happening -- a 13 percent increase is pretty amazing. Remind us what the compensation difference is for the same level of service delivered by an APRN versus as physician.

MR. O'DONNELL: Right. So from a salary

perspective, the average APRN might make around $110,000 a year, and PCPs make on average about $240,000. So that's the salary differential.

And then from the Medicare perspective, if APRNs and PAs bill directly, they're paid 85 percent of the fee schedule and not 100 percent.

MS. THOMPSON: Thank you.

DR. CROSSON: Other questions?

Pat and then Marge, Jonathan, Dana.

MS. WANG: How do urgent care centers bill, and would they be reflected? Would an internist in an urgent care center show up in the billing for primary care physicians?

MR. O'DONNELL: Right. So if there's a primary care physician, based on our definition, if it's in an urgent care center, they would show up in this category, in the PCP category, but if the APRN delivered the service in the urgent care center, it would appear under the APRN row.

When we break it out, we can break it out by place of service as well, which would be another chart, and then there, we could see the breakout of specifically all services performed in the urgent care center, if you wanted

to see that.

DR. CROSSON: Okay. Marge.

MS. MARJORIE GINSBURG: A couple questions which I'll just group together. Is this the first time that MedPAC has looked at statistics having to do with hospitalists? Or has this come up before?

MR. O'DONNELL: So to my knowledge, it's the first time we've done this deep of a dive on it, and I'll look to people who have been here longer that know it. But I think that's the answer.

MS. MARJORIE GINSBURG: And so related to that, does Medicare have a separate payment structure for hospitalists than it does for PCPs?

MR. O'DONNELL: No. So the payment doesn't differ based on whether you're a hospitalist or whether you're a PCP. I think the thing that's new for us is that there's a new specialty code in 2017 so we can identify hospitalists in the claims data much more easily.

MS. MARJORIE GINSBURG: Okay. And this report, the one we read, devotes a lot of space to discussion of hospitalists' work, but the information being presented to us really doesn't -- in terms of what we're looking at for

policy recommendations doesn't talk about hospitalists at all. So this is just background to understanding where the trajectory is for PCPs? That's the sole purpose for including a lot of information about hospitalists? I just wanted to make sure I was reading this correctly.

MR. O'DONNELL: That is right. We didn't want you to get scared when you look to November or December and you saw a big decline in PCPs. We wanted to give you some background on hospitalists since we haven't talked about it that much to say just to give you kind of a warning, this is coming in December with our normal update process.

MS. MARJORIE GINSBURG: Thank you.

DR. CROSSON: Jonathan.

DR. JAFFERY: Yeah, thanks. Great report.

On Slide 5 you show the survey result from the American College of Physicians in-training exam, and I wondered if you've thought about looking for other sources of data to figure out what people actually do become, so this is what they're planning. And, in particular, I'm thinking about longer term, not even just a year after finishing residency but -- this probably wouldn't impact the general internal medicine line as much, but thinking

about hospitalists -- people that go and become hospitalists for a year or two and then actually go back and do a fellowship in some specialized -- it may be a not insignificant percent, and it might make us think about longer-term things in terms of workforce.

MR. O'DONNELL: Yeah, and that's a great point because I think the churn in hospitalists is probably a little bit greater than the churn in PCPs. And so we've seen that in the literature a little bit, and I think that we don't have a great data source right now, but thinking about this kind of on a going-forward basis is that now that we've identified hospitalists in the Medicare data, we can then track them to see, you know, how long they stick with being a hospitalists versus subspecializing or whatnot.

DR. CROSSON: Okay. Dana.

DR. SAFRAN: Yeah, so really interesting work. I have two related questions and both sort of under the heading of I'm struggling with this idea that, you know, we have either a pretty significant substitution of hospitalists for PCPs in terms of the pipeline or I think you used the figure that, you know, one in five clinicians

that we thought was a PCP actually is a hospitalist, so 20 percent fewer PCPs than we thought. And yet the survey's telling us that hasn't introduced access problems. So I'm struggling with that a little bit. And so I'm wondering two things. One is are there some ways that we can look to see with the growth that we've had in hospitalists while we're losing PCPs, let's take for a minute at face value that we aren't creating a PCP access problem, and we'll come back to that. We're getting a whole new class of physicians. What's the evidence for the value in the dollar that we're paying for this whole new cohort of physicians? Has it so significantly contributed to improved hospital safety, you know, hospital outcomes, simply added costs, helped hospitals do better discharge planning? What do we know about, you know, what's the value coming with this tradeoff that we now understand that we're making? That's the first question.

Second question is if we want to go a little bit beyond the survey data, I wonder if we could look at some longitudinal data from claims to see -- and maybe it would be hard to go back far enough, but just see whether for the E&M codes that typically would be seeing a PCP, do we start

seeing them going somewhere else? Or are they just more concentrated with fewer PCPs? You know, so what's happening with Medicare beneficiaries' visits that have historically been to PCPs? Are they still going to PCPs, or are they going to specialists? Are we seeing fewer of those visits? Kind of what's happen so we can triangulate a little bit that data point that tells us we don't have access problems.

MR. O'DONNELL: Right, so starting with the first one, I think the value proposition -- and I'll look to the hospital CEOs here -- is that when the hospitalist field first came about in the late 1990s, you know, so there were studies looking at, you know, hospitalist care versus care of a PCP. And I think it happened in the context of managed care and DRGs. And so I think the conclusions of the literature are that, you know, it reduced costs for hospitalists -- or for hospitals, rather, primarily by reducing the length of stay, and that the quality and patient satisfaction were kind of held level. And so those are the thumbnail sketches that I have in my brain, and we can dig more, but those are kind of the basic points.

And then on the E&M codes that you mentioned that

are declining for PCPs, you know, we don't have great data on where NPs and PAs are practicing, but, you know, we showed a graph in, I think, the June 2019 report that the number of office visits, NPs and PAs, are performing increased by 184 percent over the last seven years, and that PCPs have declined by about 16 percent over that same time frame. And so I'm not saying that all the NPs and PAs are primary care, because they're certainly not, but I think, you know, with certitude a good chunk of that increase are office visits with NPs and PAs that PCPs might have performed in the past.

DR. CROSSON: Kathy.

MS. BUTO: So I really want to follow up on some of Dana's points here. I don't know that we know what the -- assuming that hospitalists do deliver some value, that we know what the right percentage of total general internists going into hospitalist care would be. So I think we do need to know more about sort of the value they deliver.

I'm also curious to know if we know anything about why they make more money because I'm assuming there's some association with value. I can think of other reasons

why they might be attracted to being a hospitalist versus being a PCP in the traditional sense because they also get to work with a team of people that you may or may not have access to outside. You've got hospital resources. There are a number of things that bring along a certain level of sort of prestige and association with a larger entity.

So I think we need a better understanding of the hospitalist, but I'd be interested to know what else we know about their impact on quality and why they're making more money. Are they being paid on the fee schedule, do you know, Brian, or whether they're being paid on salary or some combination?

MR. O'DONNELL: Right, and I just want to make clear that, you know, what's the right mixture of general internist versus hospitalist. We were staying completely away from that. We're just looking at the data. But in terms of the salary, it's really a hospital-level decision because when you look at the -- the best information we have is that, you know, hospitalists are subsidized quite heavily by hospitals, and so, you know, maybe a thumbnail sketch, $100,000, $125,000 per year per FTE are subsidized. So hospitalists are not living off of their own

professional fees billing.

And so I think that, you know, when I've talked to folks in the field, they said, look, you know, they're valuable to us for holding down costs in the inpatient. We task them with quality improvement, you know, reducing infections and things of that nature.

MS. BUTO: I think that's something we need to think about in terms of PCPs and why they're not happy with the compensation arrangement that we offer them.

I also wanted to mention -- somebody asked the question about teasing out different kinds of physician services and different specialties, and one of the bedrock decisions that was made with the physician fee schedule was that there is no specialty differential. So if you're a surgeon providing E&M services, you get paid the same as if you were a hospitalist providing that same service. So I think it would be very hard to tease apart by specialty what's going on there. But there may be greater detail than when I was familiar with it.

DR. CROSSON: Larry.

DR. DeSALVO: Can I -- I just want to make a response to Kathy's comment, if I could, that in addition

to what Brian articulated, which I think there's a lot of head nodding around the table, I think that you pretty well got that exactly right. There's also a little bit of a supply and demand that happened that hospitals really and academic health centers also wanted hospitalists. For example, in the academic health center environment, as graduate medical education work hours changed, it was more important to have physicians that could be devoted to the inpatient setting to make rounds in a timely fashion so that residents didn't have to stay too long as another example or supervision of fellows. So all these things came together at once, and there was a demand for the specialty, and so we all had to pay higher prices for salary to accommodate that and it just set the level. But it does make me wonder if our numbers on salary for primary care then also will get reset if we pull these out, pull out the hospitalists.

DR. CROSSON: On this point as well?

DR. RYU: Yeah, I'm glad you raised the demand-supply issue because I think that's what's driving a lot of this. If you think about a hospitalist staffing model, it's a 24/7 model, and so -- versus primary care which --

DR. DeSALVO: It's 24/7.

DR. RYU: Which is hidden 24/7.

[Laughter.]

DR. RYU: But I think that's one factor. And as far as the value -- and I would turn to -- I don't know if, Dave or even Larry, you might be more familiar with a lot of the data, but I know there was a lot of work done on the value of hospitalist programs coming out of David Meltzer and the University of Chicago back in the '90s, lower length of stay being the big cost driver for hospitals. It's efficiency of throughput. There's also a consistency of medical education versus if you have every primary care doc admitting their own patients, you know, that's a pretty disparate field that you're dealing with. It becomes really tough even driving will initiatives, consistency of practice, if you use something like sepsis protocols as an example, getting, you know, 150 different admitting primary care physicians to do the same thing on that is a lot tough than getting a team of 15 hospitalists to do the same thing. So I think there are a lot of underpinnings around what's driving, you know, those changes.

DR. CROSSON: Larry

DR. CASALINO: Oh, I think I'll wait till the next round.

DR. CROSSON: All right. Further questions?

[No response.]

DR. CROSSON: Seeing none, we'll move on to the discussion, and we had Karen first and then Paul are going to open.

DR. DeSALVO: It was a jump ball. Everybody wants to talk about physician workforce -- well, since I am general internist.

[Laughter.]

DR. DeSALVO: Yeah, I just want to thank you guys for the chapter and clearly for going to ground to the field to really understand the history and what it's like in the practice environment. I think that this is, though a little bit academic, important because it helps us understand how the scope of practice and the delegation of responsibilities is evolving, especially for people with significant chronic disease who are the ones that, you know, we want to make sure are getting access to really good preventive care, and it helps us start to think upstream more.

You know, the academic world has been dealing with this change, as you say, since the '90s. We started our hospital medicine program at Charity Hospital in the late '90s, and it grew out of all the things that we just discussed in terms of driving the need for change. And the field has not only evolved so far that hospitalists have a special certification and now their own code and with CMS, but it's already starting to come back around, and some of the original hospital medicine experts like David Meltzer, who was just mentioned, are beginning to build models that are outside of the site of care of the hospital and in the home, recognizing that the care of particularly people with significant, multiple comorbidities and chronic disease and challenges with some of their social determinants of health sometimes are better served not only by a person who's got experience in comfort with high-acuity patients, like a hospital medicine physician, but also it's better for the person in the home. So that the whole term "hospitalist" is actually starting to be called into question of they don't just practice in that environment any longer and that they're also in the post-acute environment.

And, in fact, in some places for a while there

was a splintering in the academic departments hospital medicine having its own section separate and apart from the ambulatory part of general internal medicine. In some places they're beginning to merge back together again in recognition of the fact that it's not site of care that defines the work; it has a little more to do with acuity of care and some of the interest on the part of folks.

I wanted to call out for your future thinking not only is this a topic of conversation in literally every department of medicine meeting that ever happens anywhere in an academic health center, but also in every hospital executive board meeting. So this is an important topic of do we have the right supply and are people working in the right place to serve the beneficiaries where they have the most need.

It's also of interest to the professional societies who have done a lot of work on looking at pipeline and looking at the impact of choices of practice for our trainees, and that has culminated in a panel that's being sat by the National Academy of Medicine looking at the future of primary care -- again, not in a negative way, but just trying to understand what is the future scope of

practice if there are hospitalists taking care of inpatient medicine, what does that -- how do we define what it means to be the first point of contact and the other descriptions that we have for primary care? So that will be, you know, 18 to 24 months, but there will be a lot of work, I would imagine, that will go into pulling literature and bringing people to the table to think about not only what does the future work look like, but then what does the workforce need to look like and train for to get there? So I wanted to make sure that I raised that.

I just had a couple of things that I wanted to mention, that one I go back to a lot, which is the way we define access to care correctly. And it's even less about how we assess it, is it the right instrument, the right survey tool? Are we getting appropriate -- you know, are we getting a good response rate from the sampling, but also is our goal right? So if, you know, still upwards of 25 percent of beneficiaries say they're having trouble getting access to care -- if I remember, that's about the number -- is that where we would want beneficiaries to be? Or do we want it to be 100 percent of beneficiaries have the kind of access to care that they want? So just thinking about what

that goal looks like, even as we feel like the pipeline for primary care might be a little tenuous, is that going to get worse? Is it ever going to get better? Is there anything we could do to actually see that all of our grandmas and grandpas and ourselves have access to care when and where it matters?

I think that kind of brings me to the second point I want to make, which is around outcomes. Access to care is sort of a proximate -- not proximate. It's probably a lagging indicator, as Jay has said, and so it may be a little too late when we know that we don't have enough folks in the pipeline.

On the other hand, outcomes might also be kind of a lagging indicator, but it might be -- given all the discussion about dividing scope of practice, so if primary care physicians are more in the outpatient setting or doing more home visits or whatever, and hospitalists are also doing home visits but also in the hospital, the point is not so much who's doing -- how many FTE are doing the service, but are the beneficiaries getting outcomes that we want them to have? And that gets to part of our conversation we're going to have in the next session. Are

we looking for ambulatory care sensitive conditions being well treated? Is that the way we would want to track on if we've got a strong primary care infrastructure? It could also be broader than that and thinking about how we're just trying to help the system organize itself not to a certain number of a certain type of doctor, if you will, but to a team that can address the needs of the beneficiary in the right place at the right time with the right kind of tools. And the more we move towards global payments, whether it's just for primary care or for, you know, a population, the more flexibility local institutions, local practices, local communities will have to figure out what's the right mix and, you know, based on a whole bunch of local conditions, but it may very well be that there's more interest in leveraging technology or asynchronous visits or team members rather than purely primary care physicians.

So I just want us to be cautious about overdefining who does the work but really thinking about what the outcomes might be in the long term.

I just maybe also wanted to emphasize that last point a little bit from personal experience, which is that having practiced medicine for 25 years, the most delightful

time of that was when we were in a global budget and building patient-centered medical homes with teams because we were really focused on prevention and on identifying gaps in services, thinking about social determinants, going to people's homes, doing all these things that you want the system to do, but you don't have to necessarily pay for the piece, you really -- if you pay for the out and give some flexibility to that team with accountability and transparency, there can be a lot more innovation inside to really meet the needs of the beneficiaries.

So I think that the data teasing out is really important. I'm all in. But I also think we've got to figure out how we focus as much as possible on the outcomes, and that the pipeline -- like what the primary care is going to be doing in ten years might look really different than what we do today. And so I just want to be cautious about overly prescribing what we want to build for a future that we don't quite know what it looks like.

DR. CROSSON: Thank you, Karen. Paul.

DR. PAUL GINSBURG: Yes, I really enjoyed your presentation and paper, and, you know, I think your analysis of that hospitalist is very solid. And it brought

a couple of thoughts to me. One is how difficult it is to assess adequacy of access by capping people, because, you know, basically we were wrong -- you know, we were overstating the trend of PCP counts until we got the specialty code for hospitalists and we were able to fix it. We don't know how many other things are going to be problematic.

Also, the question is, you know, very sharp rise in nurse practitioners, physician assistants -- what is it, about half of them, you know, some good proportion of them go to primary care. So it's very difficult to assess, you know, what does that mean? Does this mean that, you know, we have a shortage and this is making do, or is it, hey, this is a movement towards efficiency. They don't cost as much. If they're doing the rights that are consistent with their skill level, this is really a change we can be proud of. We don't know. So again, it comes back to just counting people, how difficult it is to get a meaningful assessment.

And finally, there are the productivity issues, you know, that older physicians talk about what it was like when they practiced primary care, the number of hours they

used to practice compared to today's physicians, at least younger ones. So, in a sense, this is really big. You know, if we're going from 60 hours to 40 hours a week, you know, that could overwhelm changes in counts of physicians. So it's going to be problematic.

I think, you know, the surveys are useful, but I think we have to just continue to look for different places for evidence that whether access is adequate or not, because, you know, many people, including me, have been since baffled. You know, we basically have frozen physician payment rates for a long period of time, and we don't see any change in access. Now maybe we were just paying too much or maybe we're not seeing problems.

So, anyway, it's just respect for the daunting challenge that Congress has charged us with each year.

DR. CROSSON: Thank you, Paul. So we are going to go into the discussion phase. Now we've got two proposals that I hope we can address. I haven't heard any opposition so far, but just to be clear, in terms of the data we're going to use in the future, that we're going to carve out hospitalists, and then in terms of the volume analysis we're going to split out encounters and allowed

charges. So to the extent that people agree or don't agree with that, that's fine. If you want to make other comments, that's fine too.

So, okay. Jon first, Pat, David, Jonathan, Sue, Jaewon, Larry, Kathy, and Bruce.

DR. PERLIN: Well, let me --

DR. CROSSON: I thought this was a slam dunk.

DR. PERLIN: The first is easy. I agree with the recommendations.

Now let me make a comment. Beyond that, I agree substantially with the comments of Karen and Paul, in terms of their comments.

You know, the stated purpose of this section is adequacy of Medicare payments for physicians, and behind that, really, the ultimate purpose is the assurance of adequacy of access, particularly to primary care, for all the reasons that have been so well stated.

But beyond that sort of nominal purpose of primary care adequacy, we have got a bonus in this. We got a bonus in the sense that we look not only into the changing distribution of care, in primary care, but the changing nature of care in the hospital. And I think both

are tremendously important questions to the integrated care of Medicare beneficiaries, for the reasons particularly that Karen mentioned, in terms of how we figure out what kind of care mechanisms work best to promote the best clinical, financial, and, fundamentally, integrated outcomes.

So just two suggestions. First, I think Paul made a brilliant observation here, that, you know, we are comfortable with our impression of adequacy of access, and there are at least two hypotheses. One is that access remains adequate, or, two, that we're not sensitive to changes in access. And I think we have to be particularly attentive to that second proposition.

I think that beyond, you know, sort of a Boolean choice between access, no access, that there are shades of gray in amongst some -- I've shared the story of, you know, being the fortunate son of an elderly father, a 94-year-old, who has nominal access to open Medicare practices but also, as a retired physician reports, that they're sort of parsing the day into how many complex patients, older individuals, Medicare beneficiaries, they are balancing with potentially simpler commercially insured, et cetera.

And so I think we have to find ways, as Dana alluded to in her earlier comments, whether using claims data, whether going into other health services research -- and I appreciate the challenges of our survey -- but a number of ways to really get a finer grain on access and associating that, also, with the outcomes, particularly in things that may be sensitive to integrate continuity of care. That's point one.

Point two is the bonus that you've opened up through this work, which is that from 2017 you have insight through a code on care that's rendered by hospitalists, just parenthetically. You know, the quality actually are pretty good that the upsides of hospital medicine are, you know, more consistency, reduction in negative variation, better in-hospital outcomes. Some of the downsides are the fragmentation, discontinuities, because different people are, of course, providing the care inside and outside.

But putting that aside, I thought your table on page 16, about the distribution of workload amongst different practitioners was particularly insightful, because I would posit that there is an analog to that in the inpatient environment, that the work is parsed amongst

different practitioners.

First, a hospitalist is not a hospitalist. There are hospitalists that are internal medicine. There are hospitalists that are critical care. There are hospitalists that are cardiologist. Not necessarily germane to our group, there are what we call deck docs, or obstetrical hospitalists, and as we learned earlier today, the new term SNFists, in extended care environment. And so I think we need to get another level of detail on the type of clinician.

The other dimension of that is, of course, not all of the care is being rendered by physicians. In fact, it's a team-based world. And we need to understand the effect on beneficiaries of multiple providers, I think in the same way that we entertain the identification of non-physician care providers in the ambulatory environment in a prior meeting. I would argue that we get a deeper understanding of that, not as academic exercises but, you know, really toward the broader questions, how do we assure the financial sustainability, sustainability of the Medicare program, and how do we assure the access to high-quality care?

Thanks.

DR. CROSSON: On Jon's first point, I just want to make a contribution here, and that has to do with an additional problem that we've had over time in the analysis, and that's the unevenness of distribution of access, geographically. And it is, part in part a function of, you know, unless we had a gigantic, gigantic survey, the resolving power, depending on how you broke it up locally, would be beyond the scope.

But I do remember, you know, a decade ago, when we had a discussion similar to this, the previous chairman, Glenn Hackbarth, remarking that while the adequacy seemed good overall, in central Oregon, where he lived, it was very difficult to find an internist, and that was a decade ago.

So there is an issue about, I think, about pockets of problems that it's hard to get to with even the very large survey that we do.

Okay. So Pat.

MS. WANG: I'll try to be quick here. So it's great conversation that goes so far beyond the congressional mandate that we have, which Paul pointed out

is struggling to sort of like fit all of this back into that shoe.

But, you know, I think that some of the comments here go to sort of if you look at the cup half full or half empty, like let's fill the cup up with what are the different ways that people are getting primary care? What's emerging? What do we want to encourage as we think, and make sure that we are cognizant of all of that. The cup half empty is like we had discount of primary care physicians -- we've got to take this slice out.

I asked the question before about urgent care because I wonder whether there's another slice in there, both for folks who are billing E&M codes that look like primary care, as well as APRNs and PAs are working in urgent care setting, which, you know, are kind of like they're lumpily distributed around the country but where they exist in concentration. That's not primary care, and it's not emergency room care exactly, but it's something in between, and I wonder whether there's another slice that needs to be taken out of the cup. I don't know. That's why I asked the question before.

But it's not going to get us to the right answer

by continuing to slice out what used to be in the count of primary care, so I think that Paul and Karen's comments about trying to understand what beneficiaries need, and keep a very open mind about ways to meet that need, we have to be very flexible.

DR. CROSSON: Thank you, Pat. David.

DR. GRABOWSKI: Thanks. So first I'll start with saying I'm also supportive of the recommendations, and thank you for this great work.

I'm going to echo Karen and Paul as well in saying that volume is a really noisy way to measure access, and I think we know that and we have other indicators. I think what bothers us in picking up, Jon, on your comment is that I don't know that we feel like we really are capturing access with the survey, and so how do we do that? And I'd like to give a couple of ideas towards maybe putting a couple more tools in our kit here that we could think about measuring access.

So beyond just the survey, I think some qualitative work, so more focus group-oriented work. I know we've done some of that. Could we do more directed around this issue? I suggested last year, and I don't know

that it went anywhere so I'll suggest it -- I'll keep suggesting it until you tell me it's a bad idea -- but I'd like the idea of audit studies. I know that won't get at all the different access issues, but at least seeing, you know, to the example, Jon, of your parent, and, you know, is there a panel that would take on, you know, calling around. We might not be able to determine whether could get an appointment as quickly as they want, but at least we could figure out whether or not they could get on a particular panel.

And so there are some creative ways, maybe, from a research perspective, that we could enrich our understanding of access. And so I'd like for us to think about that going forward. Thanks.

DR. MATHEWS: And just one quick response there. In the past we have sometimes selected the cities where we conduct our annual focus groups, in light of media accounts of specific access problems. So we'll go to Albuquerque, we'll go to, you know, Indianapolis, if there had been substantial media or press coverage that beneficiaries were having trouble. So we do use that in a qualitative way to fill in the survey. Again, it's not exhaustive, it's very

limited, but we are very cognizant of how this fits into our access assessment.

DR. GRABOWSKI: Yeah, and just to respond to that, I think that's great and we want to continue to do that, and it's most definitely a complement to the types of analyses, like the count of physicians, like the survey that we do. So I think that we need to look at all of these metrics and can we do more on the qualitative side to sort of expand our knowledge base.

DR. CROSSON: Sue.

MS. THOMPSON: I'll be quick as well. I'm in agreement with the recommendations -- I will go on record -- and then I just have a few comments. I mean, certainly one of the tangential learnings from this was obviously all this discussion we're having about hospital medicine. And I'm pleased very much with this work, in terms of pulling out the hospital medicine component of what we understand to be primary care.

But just a couple of comments about other dynamics going on in that arena. It is a supply and demand, and this is an expensive element to running a hospital. It has become standard of care, and that spreads

into rural communities where physician recruitment is very difficult. And so one of the observations I have made, and continue to observe growing, is the role nurse practitioners are playing in the hospital medicine field. And we are seeing rural hospitals staff their hospital medicine program with nurse pracs, and having a physician oversee that.

So there's another dynamic going on here in terms of we think nurse practitioners are going to continue to maybe be the backfill to what we understand to be primary care, while they're pulled into some of this specialty work, and in this discussion, hospital medicine, I think is worthy of paying attention to. Also, because of the expense associated with staffing a 7x24 hospital medicine program, nurse practitioners are attractive to hospitals.

And there's another new dynamic that we are beginning to take advantage of, and that's a telemedicine program of hospital medicine. So there are a lot of moving parts in this discussion, and I recognize I've gotten way outside the shoe of access of primary care, but I think it's a complicated set of dynamics we've got going on here. And to just think back 15, 20 years, most of the hospitals

I worked with, I mean, we were thinking about putting hospital medicine programs together. Today, critical access hospitals are being moved to take on hospital medicine for purposes of retaining their primary care doc, so they don't have to cover the hospital.

So it's a substantial aspect, but I think it's an important one. I think it does drive improvement in quality, but I can't substantiate that with evidence today without some refresh. So I just think this is a conversation we need to continue to have.

DR. CROSSON: Thank you, Sue. Jaewon.

DR. RYU: Yeah, so I maybe going outside the shoe here too, but the recommendations, I also agree. I think they are spot on.

The only comment I wanted to make around this notion of access, because I think, like many of the comments here, and I'm one of them as well, it just defies logic to think that it hasn't impacted access. But then when I think about what are the leading indicators that might suggest that access has been detrimentally impacted, I heard some of the comments, you know, maybe it's geographic pockets where access isn't what it should be.

Maybe there's some measures of ambulatory-sensitive conditions.

But the other one I think we need to look at is the impact on other payer classes. So Medicaid, I think, is the one that I would look at. It would be interesting to see if Medicaid members or beneficiaries have seen a deterioration in their perceptions of access. Because when I think about how a typical practice might work -- and I think this gets back to Jon's comments -- I think the first cracks in the wall won't be Medicare. It's unlikely to be commercial because of the payer rates. The first cracks in the wall, if access is a problem, will show up in Medicaid. That's the segment of the population that a lot of practices will start to triage out, and close off their panels too.

And so I think that might be a clue to look at, you know, what the perceptions have done in that environment.

DR. CROSSON: Interesting. Thank you. Interesting idea. Kathy.

MS. BUTO: So I don't totally support the recommendation, and the one I don't support totally is the

first one, which is to merge hospitalists in with other specialties. And the reason I don't support that is I think even though we definitely want to be able to separate them in terms of our analysis, I think for all the reasons that people have already stated, I think it's important for us to keep our eye on the role they are playing in care coordination inside and outside the hospital for high-risk patients who have been hospitalized. And from what I gather, it is even now going into post-acute settings.

So I'd hate to lose them in that other specialty bucket which tends to be -- I hope there are no other specialties sitting around the table, but we tend to denigrate that third bucket of specialties that, if you look at some of the areas of growth in services or ancillary services that might not be considered critical, some of those specialties are implicated. And I'd hate to have us assume that hospitalists are somehow associated with unnecessary services. From what I'm hearing, they do play an important role, maybe not everywhere, but they are sought after.

So they also are providing primary care. For that reason, I think we ought to keep our eyes on them in

the evolving role, along with nurse practitioners and physician assistants.

Secondly, I'm trying to understand -- and I think this analysis helps us understand better -- declining interest on the part of physicians becoming PCPs. So we've touched on it in talking about hospitalists. I think another element is what we're beginning to see in terms of primary care physicians opting out of Medicare.

So there are elements we should be looking at to determine if there's sort of a threshold or a canary in the coal mine for a threshold, when we really get concerned, either geographically, for some areas, or just in a more general sense. But there are a number of things going on -- movement to hospitalists, some opt-outs, some pockets of access problems. The question is, what's going on? So I think it can help us, in a broader sense, look at access.

Thank you.

DR. CROSSON: Thank you, Kathy.

Larry?

DR. CASALINO: Yeah. First of all, in terms of measuring access, I agree with what others have said. Just relying on the survey may not be enough. Focus groups is a

good idea. I don't know if it would be legal or politically wise for MedPAC to do Secret Shopper kind of phone calls like Karen Rose did, but that would be a way of getting at things.

I think another possible measure is health care fragmentation. There's ways to measure fragmentation from claims data now, and if you believe that if there's less primary care or there's fewer primary care physicians, they're more rushed, whatever, at least more fragmentation, which is a reasonable hypothesis, then you'd except to see fragmentation go up as primary care physicians go down. So that could be looked at pretty cheaply.

I'd also look at the growth of urgent care. I think that, in my mind, every urgent care visit, pretty much, is a failure of primary care, of primary care access.

You could also say, for slightly different reasons, ambulatory care and ED visits. I think if you see urgent care going up, you see ambulatory care and ED visits going up. I think you can think there's less primary care access.

Looking at units -- I agree with the recommendations, by the way. I should say that straight

up, but looking at units of service for primary care as a measure of access -- other people have mentioned this -- if physicians started doing more on the phone, for example, or by telemedicine, however you want to define it, and less in person and you couldn't measure that, it would look like less service. But it wouldn't necessarily be the case.

I also agree. I don't know if it's within MedPAC's scope to look at Medicaid, which I can tell you from experience, that will be the first thing that goes for practices is cutting out Medicaid, seeing Medicaid patients.

But maybe you already do this. Looking at dual eligibles, I think, would be of some use.

Then in terms of the supply of physicians, we had a little discussion earlier today about if primary care physicians aren't spending an hour or two a day of doing to the hospital and back and rounding in the hospital on one or two patients, could they see more patients? We actually see, in the numbers here, fewer encounters with primary care physicians per beneficiary per year. So it's not obvious that that's happening in terms of hospitals indirectly increasing the supply of primary care services.

I think that it's already been mentioned with physician assistants and nurse practitioners. There's probably a fair amount of billing done not in their name, but under the physician's name. But without being able to measure that, it's hard to know the contribution of PAs and NPs to primary care supply.

But I will say -- this may have been mentioned -- I think we're going to see fewer and dramatically fewer physician assistants and nurse practitioners working in primary care. They're working pretty much in every specialty now, and just counting encounters with NPs and PAs, without knowing whether they were primary care-based, is not going to contribute to understanding the supply of primary care services.

Long term, I think there's a tremendous -- I think we are getting behind the curve. We had the one graph that showed a 50 percent drop over not very many years in the number of general internal medicine residents planning to do primary care. Fifty percent is a lot, particularly in the last year or two, it looked like. I don't know if that's a blip, or if it were to continue like that, it would be very dramatic. So I think that's a worry

about supply and then also what I mentioned about the NPs and PAs going into subspecialties.

And then just two extremely quick points to finish, in terms of the volume measurement as a way of measuring access, I think that's fine, but it is a little tricky to interpret. In one graph that you had, imaging increased by far the least, not very much at all. So do I interpret that as a lack of supply of imaging, or do I interpret it as physicians are actually getting better at not ordering unnecessary imaging? So it can be a little tricky interpreting volume. That's not a reason not to do it, but I think it needs to be given in context.

The last thing I would just caution is be careful with percentages versus absolute numbers. A 13 percent increase in encounters for nurse practitioners and physician assistants over the last few years, average a year, that sounds pretty impressive, but actually over three years, the increase in absolute numbers was 1.1 to 1.8. Looked at in those terms, it's not as impressive as the percentage terms.

Also, it was mentioned 16 percent versus 84 percent. I can't remember exactly what that was. I think

one was NPs and PAs; the other was primary care physicians. Again, given the very different denominators that we're looking at, it's misleading, I think, to try to compare 16 to 84 percent. I'd always try to look at absolute numbers and absolute differences as well as percentages.

DR. CROSSON: Okay. Dana and then Bruce. I'm sorry. I wasn't keeping up with the list. So Bruce, Paul, and then Dana.

MR. PYENSON: Thank you very much. I support the recommendations, though I would ask consideration for an RVU work unit-based metric taking out the practice expense and the medical professional liability piece. It might be useful or just another metric to test for consistency.

I think on the broader issue of the ultimate chapter and the tasks we have, some recognition of the changing nature of physician employment would be helpful.

I think much of what we do, perhaps even the physician fee schedule, has an underlying assumption of individual physicians who are self-employed or working in small groups, and that is an assumption that may affect the way we look at health care more broadly.

For example, a self-employed physician may have

different behaviors with respect to how they think about answering emails and phone calls because they're building a panel of patients, if you will, a business that's going to persist for years. Whereas an employed physician who doesn't get paid for that may have a different view of how they work.

So it seems on the one hand almost easier to think about physician practices in the same way that we think about the financial indicators for adequacy of hospitals or adequacy of other enterprises by looking at whether there's adequate capital and other financial metrics. How are the publicly traded outlooks? How is that perceived?

So just some ideas on the broader topic to recognize the changes, I think, all the Commissioners have spoken to from our adequacy analysis.

DR. CROSSON: Thank you, Bruce.

Paul?

DR. PAUL GINSBURG: This is my second time, so let me --

DR. CROSSON: Oh, okay. Dana?

DR. SAFRAN: Thank you.

So I guess I wanted to make two comments about this was a great discussion, and I think the opportunity that I see in front of us is really to leverage a workforce that we didn't fully know we had. But in listening to a lot of the comments of my colleagues, I see two things in particular that I wanted to call out.

One is the opportunity to really in a formal and very purposeful way integrate what happens for a patient in the hospital back out to their primary care physician in the community has been a gap forever. It's one that ACOs are, I think, working to close, but I think it would be good to harness the workforce that we have in hospitalists to really formalize that and make it an expectation that when a patient has been hospitalized that doctor to doctor can really connect the dots for that patient and what is needed for their care, even if they're not in an ACO, so that that doesn't fall through the cracks.

The other is I was really struck by what Karen was sharing about kind of seeing hospitalists as people trained in internal medicine but who are really comfortable with the high acuity and complexity, and thinking about Jonathan's comments about his dad, remembering my own

experiences with my dad who passed away in 2012, but during a several-month illness said that his primary care doctor told him he could no longer take care of him because he was too complicated.

So harnessing this idea of hospitalists as part of the primary care workforce, though, I definitely support segmenting them out so we don't lose track.

Doing what we can do to potentially promote this idea that maybe they are really useful workforce, not just when patients are in the hospital but when our beneficiaries are complex and need a clinician who can look after them as a primary care physician outside of the hospital and is comfortable with that complexity and high acuity.

So thanks.

DR. CROSSON: Thank you, Dana.

Paul?

DR. JAFFERY: Jay?

DR. CROSSON: On her point?

DR. JAFFERY: Yeah, it's sort of related to that. I'll be very quick.

Thinking about the idea of people being

comfortable with their hospital training, then becoming hospitalists, on Slide 4, you talk about the factors that might influence decisions to become hospitalists.

The one thing that I don't think we heard come out would really fall in that training, that first bucket, the training one, which is that hospitalists or internal medicine residents train largely in hospitals and are comfortable in that role. I think it's just important for us to call that out and think about it, maybe not so much for this report specifically but going back to last month in our conversations about graduate medical education funding. It's something we should think about, how these things track.

DR. CROSSON: Okay. Paul?

DR. PAUL GINSBURG: I just wanted to mention that for our March reports on beneficiary access, the context may have changed substantially because of the proposed rule for the Medicare fee schedule that CMS has issued, and the Commission has commented very favorably on a very substantial increase in relative payments for outpatient ambulatory evaluation management services. Of course, this won't go into effect until, I guess, next year, and we'll

know this in November.

But the interesting thing is that it's probably the most striking policy over a long period of time that's specifically relevant to this issue of access to primary care.

DR. CROSSON: Thank you, Paul.

Good discussion. Thank you, Brian and Carolyn and Kevin. Thanks for coming back, Kevin.

[Laughter.]

DR. CROSSON: We'll move on to the next discussion. Thank you.

[Pause.]

DR. CROSSON: Okay. We're going to move on to the last presentation for the day. That has to do with the continued discussion on the development of population-based outcome measures, specifically avoidable hospitalizations and avoidable emergency room visits.

Ledia is going to present. You have the mic.

MS. TABOR: Good afternoon. Today I'll present background and analysis on two population-based outcome measures -- avoidable hospitalizations and ED visits.

Consistent with the Commission's principles,

these measures are patient-oriented, encourage coordination across providers and time, and promote relevant change in the nature of the delivery system.

After the presentation, we would like your feedback on next steps for our work with these measures.

The Commission's goal for quality measurement is to use a small set of population-based outcome, patient experience, and value measures to assess the quality of care and create aligned incentives across different populations such as beneficiaries enrolled in Medicare Advantage plans, accountable care organizations, and fee-for-service in defined market areas.

Today we'll talk about the use of avoidable hospitalizations and ED visits as concepts that could be translated into claims-based outcome measures to compare quality of care for fee-for-service populations, given the adverse patient impact and high cost of these events.

We contracted with RTI International to define uniform avoidable hospitalizations and ED visits measure specifications.

Hospitals are important to the delivery system and are necessary to diagnosis and treat the sick and

injured. However, hospital stays can pose risks to patients, particularly the elderly.

The inpatient environment itself can lead to a reduction in elderly patients' independence as they cope with functional loss that can stem from extended bed rest or delirium.

Adverse events during the hospital stay also represent a risk, including hospital-associated infections, medication errors, and pressure ulcers.

Similarly, EDs are not the ideal venue for treatment of non-urgent acute conditions and management of chronic conditions because non-urgent utilization detracts from ED resources for providing emergency and lifesaving care.

Also, clinicians in the ED typically lack a relationship with the patient and are unfamiliar with the patient's baseline state.

Conceptually, avoidable hospitalizations and ED visits may result from inadequate access to ambulatory care or inadequate coordination of care received and as such may reflect the effectiveness of the ambulatory care system.

Avoidable hospitalizations and ED visit measures

based on administrative data, if properly calibrated, can be useful indicators of potentially high- or low-quality care.

In practice, not every avoidable hospitalization or ED visit can be avoided, but they can demonstrative relatively quality.

We defined avoidable hospitalizations using existing measures of ambulatory care sensitive conditions that are currently used in the Medicare program. For avoidable ED visits, we applied the same set of conditions as used in defining avoidable hospitalizations and incorporated other acute conditions from additional research because there are less comprehensive existing measures currently used in Medicare.

Two categories of ambulatory care-sensitive conditions are counted in the measure definitions; first, chronic conditions including diabetes, chronic obstructive pulmonary disease, asthma, hypertension, and heart failure; second, acute conditions including bacterial pneumonia, urinary tract infections, cellulitis, and pressure ulcers. The ED visits'
definition of avoidable conditions also includes upper

respiratory infection, otitis, rhinitis, influenza, and non-specific back pain.

The measures assume that not every hospitalization or ED visit tied to these conditions can be avoided, but they can be used as relative markers of quality.

Our definition of avoidable hospitalizations included both inpatient admissions and observation stays. From a patient's perspective, an observation stay in a hospital is similar to an admission.

Our measure of avoidable ED visits consisted only of ED visits that did not result in an admission or observation stay.

Now that we have defined the two population-based measures, I will walk through some of our analysis, calculating measure results for the fee-for-service population using 2017 claims data.

In 2017, about 4 percent of fee-for-service beneficiaries had at least one avoidable hospitalization while roughly 7 percent experienced an avoidable ED visit. Nationally, the average rate of total observed avoidable hospitalizations was 50.5 per 1,000 fee-for-service

beneficiaries, and the average rate of total avoidable ED visits was 94.3 per 1,000 fee-for-service beneficiaries.

Avoidable hospitalizations due to chronic conditions contributed more than avoidable hospitalizations for acute conditions. This trend was reversed with avoidable ED visits, with more avoidable ED visits for acute conditions than chronic conditions.

For quality improvement, it is important for the Medicare program to understand the nature of variation and avoidable hospitalizations and ED visit rates across local health care markets and the degree to which it reflects genuine differences in quality versus differences in underlying patient risk. Calculated at the local market area level, comparatively high risk-adjusted rates of avoidable hospitalizations and ED visits can be used to identify opportunities for improvement in an area's ambulatory care systems, even though not every hospitalization or ED visit can be prevented.

In the risk adjustment model, we controlled for patient demographic characteristics such as age and gender and clinical conditions primarily based on HCCs. Consistent with the Commission's principles for quality measurement,

we did not adjust for social risk factors in the risk adjustment model itself to avoid masking disparities in care.

To understand the nature of variation in avoidable hospitalizations and ED visits across local health care markets, we calculated risk standardized rates of avoidable hospitalizations and ED visits for two different types of market areas.

First, MedPAC has previously defined a set of about 1,200 MedPAC market areas that are designed to reflect local health care markets. The average fee-for-service population in each MedPAC market area is about 25,000 beneficiaries.

We can reliably measure avoidable hospitalizations and ED visit rates for most fee-for-service beneficiaries in these larger areas. However, the values may not be actionable for ambulatory care systems, so we also calculated avoidable hospitalizations and ED visit rates for more narrowly defined hospital service areas.

There are about 3,400 Dartmouth-defined HSAs comprising zip codes whose residents receive more of their

hospitalizations in that area. There are about three times the number of HSAs than MedPAC market areas. The average fee-for-service population in each HSA is about 10,000 beneficiaries.

This slide shows the distribution of percentiles of performance for the MedPAC market areas. The MedPAC market area at the 90th percentile of avoidable hospitalizations had a rate that was 1.8 times the MedPAC market area at the 10th percentile.

The MedPAC market area at the 90th percentile of avoidable ED visits had a rate that was 2 times the MedPAC market area at the 10th percentile. This variation in performance signals opportunities for improvement.

Comparatively high or low risk-adjusted rates of avoidable hospitalizations and ED visits can be used to identify opportunities for improvement or best practices in an area's ambulatory care systems.

To further understand the nature of variation in avoidable hospitalizations and ED visit rates across MedPAC market areas, we looked profiles of the MedPAC market areas at selected percentiles of avoidable hospitalizations.

The Seattle MedPAC market area could be

considered a relatively high-performing area because its rate on the avoidable hospitalizations measure -- the green square -- is relatively high performing, and its rate on the avoidable ED visit measure -- the orange triangle -- is also high performing.

One of the rural Nebraska MedPAC market areas could be considered a relatively average performing ambulatory care system on both measures.

A rural Arkansas MedPAC market area could be considered a relatively low performing ambulatory care system because of its low performance on both measures.

MedPAC market areas may have relatively high performance on one measure and not pm the other.

For example, a MedPAC market area in rural Ohio is a relatively high performer on the avoidable hospitalization measure, but low performing on the avoidable ED visits measure.

By contrast, the Greenville, North Carolina, MedPAC market area is a relatively low performing market area on the avoidable hospitalizations measure, but a higher performing MedPAC market area on the avoidable ED visits measures.

I'll now switch to discussing results for the more narrow HSAs.

This slide shows the distribution of percentiles of performance on the measures of avoidable hospitalizations and ED visits across HSAs.

The HSA at the 90th percentile of avoidable hospitalizations performance had a rate that was 1.9 times the HSA at the 10th percentile. The HSA at the 90th percentile of avoidable ED visits performance had a rate that 2.4 times the HSA in the 10th percentile of performance. This variation in performance across HSAs signals opportunities for improvement like the MedPAC market areas.

HSAs are more representative of ambulatory care systems than the larger MedPAC market areas. So policymakers, providers, and beneficiaries may find it beneficial to see the performance of HSAs compared to other contiguous HSAs.

To further understand the nature of variation in rates across contiguous HSAs, we selected one MedPAC market area (Northern Virginia) and compared the rates of the 12 HSAs within that market area to each other.

For the Northern Virginia market area, the mean risk-adjusted rate of avoidable hospitalizations is about 50 per 1,000 beneficiaries, and the rate of avoidable ED visits is about 90 per 1,000 beneficiaries.

There are HSAs that are relatively high-performing, low-performing, or average on both measures, while other HSAs have relatively better performance on one measure than the other. For example, HSAs 2 and 5 are relatively high performing with both avoidable hospitalizations -- the green squares -- and ED visits -- the orange triangles -- having rates below the means.

HSA 7 is relatively low performing with both avoidable hospitalizations and ED visits rates above the Northern Virginia mean.

HSA 10 is a relatively average performer on both measures.

The other areas have about the same level of performance on the measures or may be higher or lower performing on one of the measures.

In summary, we developed uniform, claims-based, risk-adjusted measures of avoidable hospitalizations and ED visits. We compared the quality of care for fee-for-

service beneficiaries across two different local market areas.

Overall, the variation in risk-standardized rates of avoidable hospitalizations and ED visits for both the MedPAC market areas and the HSAs signals opportunity to improve the quality of care for fee-for-service ambulatory care, especially in those areas with comparatively low performance for both avoidable hospitalizations and ED visits.

We plan to report out fee-for-service avoidable hospitalizations and ED visit results as a part of the physician update in the March reports to the Congress

This brings us to your discussion. We would your input on potential next steps for our work including analyzing areas that are both relatively high performing and low performing to identify factors that affect performance.

For example, we could analyze common factors across high-performing HSAs that may lead to better preventive care, such as higher rates of primary care clinicians per capita and ACOs in the area that have incentives to improve preventive care and lower

hospitalizations and ED visits.

The goal of this analysis would be to identify best practices that may lead to higher performing ambulatory care systems, which could help inform Commission discussion on a variety of different topics.

As a part of this work, we would include areas with a higher proportion of patients with social risk factors that achieve relatively high performance. We know that social risk factors can affect measure performance, so effective technical assistance should be targeted to the low-performing areas.

We can also continue to explore using these measures to compare the quality of care across fee-for-service, ACOs, and MA.

Thank you, and I'll turn it back to Jay.

DR. CROSSON: Thank you, Ledia. Excellent.

Let's have clarifying questions. We'll start with Marge.

MS. MARJORIE GINSBURG: This is very exciting work, and it's wonderful to really start focusing on something that has such a need.

The goal is to look at all three types of

services -- MAs, ACOs, and fee-for-service. All the information presented here looks like it's just on the fee-for-service world. Is that because they were the easiest ones to pull and until you get a thumbs up from us you weren't going to try to figure this out for the ACO and MA world?

MS. TABOR: That's a great question. So the analysis that we presented here today includes fee-for-service plus ACO beneficiaries, so it's the global fee-for-service. And you're right, we did just kind of want to start off -- I think the biggest goal that I had in mind was creating uniform measures because we don't have those. So now we have those. We tested them out on fee-for-service. They seemed to work well. Now if you all would like, we can go forward and kind of try to do ACO and MA. I will say it's not going to be easy, particularly with MA because of the encounter data not being as complete as we would like it to be, and then also we'd have to look at kind of coding differences between the populations. So I think we can kind of keep exploring it, and this was a good first step.

DR. CROSSON: Thank you, Marge. Larry.

DR. CASALINO: Yeah, just a question about what you called in the report a weak correlation. By the way, I thought it was a great report, and I love ambulatory care sensitive admissions. Now I don't really want to participate in --

MS. TABOR: Yeah, right.

[Laughter.]

DR. CASALINO: But you point out that there's a weak correlation, and the graph seemed to show that. But I wonder if there's one thing that's a little bit of a problem for that analysis, and maybe it needs a little deeper digging.

If I understand correctly, so if there's an ambulatory credit sensitive hospitalization that happened, you know, first someone comes into the ED, it's an ambulatory care sensitive ED visit, then they get hospitalized. You're counting ambulatory care sensitive hospitalization but not the ambulatory care sensitive ED visit.

MS. TABOR: Right.

DR. CASALINO: And that makes sense from a point of view of not double counting, I think. But if you want

to talk about correlations, the more ambulatory care sensitive hospitalizations they are, assuming that most if not all of them are associated with ambulatory care sensitive ED visits, the fewer ambulatory care sensitive ED visits there will be, if I'm thinking about that correctly. So that would weaken the correlation, I think, and so it might be interesting to try to look at the correlation if you count all the ambulatory care sensitive hospitalizations and all the ambulatory care sensitive ED visits and see if the correlation is higher. I suspect it would be.

MS. TABOR: Yeah, I did not look at that, but that's an interesting idea.

DR. CASALINO: And I think that's not true, though. I mean, I think that actually makes a difference.

MS. TABOR: Right.

DR. CASALINO: Because I would actually expect them to be fairly highly correlated, and it's a little bit of a mystery to me why they aren't. That might explain part of it least.

MS. TABOR: Yeah, that's a good point. We can look at that.

DR. CROSSON: Dana.

DR. SAFRAN: Exciting work, glad that you are undertaking it, and it feels like it could be a long road. So it's good to take the first step -- right? -- as the saying goes. A couple of thoughts, one sort of where Larry was going. Because we know that such a high percentage of emergency room care by other algorithms is coded as unnecessary and so much of admissions comes through the emergency room, it does seem important to just get a read on how much of these emergency room visits are turning into admissions. So that's one thought.

The second thought is on Slide 12, I think it was, where you showed the MSA view, I think I get with your benchmarks, your two different benchmarks there, that actually these paired data points don't tell that different of a story from the story we saw a couple slides before it.

MS. TABOR: Right.

DR. SAFRAN: But on the face of it, it looks like it tells a really different story, so I would just flag that and say like the y axis that you used before around percentile -- what did you use? -- percentiles of performance is probably a helpful way to look at that, just

so we can get a better sense of how tightly these things are related.

I wondered two things. One is do you already know sample size needed for reliable measurement here?

MS. TABOR: Right, so based on some previous work, we used a minimum sample size of 1,000 beneficiaries, and we're actually working with the same contract team to see how much smaller we can go.

DR. SAFRAN: Yeah.

MS. TABOR: So we did kind of -- so we'll have more information, I guess, when we come back, but 1,000 was our reliability standard.

DR. SAFRAN: And does 1,000 get you 0.7 reliability at the --

MS. TABOR: I don't want to say a number yet --

DR. SAFRAN: -- you're looking at?

MS. TABOR: -- because, again, we're still working on it.

DR. SAFRAN: Okay.

MS. TABOR: We felt kind of confident enough with the 1,000 just based on our kind of back-of-the-envelope stuff, but as far as getting an actual reliability metric,

we'll come back to you.

DR. SAFRAN: Okay. The reason I want us to keep that in our sights is at some point you probably want to move this measure from, I'll call it, surveillance measure to an accountability measure. And I think we're going to be challenged with that. I mean, anything that has potentially avoidable is always a hard sell with those who are being held accountable for it if you can't prove that it was avoidable. But just getting a handle on the sample size, it seems important.

Then my last question was -- what? Oh, avoidable ED, when I looked at your list, I wondered how often do we think that the beneficiary would kind of know that -- like if they understand the distinction between like what you need an emergency room for and what you don't, how often they would actually think this is potentially an emergency? Like the unspecified back pain or however you described that, you know, somebody could think they're having a heart attack and go off to the emergency room. It turns out it was, you know, just unspecified back pain. But I just -- I wondered if you've looked at the ED measure through that lens of, you know, whether the beneficiary could actually

think there is an emergency here and should we be trying to parse that out from the avoidability or at least keep -- even if we lump it in, know which segment of avoidable ED visits may not be avoidable based on what a person thinks is the level of care that they need.

MS. TABOR: Yeah, that's a good point. I will say that patient preference definitely plays a role in this, and the literature talks about that. And I'm not a clinician, so I kind of, you know, won't get into what truly is preventable or not, but I think this is just kind of a good sense of this could be potentially preventable, knowing that not everything can actually be avoidable.

DR. CROSSON: Karen, do you want to come in on this?

DR. DeSALVO: Maybe just to make a -- to this accountability point, I could easily see how if everyone were -- if all clinicians were held accountable for avoidable ED admissions, you could go down a pathway pretty clear where there'd be contested diagnostic codes based upon what the ER put in or the hospital, and that could create some -- the opposite, of coordination of care and communication, and so just being careful about exactly

making sure the measures are right and that we're threading that needle well, so we're creating teams and partnership and not a battle on the front line.

DR. CROSSON: You know, I know from -- in the insurance world in terms of coverage, thinking about this, it's often better to look at the presenting complaint than it is to look at what the diagnosis at the end is. That gets to the question of what the beneficiary thought they might be having a heart attack or whatever. I don't know how accessible that information is.

DR. DeSALVO: Yeah, I was going to ask that question about which codes these are, and not to be very negative late in the afternoon, but you could also see a world in which there was some gaming of documentation, to document things that were --

MS. TABOR: Absolutely.

DR. DeSALVO: -- different than maybe the presentation just so that you didn't get dinged with avoidable admissions.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: Great. Thanks, Ledia, for this work. I think it's shaping up really well.

I wanted to ask about the ambulatory care sensitive condition. Similar to Larry, I've worked with those, and we like them. One thing, however, you know, we've gotten -- when we've obtained these really interesting results, we've then gone and run the model on all hospitalizations and gotten the same result. And so this speaks to Karen's issues and others that these measures aren't maybe picking up quite what they think -- what we think they should be. And so I just wanted to ask, have you looked at all sort of conditions and whether those results look kind of different across markets? Or are these sort of ambulatory care sensitive hospitalizations -- we haven't looked at ED visits in our work. Maybe others have. But at least in our work, the hospitalizations seem to be pretty well correlated with overall hospitalizations. Is that true here?

MS. TABOR: They are correlated. I haven't looked at them kind of market by market, but just on a national level, there's a correlation between both the hospitalizations and the ED visits, and that would be, I think, an interesting kind of follow-up piece to do of looking at just risk-adjusted total admissions in a market

area versus these avoidable and do the same for ED.

DR. GRABOWSKI: Yeah, and then it --

MS. TABOR: We can come back to you on that.

DR. GRABOWSKI: Oh, sorry. Go --

MS. TABOR: I was going to say we can come back to you on that.

DR. GRABOWSKI: Yeah, and I think it may get you out of some of these issues Karen just raised about coding and other things, just to look overall. I realize there's something very nice, and I agree with Dana, you don't want to use the word "potentially avoidable," but there's some -- I find something very maybe simple about just using all hospitalizations.

My other question was about competing events, and in addition to ED visits and hospitalizations, we hear a lot about observation stays, and is that something that's important in this context?

Then I guess the other competing event is obviously mortality, and can you look at these rates without thinking about those other competing events?

MS. TABOR: So we purposely actually did consider the observation stays, and we included those in the

avoidable hospitalizations. So if you -- they're in there, yeah. And I think in general we're trying to do that with all of our quality measures just because, again, from the beneficiary perspective, they're an admission.

And then your second point about mortality is that we -- I haven't looked at them kind of all together, but you'd think that we'd need kind of a full set of outcome measures, which, depending on the accountability program, could or could not include mortality.

DR. GRABOWSKI: Thanks.

DR. CROSSON: Okay. Thank you. Sue.

MS. THOMPSON: Thank you, and thank you, Ledia. I, too, am excited about this conversation. In relation to the question that Marge began with in terms of fee-for-service, ACO, MA, by very nature of being an accountable care organization, ACOs are astutely aware of what their emergency department utilization rates are or what their admission rates are and work to obviously reduce those and provide the right care to the right patient at the right time.

I'm curious. In the absence of some organized system of care or an ACO, who's the accountable party for

ED utilization or an unnecessary admission? Have we thought about that in the context of the broader fee-for-service world?

MS. TABOR: I guess I would kind of turn that over to you guys too.

I mean, one, I will say that, in principle, when the Commission discussed the Voluntary Value Program, which could replace MIPS, that one of the measures we talked about using as an accountability for a large physician group would be these two measures. I think we haven't tested it out that way yet, but that's one direction this could take.

DR. CROSSON: That would have been my answer as well.

DR. MATHEWS: And another way to think about it would be if there already is accountable entities, ACOs that make plans, you could use the ambient fee-for-service performance on these measures as a benchmark against which their performance is assessed. So the rewards and penalties aren't necessarily applied to a random collection of fee-for-service provider, but is the accountable entity doing sufficiently better to warrant a bonus, something

like that.

DR. DeSALVO: I also think that, probably, it could -- potentially, it could encourage more team-based care in the primary care environment. So these models like global primary care payment that are being experimented with by CMI or Medical Homes, they wouldn't necessarily have to be part of a larger organization.

MS. THOMPSON: That's what I was going to say in Round 2, but that's good.

[Laughter.]

DR. CROSSON: Round leakage.

Okay. Pat?

MS. WANG: I think it's more of a Round 2 comment too.

DR. CROSSON: Round 2. Okay, honesty. Okay.

[Laughter.]

DR. CROSSON: Bruce?

MR. PYENSON: I want to pick up on David's Round 2 comment.

[Laughter.]

MR. PYENSON: Just on Slide 11, if we could go to the numbers here, I think the background here, the average

admits per thousand in the Medicare population is perhaps 350 or something.

MS. TABOR: Yeah. I would adjust those. Yeah.

MR. PYENSON: I'm sorry? Oh. But something just to put it in context.

So we're talking about at the 50th percentile a pretty big chunk of at least the national average admissions. Is that the right interpretation?

MS. TABOR: I guess I haven't thought about it with percentiles, but I have thought about it with percentages. So about 18 percent of fee-for-service beneficiaries have a hospitalization a year and about 4 percent have an avoidable hospitalization, so that's about a third.

MR. PYENSON: But the 18 percent, it includes more than one hospitalization, perhaps, probably?

MS. TABOR: Correct, correct.

MR. PYENSON: So your number was about a third?

MS. TABOR: About a third, yeah.

MR. PYENSON: A third. I mean, this is a big deal, right?

MS. TABOR: Yeah.

MR. PYENSON: Another question, we're calling these "avoidable hospitalizations," and others have said "ambulatory care-sensitive admissions." It strikes me there's other categories of avoidable admissions.

MS. TABOR: It's really just nomenclature. So AHRQ has used this term, "ambulatory care-sensitive conditions." 3M used "potentially preventable." NCQA uses "potential complications." So we just kind of picked a nomenclature of "avoidable" and stuck with it.

MR. PYENSON: But there's also like "preference-sensitive," like someone gets back surgery or hip surgery, and that was the preference of the doctor or patient versus --

MS. TABOR: Right. I would say that's different, though, because I don't think we necessarily included any preference-sensitive conditions, other than you preferred to go to the ED and you went.

MR. PYENSON: In terms of when we think about regions that have low hospitalization rates, overall that could reflect preference-sensitive as well as other -- as the ambulatory care-sensitive.

DR. CASALINO: [Speaking off microphone.]

MS. TABOR: Right.

DR. CASALINO: Ambulatory care-sensitive in total.

MR. PYENSON: Yeah. In total.

MS. BUTO: [Speaking off microphone.]

MR. PYENSON: As Kathy said, read.

My view is the same as David's that they're all correlated, the lower admission, lower readmissions, low preference-sensitive admissions, lower ambulatory care-sensitive admissions."

I'm wondering if that kind of lining those up would be -- if the data holds or the hypothesis holds. What do you think?

MS. TABOR: We haven't looked at it that way, but I think it would be interesting. So we can do that as a follow-up step.

MR. PYENSON: Thank you.

DR. CROSSON: Marge, question?

MS. MARJORIE GINSBURG: So for unnecessary ER visits, would it make a difference if, in fact, the patient called their doctor and the doctor said go to the ER, mainly because they didn't have any openings in their

appointment that day, and they basically wanted to get off the call? So is there any way at all of tracking that, and would that make a difference?

MS. TABOR: In our current world of the data we have available to us, we wouldn't be able to make those distinctions.

DR. CROSSON: Okay.

UNIDENTIFIED: [Speaking off microphone.]

DR. CROSSON: All right. You've taken a long lead off of first base, I can see. Yes.

UNIDENTIFIED: [Speaking off microphone.]

DR. CROSSON: Yes. Go ahead.

DR. DeSALVO: I'm sorry. No, I'm not going to steal your thunder. Never do that.

I just wondered if you have the level of data to know what kind -- what the code was of the clinician, the doctor that admitted them. So you could look at whether the hospital was staffed by a hospitalist or the primary care physician had to come in and do the admission. I'm just trying to figure out this weirdness where sometimes people are not admitted, you know, in some communities where there's more ED visits than hospital. And it might

have something to do with who's actually --

MS. TABOR: Doing the admitting?

DR. DeSALVO: -- literally on call or --

MS. TABOR: Yeah. That is an increasing question that I'd have to look into some more.

DR. CROSSON: Okay. So we are now at the discussion phase, and Amol will begin.

DR. NAVATHE: So, Ledia, as always, thank you for a clear, concise presentation and paper.

I think as we kind of put focus on these two measures, my sense is, the way you kind of put them forward as consistent with Commission priorities, I think, makes a lot of sense. I think we generally, of course, want to support transparent, simple measures that can be commonly measured across different types of programs, and I think that makes a lot of sense.

The other thing I'll say is that as somebody who works with these types of measures quite a bit, there's obviously no such thing as a perfect measure, and so, at some point, we're going to have to pull the trigger and say this is a measure we want to use and double down on.

I think it's also nice that there's alignment

between these measures and other measures that we see in other programs, including ACO programs and more recently primary care first and the direct contracting for Medicare. So I think that alignment is beneficiary because it means that it's less jarring to the extent that we propose this in order to get it adopted to providers who are actually operating in various models in a kind of longitudinal sense.

I do think it's worth pausing on the nomenclature a little bit, and we should think about it because I think it does have a psychological impact on how people think about the measure. So the distinction between ambulatory care-sensitive and avoidable is actually pretty different in terms of what we're telling people it means. So that's worth visiting.

I think there's a couple other pieces that I would highlight and perhaps some suggestions that build upon what other Commissioners have already started to, I think, get at in terms of exploring the value, the validity of the measure in a kind of broader sense.

So the one observation, I think, that's important to think about is to the extent that we're using this as a

measure of the performance of the ambulatory care system within a market, then to me, it seems like the conceptual framing there is we should have a common performance across both measures. So if we have a well-functioning ambulatory system, then we should both get lower avoidable ED and lower avoidable hospitalizations.

I think the observation -- so I think it was on Slide 10, for example -- that you have specific HSAs or markets where there's discordance between the two is potentially a problematic piece.

I think Larry pointed out important potential "fix" on it, but I think that also perhaps brings a convergence of the measures because if we are including avoidable ED within hospitalization, then I think, in some sense, the difference between them starts to blend. The correlation will certainly go up, but then the distinction also goes away.

So one thought is, Should we be thinking about this as avoidable ambulatory care-sensitive events or something like that as a way to unify the two and have a measure which is more likely, presumably, to be consistent?

I could imagine again being in the room with one

of our hospital administrators or primary care physician practices and them saying, "So the same infrastructure is leading me to perform the top quartile of one measure and then the bottom quartile, and we're doing the same stuff for both of them." So I think we want to try to avoid that discordance because that could, I think, be particularly pernicious to the success of the measure from an engagement by an adoption.

DR. CASALINO: [Speaking off microphone.]

DR. NAVATHE: I'm sorry?

DR. CASALINO: [Speaking off microphone.]

DR. NAVATHE: Unify them, making it an ambulatory care-sensitive events measure, encompassing both pieces of it.

In terms of other things that one could do or we could do here to sort of build some validity around the measure, we have done work on other measures, like readmissions measures, where we see really big swings in longitudinal variation.

For example, I was observing here that we're using 2017 data. When we looked at the readmissions measure -- this is a few years ago -- we saw that hospitals

could go from bottom quartile to top quartile year to year, and there was actually a pretty large share of them that were bouncing around. It's very unlikely that big infrastructure is changing so much year to year, such that we would see that volatility.

So I think one thing we could do here is look at the longitudinal variation within markets and see how much we're seeing. If we're seeing a lot of variation, I think that would kind of raise a question of how valid it is.

Another question is thinking about this notion, and I think Bruce was getting at this, which was kind of practice style, preference style within a market, and can we do something to actually account for it?

If we were to do this at the provider level, we could actually try to control for the sort of market style in some sense by looking at everybody else outside, except for them in the market, and using that as a variable to control for. So that might be a way to try to get away from just capturing purely practice style and trying to actually understand what performance is looking like. That would be hard to do at the market level, easier to do at the provider level, as we get there.

The other thing we could do is look within condition here. I think we have a set of conditions, and ensuring that we have validity within condition would also, I think, build a case that consolidated across condition measure also makes sense.

The two last suggestions -- and then I'll close here -- to the extent that we decided we wanted to use the word "avoidable," I think it would behoove us to do some deeper work to see what proportion of these ambulatory care-sensitive condition admissions are actually avoidable. That would mean getting access to clinical data or doing some sort of deep dive, so to speak, charge review type of work in perhaps a selective fashion to really try to elicit that. Otherwise, I think it's hard for us to push to call it "avoidable."

And the last piece, I would say I support a lot of -- I think the general construct, of course, of the measure/measures, that follow-on analyses that you have outlined as next steps, I think, make a lot of sense and in particular would support the idea that to the extent that there are unified markets where we're seeing high performance, that there are lessons we can take around the

capabilities of those markets, the practice patterns, composition of the types of providers that are in those markets. I think we could actually learn a lot there, and I think that sort of positive deviance analysis could be very helpful as we start to think about translating this into technical support and more tactical sorts of recommendations.

DR. CROSSON: Thank you, Amol.

I just want to make a comment. First, I think I like the direction you've taken with respect to the ambulatory-sensitive one. I think for a lot of different reasons, it avoids some opposition which occurs reflexively.

The notion of combining the two under a terminology of "ambulatory-sensitive events," the first question I had in mind is, Are there other events other than hospitalization or ER visits that you would think might or should be included in that? Maybe you can just think about that because, I mean, I don't know, but I would imagine that there are some.

DR. PERLIN: Drug-drug interactions from different providers.

DR. CROSSON: That's certainly one.

DR. NAVATHE: Yes. I think that's a great point, and I don't have an answer off the cuff for you. But I think I'll put my thinking cap on and get back to you.

DR. CROSSON: Yes, Jim.

DR. MATHEWS: Yes. When we kicked this around internally, we also were struck by the fact that performance within an area was not consistent on two measures that ostensibly reflected the adequacy of the ambulatory care infrastructure.

Again, this is kind of developmental work. We're just kind of figuring it out, but one of the things we talked about pursuing when we start doing case studies, if that's what we end up doing, is things like does the supply of urgent care centers in an area represent a safety valve that could keep patients from showing up at the emergency department, while still showing up at fairly high rates in the hospital inpatient setting.

So there are things we still want to pursue here, but the ideas that have been expressed here are extremely helpful in that regard.

DR. CROSSON: I'm sorry to interrupt, but I just

want to make one more comment on top of Jim's there. And it has to do with potential explanations, not for the divergent examples here, but for the convergent one on the left, which is Seattle.

Now, I think in addition to looking at ACOs, looking, if it's possible, more broadly at the presence of integrated delivery systems of various types would be useful, whether they're ACOs or not, because I know Seattle is one of the most concentrated markets for that model of care. And that could explain not anything to do with the divergent markets but the convergence and the quality, the relative high performance on both measures.

Okay. I'm sorry. Let's go. Pat, Jon, Dana, Larry.

MS. WANG: So I'll slide into Round 2 with what I was going to ask in Round 1.

I just want to confirm that what you're describing here as avoidable or whatever calling admissions includes avoidable readmissions.

MS. TABOR: We only count it based on the initial admission.

MS. WANG: Okay.

MS. TABOR: So if you are readmitted, you only get once, and that was a question that we thought about with measure developers and just picked away.

MS. WANG: Okay. Because that is, obviously, like already an area of deep examination and opinion.

MS. TABOR: Right.

MS. WANG: I don't know. Maybe there's a way to reconcile that these things either are alike or not alike because the description of the events as ambulatory care-sensitive, I really appreciate what you said, your suggestion about this.

I am uneasy, though, that it's really all about ambulatory care. I do think that there are a lot of other things going on here. It's very complex. Everybody around the table has sort of acknowledged that, but there are many truths going on at the same time. I mean, there are, in most states, actually prudent layperson laws that require insurance companies to pay for avoidable emergency room care if the patient thought that it was an emergency and that they were in imminent danger of severe injury, death, blah-blah-blah.

So the concept that people were talking about

before the subjectivity about what brings somebody to the ER and maybe get treated and released from the provider's perspective is that's a prudent layperson. The person actually thought they needed it. I'm not sure what having the greater ambulatory care system in the world would do to avoid that.

Another sort of set of cognitive, dissonance truths is that from a hospital perspective, what we're calling an "avoidable admission" is medically necessary. So from their perspective -- the person walks into the ER. They don't have any contact with them. They've never seen them before. They admit them. It's medically necessarily. So to kind of characterize that as something that could have been avoided, it goes to the question of "What does that mean, 'Who's accountable for that?'" I think that, in that regard, we do have to be kind of -- I think the work is really, really important, and the refinements that people have suggested in sort of reconciling the data and so forth is great.

But I think that we should be careful about rushing to like we're going to use this to reward and punish across provider sectors, across payment systems.

Just hesitate a little bit on that because when you talk about avoidable and the sufficiency of an ambulatory care system to prevent much of what you have displayed here, I think people would say, "Look this is beyond me." It's housing. It's food. It's people's fears. It's their psychology.

They may have the greatest relationship with their PCP in the world, and the PCP might be fantastic, but a PCP will say, "I can't stop my patient from going to the emergency room. She just likes to go to the emergency room." It sounds weird, but it's true. I mean, people go to the emergency room for really strange reasons, and I don't think it's a very simple -- I think it's hard to pin that all no sufficiency or deficiency of an ambulatory care infrastructure.

The other sort of thing that I know you mentioned and I think is critically important is, at some point, looking at socioeconomic status, and to the extent that we are looking at sufficiency and influence of ambulatory care infrastructure, I just wonder whether an additional factor in that adjustment or look would be sort of the distribution of health profession shortage areas, which if

there are still legitimate designations, sort of our markers of areas where there is insufficient physician supply, that might help explain or not maybe some of the incidents and the utilization that you see.

The final thing is just a small one. When you do get to looking at Medicare Advantage, which in the Star system is held to an all-cause readmission rate -- and there is reward and punishment around that, and it's true that it's plan to plan. But plans in New York City are compared to plans in Seattle in terms of their success or failure at that metric. But when you get there, I think this measure specification changed recently. So I think it's still on display to include denials, which is very important because what you don't want to be capturing is what looks like a great rate because of payer practices around denials. So just put it on your radar screen.

Thanks.

DR. CROSSON: Thank you, Pat. Jon.

DR. PERLIN: Well, thanks. This is really an important line of inquiry and thank you for a really thoughtful review. I want to identify with Pat's and previous speakers' comments on a number of areas.

I, too, would agree that this is directional but not diagnostic, and I think, Pat, you said it really well, is that this probably reflects more about integrity of the overall infrastructure than just, you know, sort of ambulatory services, but that would be a large part of it.

I can't help but wonder how social determinants -- geographic, urban, rural -- and patient behavioral factors play into the differences in utilization, as well different sort of characteristics about how people access care in different environments. Having the privilege of being in a large distributed system across numerous states, the infrastructure so very different but so, too, are the behaviors about when and how people seek care. I have to just say that New York and Florida have more income than Florida and parts of Georgia. And, you know, it's pretty well demonstrated in a variety of metrics.

I do think this does relate to our prior conversation, though, and I wonder about this as a bit of a referendum or another piece of data on primary care infrastructure access sufficiency.

I, too, had noted, you know, Jim, the question about whether urgent care centers do, in these instances,

provide somewhat of a safety valve. We talked previously about whether they were concentrated in more commercial areas, but, in fact, in areas where they may exist in Medicare populations is a very important question.

I think we have to have, you know, some sensitivity to the patient behavioral factors that actually were really well reported, by you, and the comparison of ER versus urgent care center utilization. If you recall, for just nominally the same conditions, patients who presented to emergency rooms, if I recall the numbers, had -- what was it? -- 3.41 comorbidities compared to urgent care presentations, for the nominal same condition, 2.0 comorbidities. So there was some sort of self-selection about when and how people accessed care.

So putting it all together, along with maybe a final comment on, you know, our confidence in the definition of what, in fact, is avoidable, you know, particularly along the lines, as I just mentioned, if you have a bunch of comorbidities -- you know, diabetes, heart failure, hypertension, coronary artery disease, and a cough -- you may have a real different sensitivity for access than if you have, you know, a cough and the absence of

those comorbidities.

So to your sort of three questions there, yes, I think continue the analysis and begin to understand, you know, what is, in fact, just not directional but diagnostic.

I think the second question may be premature. I think it's difficult to say at this juncture what are the best practices until we understand what the features are that really lead to the utilization, though that line of inquiry may inform the former. And I think it is worth looking at other payment models to understand what it is that makes a more robust infrastructure.

Thanks.

DR. CROSSON: Okay. Thank you. Dana. I'm sorry. No, Jonathan, were you in line?

DR. JAFFERY: I thought I was.

DR. CROSSON: Okay, well, we may have gotten your name wrong.

[Laughter.]

DR. JAFFERY: I'll be Jay.

DR. CROSSON: Okay. Can one of you change your name?

[Laughter.]

DR. CROSSON: Jonathan and then Dana.

DR. JAFFERY: Thanks. Ledia, thanks. I really appreciate you diving into what obviously could be a long-term thing.

So, you know, I think it's great to try and get to things that we can compare across the ACOs, MA, and traditional fee-for-service. So even though it can clearly be a big lift, this is good work.

I think, you know, you are asking, in the first bullet point, about different ways to identify factors that affect performance, and one thing that came to mind is that, you know, there's some stuff in the literature about, thinking about ACOs in particular, about physician-led ACOs versus ACOs that include hospitals. Various conclusions have been drawn and I think some of our own work here maybe doesn't totally align with.

But in any event, that might be an interesting thing to look at, when one of the proposals or hypotheses has been that ACOs that include hospitals aren't incentive to avoid these kinds of things, because they get paid this way. So that's something to think about.

I think also the point about combining events to get at some of the divergent issues is interesting, and I do wonder about if the absolute numbers, for example, the absolute number of ED visits might overshadow things. I mean, if you look at the MedPAC market area there are more ED visits in the 10 percentile than there are avoidable hospitalizations in the 90th. And so that would be something to have to think through.

And then, finally, just in the report you talk about some of the -- you have a description of some of the negatives of avoidable events, and one thing that isn't there, that I think might be -- you might be able to quantify that and would be good to try to report on more in general, is what the cost is to beneficiaries. We talk about the cost of the system and the life impact to the beneficiary but there are some quantifiable costs to beneficiaries that it would be nice to try and avoid.

So thanks.

DR. CROSSON: Thank you. Dana.

DR. SAFRAN: Great. Thanks. So late in the day this may be an idea that makes no sense at all, or it may be so obvious that we'll think, like, why didn't we think

of this before? We want to compare across these different major system approaches that we have, and I'm wondering, as I sit here, knowing that ultimately where we'll want to go with this is having the providers that work in these systems act on the information, and, therefore, likely be accountable, I'm wondering if we're starting in a place that's too hard.

That is, we've talked quite a bit in the last hour about how challenging it will be, even if we change the nomenclature, to get from measures that really were uncertain whether something was avoidable or not, and whether the source of the avoidability, if it was, is care versus other things. And I'm wondering, why not start actually with some of the accountability measures that we have today and use those to measure across systems?

Now I know when we've talked about it before, the data from the Medicare Advantage system, or, to some extent, the rate limiter hike, so, all right, well, so let's start with the measures of accountability in the Medicare Advantage system and work our way out from there and say, if we compare ACOs and the broader fee-for-service system, absent ACOs, to Medicare Advantage performance on

things like 30-day readmissions, or the other things where we feel more confident in the underlying data from Medicare Advantage because they're being held accountable, might that be our best path for comparing across these three pieces of the system, because once we have an answer then -- well, first, we've already got validated measures that are accepted and being used for accountability, and second, we know how to point to where the action needs to happen.

So I hope that's a helpful thought, and if it's not then we can just set it aside and keep working on new measures.

Thanks.

DR. CROSSON: Thank you, Dana. Larry and then Bruce.

DR. CASALINO: Thank you. I just want to come back to the 1,000-beneficiary level, that you said if you have 1,000 beneficiaries you can get reliable measures. I think, you know, that is incredibly valuable information, you know, if true, and if you can really strongly support that, that really ought to be published, because it has implications for all kinds of programs, all kinds of accountability programs, all kinds of research. So I

didn't want that to get lost.

It would be worth looking at that year over year too. So if you have 1,000 beneficiaries, minimum, how correlated is the performance over a period of several years? So that would be one point, which I really think is important, actually. I wouldn't just let that go.

The second thing is, just want to talk about whatever this is as a measure. Well, first of all, this, as a measure, I really haven't listened to discussion -- or to say it even more strongly, I think emphasizing the disjunction between ED and hospitalization really is a mistake, for the reason I just said. Every hospitalization is going to reduce the ED, if you count it the way you're counting it, and that doesn't make sense.

There are also problems with counting them both, as Amol pointed out, and I think the composite measure would solve that problem. Actually, presenting all three ways of doing it could be useful.

I think that it would be useful -- Bruce kind of was, again -- it would be useful within the tables, that you showed us in the report, I think to show not just rates of ambulatory care sensitive admission, but also -- and let

me just, by the way, I think it needs to be emphasized that when we say ambulatory care sensitive or potentially avoidable, we're not saying every one is avoidable. We're saying on average they are somewhat avoidable. And so, you know, you're comparing people on average to other people on average. You're not saying you should avoid every one of these. And providers' instinctive responses are going to be, "Oh, you're saying I can avoid every one of these." That's not true. That needs to be emphasized, I think.

But it would be good, I think, to show in tables rates of ambulatory care sensitive admissions, overall rates of hospitalization, 30-day readmissions. It would be very illuminating, I think, to see those.

I do want to just say a little bit about ambulatory care sensitive admissions to hospitalizations or ED visits as a measure. We've had some discussions, like the kind of things Pat was saying, I think, all true about, you know, why these things might not be avoidable and all the other factors that could come in. But you can say that about a lot of performance measures, except for the ones that are so dinky that they don't, in my opinion, mean anything, like did you counsel your patients about stopping

smoking, or did you ask them if they smoked?

And, to me, one of the attractive things about ambulatory care sensitive admissions is that is a global measure, I think, to some extent, of how a system is taking care of its patients. True, there are always problems with it, and maybe the problems are enough not to use this as a measure, but then I'm not so sure that the problems with this are worse than with other measures that are being used a lot. So I think everything has to be comparative.

And I would say, also, that, yes, if someone has crushing substernal chest pain they are probably not going to call their primary care physician and ask them should they go to the emergency room, and that's fine. But most emergency room visits are not for that, and I would argue that if a system of care and a primary care physician have proved their value to their patients, they will call their primary care physician first, if they really think that it's worth it, not if they have substernal chest pain but if they have a cough or back pain or whatever.

So I'm not entirely sympathetic to the argument, "Oh, my patients just do whatever they want. I can't stop them from going to the emergency room when they want to."

There's something to that.

And the last thing I'll say is in terms of trying to -- not too much has been said about it today but quite a bit in the report -- trying to compare high performers versus low performers, in terms of what makes them high and low, I think we have had some people here say that's not worth it right now because the measures aren't good enough. But just assuming that it is for the moment, I don't know if that much would come out of looking at this at a geographic level, even a relatively small geographic level.

You know, Dartmouth didn't have, in my opinion, a whole lot of luck explaining the geographic variation they found in utilization by market level characteristics. I think it is probably worth looking at social deprivation indexes you suggested, things like that. But it probably would be better done at the provider organization level, like a hospital system in an area or whatever. In a lot of those you would have enough beneficiaries.

There is a way of kind of systematically doing that qualitatively that is pretty rigorous, and Betsy Bradley used it and got a qualitative study published in JAMA using it. I don't want to bore people with that right

now but I'd be happy to talk to you offline. It's something that would be well within MedPAC's capability at a quite reasonable cost. If you're measuring at the provider system level I think it would be a good thing to do.

Just the last thing I wanted to say, actually, about this 1,000 beneficiaries, assuming that is the number, what does that say then about MedPAC's principle of not adjusting for SES in risk adjustment formulas but using strata, and where would you be able to -- how would that affect the ability to compare performance within socioeconomic strata?

DR. CROSSON: Some data sets it would and in others it wouldn't.

DR. CASALINO: Yeah.

DR. CROSSON: Bruce and then Kathy and then Jaewon.

MR. PYENSON: Well, thank you very much. Ledia, as you know, I'm enthusiastic about this work. I'm actually not in favor of the first two bullets but perhaps for reasons other than questioning the validity of the metrics. I suspect what we'll find is what others have

found, which is it's incredibly hard to figure out how or why particular regions accomplish what they do, partly because there's lots and lots of different routes and partly because it's more determined by the local culture, defined very broadly.

And so I think others have certainly explored that, and this is a well-worn area of research. There's lots of different tools out there. 3M has its tool. Dartmouth Atlas, you know, you go back 20 years, this is a very well-worn area and I think incredibly valuable. But what it identifies, I think, is that so many of the determinants of health care are not medical, and I think it's a mistake to try to medicalize population-level outcomes such as we're talking about here.

And, in particular, I was happy to see mentioned in the report the negative outcomes associated with admissions such as delirium and debilitation, which are mentioned but are not often measured. We tend to measure things we can medicalize -- drug-drug interactions or wrong-side surgeries or hospital-acquired infections. To the extent we can measure any of them, they are well-defined medical phenomena. But things like debilitation or

the effects of delirium post-admissions are perhaps not what we normally think of as medical phenomena or medical acute events, so are often not measured on a population basis but maybe much, much more important than we think. So I was very glad to see your mention of those in the report.

So in summing it up, I think we have some really, really valuable work here, and it's really population-based. It's not medical. It's population, and it's system outcomes. And I think if we recognize it as that, then we can make a lot of progress.

DR. CROSSON: Thank you, Bruce. Kathy.

MS. BUTO: So I've been struggling with this area because although we are sort of taking this up, and the work here is excellent, under the overall rubric of sort of how did we come up with population-based measures that are useful in looking at quality incentive programs, this feels to me a lot like -- well, it feels like we are really just looking at the adverse outcomes of not having good quality, as opposed to how do you actually, step-wise, get to measures that reward quality. So we're looking at outcomes that really would come about because we think quality is

not there, whether or not the measures are good ones or need to be refined.

I guess I'd feel better about this if we were sort of on the road to looking at some of these ambulatory sensitive conditions or avoidable ED visits or whatever in relation to some of the conditions that you were talking about in the chapter, like COPD, I guess diabetes, cellulitis, et cetera, mental health conditions, that, yes, we'd like to avoid. But I think what we really want to get after here is how do you reward good practice? So can we get to it by starting with these are things we don't want to happen but we really want to get to a place where we can identify and reward practice that is setting a standard or meeting a new patient standard that needs to be met.

And so it's an issue I always have with these negative parameters or measures for judging quality, is we still haven't gotten to how do we actually incent the kind of practice that we want to?

So I would just say that as we go down the road if we can think about that, sort of the positive side of good practice, not just the negative outcomes that we don't want to happen. I think that would be a great way to think

longer term about this area.

DR. CROSSON: So, Kathy, I don't want to pin you down and say what do you think those might be, but I would ask you to think about it.

Sometimes, not always but sometimes the positive is, of course, the reciprocal of the negative. So, for example, rather than measuring the number or the length of hospitalization for a patient with diabetes in a year, you could also measure the number of -- we have toyed with this in the past in some ways, you know, when we were talking about healthy days at home. So you could get to this same place by measuring -- I'm just making this up, but measuring, you know, the number of days -- of healthy days at home for a diabetic, which, of course, in many ways it's a reciprocal of being in the hospital.

MS. BUTO: Healthy days at home I thought was a really good place to start going down that road. I know from work that was done in the short time I was at CBO that diabetes is a root cause condition that drives a lot of cost in Medicare. We never talk about it. We don't talk about it here at MedPAC. There should be something we can do proactively to promote a better reward system to reward

good treatment of people with diabetes or early detection or whatever it is. I don't know what it is. Healthy days at home I thought was a really good start.

DR. CROSSON: Okay. Thanks. On this point?

DR. SAFRAN: Just picking up on Dana's comment earlier about there are -- in the Medicare Advantage Stars program, medication adherence for diabetes medications as well as others, and outcomes measures like blood sugar control, it is absolutely one of the Star measures, and those are outcomes measures that are very pinpointed in the direction that you describe. So it might be a good place to look.

DR. CROSSON: On this point as well?

DR. PERLIN: Yeah. Thanks. I think this point actually connects with Bruce's point in terms of being a sort of population which means sort of integrity of the system. I think that's the first piece. So some of those markers may not be individual markers.

That said, something we haven't talked about, you know, when I had the privilege of running the VA system, one of the things we looked at was patient functional status. You know, this so transcended whether the

patient's blood pressure was 120/80, but, you know, could she carry groceries from car to kitchen? Could she drive? Was she ambulatory? You know, days free of pain, et cetera.

To me, as we move forward in terms of thinking about both the integrity of the system, writ large, on the success of a health care system with respect to the individual, I think we need to begin thinking about different sorts of measures like that.

Thanks.

DR. CROSSON: Thank you. Okay. On this point as well?

DR. GRABOWSKI: Jon, how did you measure that in the VA relative -- it would be interesting to try to learn from those lessons. We have obviously provider-reported functional status in long-term-care settings. I don't think we believe that. It would be interesting to --

DR. PERLIN: Yeah, it was patient-reported on the SF-12, and because the population was more akin to dual eligibles with floor effects there was an SF-12v to take account for the general lowering. What was really remarkable and gratifying was to see policy changes over

time correlate with not just increases in longevity at lower cost but actual improvements in function.

DR. GRABOWSKI: And you surveyed them every time they touched the health care system or annually or what?

DR. PERLIN: There was a sample that was done annually. It may not be the same individual. It was really sort of a population or other marker of system integrity.

DR. CROSSON: Okay. Jaewon.

DR. RYU: Yeah, thanks, Ledia. I like the direction of the measure, and I think it's exactly right. I love the analysis. I do feel a little bit conflicted because I think there's a natural tension and a balance question as I start thinking this through.

I think the measure itself -- and maybe this gets to Bruce's point a little bit -- by virtue of it being a population-based measure, it's really a statement on the overall ambulatory environment and infrastructure that's out there. And as a result of that, it feels very multifactorial as far as what feeds into success or lack of success on the measure. And I do -- you know, maybe it's true for most population-based measures. The one that

comes to mind is even readmissions to some degree is measuring an entire system. It takes a village to avoid a readmission. It takes a village to make sure that ambulatory sensitive ED or hospital stays in that ambulatory arena. And I think this ultimately to me gets to Sue's earlier point around who's accountable or who's responsible. This is why I love Amol's concept of combining the ED and the hospital, but I also struggle with it because if you look at ambulatory sensitive ED and you ask the question who's accountable or who was in the last position to have done something about it, I think that's probably the primary care doc.

But if you then look at ambulatory sensitive hospital and you ask the same question, who was in the last position to be able to do something about it, I think it's the ED physician because most of these are coming through them and getting admitted. So I do think there's still a value in bifurcating those, although maybe you also put them together for simplicity's sake.

I don't know the right answer to that, but that's why this area feels a little bit conflicted to me, but I think we're trying to do drive a population-based measure

which is sort of a look at a system. But at the end of the day, some actor should be accountable for it, and those two things wend, at least in my head, in two slightly different spots.

DR. CROSSON: Karen, on this or just in line?

DR. DeSALVO: Just I guess on this, to say that to me part of the point is to catalyze shared accountability, and I think that's why it's worth continuing to think about this and all of the potential actors and drivers, including the social determinants and the public health infrastructure, because that is -- ultimately those are the supports that we want for beneficiaries.

So I hear you, but I also think this is kind of the point for me, is to find something that would bring everyone to the table for shared accountability.

DR. CROSSON: Okay. Amol, you started. You can wrap.

DR. NAVATHE: So Karen gave me a perfect segue because I think at the end of the day we are interested in system integrity. We are interested in how -- you know, not just the primary care doctor or not just the

specialist, not just an NP, not just the ED, can actually help to improve these outcomes. And I think picking up also one thing that Larry said, you know, the idea that we think about patient preference or we think about social determinants of health, and we take a view perhaps that, okay, this measure will vary certainly by those levels of those kinds of variables, and to then turn around and say, well, in that case if I have a bunch of patients who just prefer to go to the ED, I should not be held accountable for that.

I think that's actually going the wrong direction, and if we've learned from what integrated delivery systems have done, the Kaisers of the world, I think we've learned that by setting up infrastructure and creating patient-centered services, we can affect these population outcomes and we can educate patients that going to the ED is not necessarily the most, one, beneficial but probably rewarding even for their own personal goals pattern. And if we don't start to think about accountability, if we don't think about measuring, we don't advance and put some oomph behind it, I think we're actually doing a disservice for our populations who have

challenges with social determinants of health and, you know, other sources of morbidities and comorbidities.

So I think it's just maybe a little bit of a sort of re-upping of things. This is really important, and we're not going to get to a perfect measure, but I think it's really important that we keep this in focus, that we do need to advance population-based measures that cut across conditions, that try to capture how we're doing it in an aggregate level; and that if we can use those conditions very well, we can actually catalyze system transformation, which is what we're really after here.

DR. CROSSON: Okay. Well said. Thank you.

We've come to the end of this discussion. Thank you, Ledia, for getting us going here. Very nicely done.

We now have the opportunity for public comment. If there are any of our guests who would like to make a comment on the business before the Commission this afternoon, please come to the microphone

[No response.]

DR. CROSSON: Seeing no one at the microphone, we're adjourned until 8:30 tomorrow morning.

[Whereupon, at 4:20 p.m., the meeting was

recessed, to adjourn at 8:30 a.m. on Friday, October 4, 2019.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 4, 2019
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Okay. I'd like to welcome our guests to this morning session of the October MedPAC meeting. We have two items on the agenda this morning, and the first one, Carol and Carolyn will be here as part of our ongoing work on the unified PAC PPS and specifically will be looking at some policy options.

Carol, you are going to start.

DR. CARTER: Yeah, I'm going to start.

Good morning, everyone. Over the coming year, we plan to continue our work on a unified payment system for post-acute care by considering how to align the benefits and cost sharing across all PAC.

Carolyn and I will outline possible changes to benefits and cost sharing that could be made, and we would like to get your input on three key design decisions.

I wanted to step back for a second and remind everybody about the context for PAC reform.

Our work and that done by others has found that many similar patients are treated in the four settings, but payments can differ substantially because Medicare uses

separate payment systems for each.

Given the lack of clear guidelines about who needs PAC, where that care would be best provided, and how much care would result in the best outcomes has resulted in per capita program spending that varies more than for any other service.

Setting-specific patient assessments and outcome measures make it difficult to compare patients, their costs, and outcomes across settings.

Another concern was the shortcomings in the current designs of the current payment systems warrant correction. Providers can vary their payments with their coding and therapy practices.

Finally, Medicare's payments for PAC are high relative to the cost of care. For about a decade, the Commission has recommended to the Congress to lower or not update payments to PAC providers.

Over the past 5 years, the Commission has examined the design, implementation issues, and a value incentive program for a unified payment system.

We recommended design features of a unified payment system that uses a stay or, in the case of home

health care, an episode of care, and estimated the impacts and redistribution of payments. We examined paying for sequential stays and paying for an episode of sequential PAC stays.

Regarding implementation issues, the Commission recommended lowering the level of payments and having a multiyear transition. Until a unified payment system was implemented, the Commission recommended blending PAC PPS rates with setting specific rates to begin to realize some of the benefits of the redistribution that would occur.

We also outlined an approach to align the regulations so that providers face similar requirements and their associated costs.

And as we discussed last month, we've developed uniform outcome measures and plan to develop an illustrative design of a value incentive program for all PAC providers.

Our presentation today will go over aligned benefit and cost sharing across PAC. This is another important implementation issue associated with our ongoing work on a PAC PPS.

The goal of a unified payment system is to pay

similar rates for similar patients, regardless of where the beneficiary is treated.

Payments and regulatory requirements would be aligned so that distinctions between settings would become less meaningful.

When payments and regulatory requirements are aligned, cost sharing and benefits need to be aligned so that beneficiaries have the same coverage and face the same cost sharing

Aligned benefits and cost sharing would remove financial considerations from beneficiaries have in affecting their decision-making about where to get their care.

The current benefits and cost sharing differ considerably by setting, and on the left are the key differences, whether a prior hospital stay is required, if there are limits to coverage, whether the beneficiary is responsible for the inpatient deductible if they are admitted from the community, and the daily copayments that apply.

When beneficiaries use home health care, there are no limits to benefits and there is no cost sharing.

If a beneficiary uses a SNF, the stay is covered only if there was a three-day prior hospital stay and coverage ends after 100 days. Copayments are assessed beginning on day 21 of the stay.

Finally, when a beneficiary uses an IRF or an LTCH, a prior hospital stay is not required, but then the beneficiary is liable for the inpatient deductible, and coverage ends after the lifetime reserve days have been used. Copayments begin on day 61 of the combined hospital and IRF or LTCH stay.

So, given these differences, beneficiaries may base their decisions about where to get their care on coverage or cost sharing considerations.

There are three changes that could be made to align benefits and cost sharing that we will go through today.

On the benefit side, policymakers could align the requirements for a prior hospital stay and the limits on the days covered by the program.

On the cost sharing side, the copayments could be aligned.

Our work on a unified payment system considers

IRFs and LTCHs as PAC providers. As such, the inpatient hospital requirements would be replaced with the uniform benefits and cost sharing for all PAC providers. Aligned benefits and cost sharing would reinforce the concept of a PAC provider and be consistent with a unified payment system.

Turning to the prior hospitalization requirement, before we discuss that, I wanted to show you the share of stays that have a prior hospital stay. Most institutional PAC stays have one, while the majority of home health stays do not. So a uniform requirement for a prior hospital stay would disproportionately affect home health care users since the majority of them are admitted from the community.

To align benefits, policymakers could require a prior hospitalization for all coverage of all post-acute care or could eliminate the current requirement that SNF users now face.

If a hospitalization were required, just as we saw, this would affect the coverage for a minority of IRF and LTCH users but the majority of home health care users. This would lower program spending associated with the community-admitted users.

Alternatively, policymakers could eliminate the prior hospitalization requirement. This would increase coverage for SNF users. Because Medicare payments are higher than those made by other payers, nursing homes would have a financial incentive to qualify their long-stay residents as Medicare-covered short stays. As a result, removing the requirements for a prior hospital stay is likely to substantially increase program spending.

Another benefit to align is the number of days covered by the program, either by establishing a uniform limit or eliminating the various existing ones. Remember that the unified payment system would be a stay-based design, so payments would not vary by length of stay. So what we're considering here is how to align the benefits or coverage.

Establishing a uniform day limit would eliminate the open-ended coverage for home health care and would align the current limits that vary across the institutional PAC settings.

Alternatively, policymakers could eliminate the existing limits on coverage. This would retain the open-ended coverage for home health care and would extend

coverage for the small share of beneficiaries with long institutional stays.

And now Carolyn will talk about aligning the cost sharing.

MS. SAN SOUCIE: First I will go over PAC cost sharing in 2017, and then I will go over elements to include in the design of a per-stay copayment for aligned post-acute care cost sharing.

In total, beneficiaries who used PAC services were liable for $5.2 billion in cost sharing in 2017. This is equal to approximately 9 percent of Medicare PAC spending in that year. Home health care made up slightly less than three-quarters of PAC stays, yet these users paid no cost sharing for those services. Those stays are not represented in this figure.

SNF stays made up about one-quarter of PAC stays but accounted for almost the entirety of PAC cost sharing, close to 93 percent.

In comparison, cost sharing associated with LTCH stays was about 6 percent of total PAC cost sharing, while that associated with IRF stays was about 2 percent.

The 5.2 billion in PAC cost sharing represented

on the previous slide was mostly incurred through daily copayments. However, the requirements for daily copayments vary widely by setting, and additionally, the majority of stays do not incur any cost sharing through daily copayments or otherwise.

In order to align cost sharing for PAC, we will be modeling a per-stay copayment. In this case, a beneficiary would be responsible for a copayment for each PAC stay. If a beneficiary transitioned between providers or was recertified for an additional home health episode, the beneficiary would be responsible for separate copayments for each stay.

This is consistent with, but goes further than, the Commission's 2011 recommendation for community-admitted home health users.

Additionally, this would be consistent with cost sharing in other parts of the Medicare program.

In 2017, more than three-quarters of all PAC stays did not incur any beneficiary cost sharing, driven by the volume of home health episodes. Ten percent of stays incurred cost sharing above $1,600, and 1 percent of stays incurred about $11,000 in cost sharing. These numbers

represent beneficiary cost sharing liability and does not reflect what the beneficiary actually paid. Supplemental coverage may have reduced beneficiary out-of-pocket spending.

Because home health makes up the majority of post-acute care, a copayment assessed for each PAC stay will result in a considerable redistribution of cost sharing from the minority of stays that currently incurs cost sharing to the bulk of PAC stays that incurs none.

Now let's look at the per-stay cost sharing by setting, where the variation in cost sharing across PAC settings is quite substantial.

The graph in the upper left-hand corner is the same as the one on the previous screen. This is showing the distribution of cost sharing across all PAC stays.

The graph in the upper right-hand corner shows the distribution of cost sharing for SNF stays. Over half of SNF stays incurred about $1,000 in cost sharing, while 10 percent incurred close to $7,500.

The graph in the lower right-hand corner shows the distribution of cost sharing for LTCH stays, where more than half did not incur any cost sharing. Ten percent of

LTCH stays incurred over $7,500 in cost sharing, similar to top decile of SNF stays. However, the most expensive LTCH stays were much more expensive than those in any other setting.

Lastly, the graph in the lower left-hand corner shows the distribution of cost sharing for IRF stays. Over three-quarters of IRF stays incurred no cost sharing.

The implementation of a per-stay copayment will result in a large redistribution of cost sharing for all of these stays.

Per-stay copayments could either be the same across all PAC settings, or different by setting.

A uniform copayment would fully align PAC cost-sharing. Because payments for home health care would be adjusted downward under the PAC PPS, a uniform copayment would result in home health users being liable for a higher share of the total payment for a stay than would users of institutional PAC. However, this would eliminate the incentive some beneficiaries currently have to base where they receive their PAC on financial considerations.

Alternatively, a copayment could be different across PAC. In this case, one lower copayment amount would

be assessed when home health care is used, and a higher amount would be assessed when institutional post-acute care is used. This two-tiered approach would result in considerably lower copayments for beneficiaries treated by home health agencies compared with those treated in institutional PAC settings. However, it would retain cost sharing differences by setting, thereby undermining one of the goals of aligned cost sharing. As a result, it may encourage beneficiaries to base their decisions on financial considerations, choosing the use of less costly services.

Policymakers will need to decide on the importance of having a uniform cost sharing amount that removes financial considerations from where beneficiaries get their PAC.

Regardless of if copayments were to vary for home health and institutional stays, policymakers would need to establish the share of a stay's payment that would be the beneficiary's responsibility.

For example, in previous benefit design work, the Commission modeled a home health copayment of $150, which approximated 5 percent of program spending on home health

episodes. We could use the same approach and model a copayment that equaled 5 percent of program spending for PAC, or we could consider am amount that represents a higher percentage, more in line with the current levels of aggregate cost-sharing requirements for PAC, which is about 9 percent.

Additionally, we could consider an amount that represents a percentage that would be in line with cost sharing of other program services. For example, 20 percent would be identical to the cost sharing required for Part B services. While a larger percentage may discourage the use of unnecessary PAC, it also could discourage the use of needed services.

In summary, a unified PAC PPS will align payments across PAC providers. Consistent with that, differences in the regulatory requirements for PAC providers will narrow.

Accordingly, beneficiaries should have the same benefits and face the same cost sharing regardless of where they receive post-acute care.

In the spring, we will model some illustrative benefit designs and cost sharing based off of your guidance in the discussion that follows.

There are three areas that we seek guidance on. The first, should a prior hospital stay be required for covering any PAC use? A prior hospital stay could be required only for covering institutional PAC, or the requirement could be eliminated.

The second question that we seek guidance on is whether there should be a uniform day limit on coverage or should the current limits be eliminated.

Lastly, we would like your feedback on the implementation of a per-stay copayment. Should the copayments be the same for all PAC stays, or would the copayments be proportional to the average PAC PPS payments?

We look forward to your discussion, and with that, we'll turn it back to Paul.

DR. PAUL GINSBURG: Thank you, Carolyn.

This has been really helpful and clear in presenting the issues.

As a context, we have a vintage 1965 cost sharing system for most post-acute care, and it's been amazing how it's been ignored over the decades, and by pursuing the PAC PPS, it just forces attention to these issues because, obviously, you have to have something more uniform than you

have today.

So let me begin by asking for clarifying questions.

Yes. Marge and then Jonathan and Amol.

MS. MARJORIE GINSBURG: Great. Thank you. Good work.

I used to work in home care many, many years ago, and the thing that most surprises me about all this is the -- it sounds like there's virtually no difference in the services offered at the institutional PACs, not counting home care, and the idea that patients can decide then which institutional PAC they want to go to based on how close it is, whether there's copays, I have to say really surprises me.

I actually thought these organizations, these entities were set up because they met very specific needs of patients. Somebody would qualify for a SNF, but they wouldn't qualify for a long-term institution.

So could you give me more about the background, and why did these things all merge in concept? But somehow these are not specific entities that serve specific purposes.

DR. CARTER: So this work assumes that when the patients are similar they will receive similar payments. We recognize that home health has different services because there's no facility, and that's recognized in the payment system, setting a much lower payment for home health, like one-sixth. And so we're recognizing that the services are different in home health and the payment reflects that.

What we're saying is let's take a patient -- I was just talking with Kathy about this before the meeting -- let's take a patient who is recovering from hip replacement. They can go home, with home health, on a part-time and intermittent basis, or they may go to a SNF, and if they qualify for intensive therapy they may go to an IRF. There is an example of a patient who might look similar, in terms of their clinical characteristics, but may be treated in very different settings.

So I don't think we've said that the services are the same, and, in fact, our payments reflect that they're not the same. What we're saying is that we are hoping that the risk adjuster captures differences across the patients, and when those are different the payments will be

different.

MS. MARJORIE GINSBURG: So just to make sure I'm clear on this. Since patients don't get into any of these programs without a referral from the physician -- they don't get home care, they don't go anywhere -- physicians simply don't discriminate? Nobody discriminates between the appropriateness of the patient's particular needs and the virtue that particular settings -- I mean, it just -- I feel like I've just dropped in from outer space. I missed something in the last 30 years, as I got out of home care. But suddenly everything feels like it's just been merged into one pot called PAC, and that baffles me still.

I mean, I wonder whether there's some background here about when disease settings all start. Have they always been -- has it always been so fluid about where patients go after the hospital, or from the community, that it really is often up to the patient to decide where they want to get services? Isn't there something wrong with this picture here?

DR. CARTER: I guess I would say that beneficiaries most often want to go home when they can, and some patients don't have either the family support or able

and willing caregivers at home to do that. And so there you might see a patient that looks really identical, but they've ended up in an institutional setting because they can't go home.

I think that there's been a lot of work. We've done a little bit but there's also literature about PAC placement, and I think that there are all kinds of factors that go into that decision, and some of it are clinical care needs. Sometimes it's availability of a bed. Sometimes it's proximity to where, you know, your daughter lives. I mean, it's a whole constellation of things.

Dana and I, before this PAC PPS work got started, we did a lot of work looking at the overlap between IRFs and SNFs, and I think I've said this before, we talked to the directors of five or six stroke centers around the country and they were all very clear about where they sent stroke patients. The problem was they completely disagreed with each other. And I think it had to do with how good was the SNF in your market, and could that SNF handle the complexity of that patient. And if there wasn't a SNF with an available bed in the market, those patients went to IRFs. Now that's not a clinical discrimination. That's

sort of the lay of the marketplace.

So I don't think you've landed in from outer space. I think we recognize that -- and even in the discussion we talked about, in terms of regulatory requirements, we know that the regulatory requirements for home health are going to be a little different, right, because if there's no facility and there are all kinds of things that come with having a facility that you don't need to regulate. But things like physician oversight and the training and the skill level of your staffing probably should be the same, or similar.

And so we're trying to have some nuanced approach to when differences in home health care are warranted and when they're not.

DR. CROSSON: Kathy.

MS. BUTO: Marge, I realized in your question how much of a gap there is between the early work on PAC PPS, which has been going on for some years, and your sort of landing from outer space recently, on the Commission. And so I think part of your question is, are these patients really totally interchangeable and are these facilities interchangeable.

And I think we've been approaching it, with Carol's guidance and help, as where they are, the payments should be pretty much the same. They shouldn't differ by weird characteristics of the way the facility has been structured under some regulatory rules that were designed in 1965.

Where they're not -- say vent patients, stroke patients, different kinds of patients, community-originating home health patients -- the payments will be different but it will be really based on the patient's condition rather than what facility or type of PAC you sort of land in.

So I think it was really more an issue of where they're similar, the differences in payment were so stark from one place to another, and I think that's a lot of what this tries to address. Where they're different, I hope we preserve the ability to provide specialized care for the patients who really need it. So I think that's really just -- because, you know, this whole system has been evolving under the Commission that that nuance may have escaped you.

DR. CROSSON: Jonathan.

DR. JAFFERY: Yes. Thanks. First of all, this

is great, and as Paul said, this really pulls together how something that I think we're all excited about coming up with some more aligned payment system, and when you start to do it, it calls out what are those issues.

I have two or three questions, and the first one sort of follows up a little bit on what Marge was starting, but I don't think you came in from outer space. You may have dropped into outer space --

[Laughter.]

DR. JAFFERY: -- talking about U.S. health policy.

So is there some data we know about beneficiary preference in choosing, in terms of price sensitivity? Because a number of things -- none of the questions sort of speak to that and how that might change behavior, and do we know anything about that in particular?

DR. CARTER: We haven't looked at that yet, and, of course, you have the whole backdrop of supplemental, which is, you know, immuning many beneficiaries from first-dollar coverage. But if you would like we can look into that a little bit. We have not explored that yet.

DR. JAFFERY: Okay.

DR. GRABOWSKI: Can I say something on that? We actually have a paper where we are able to exploit the CAHPS data and we know who has supplemental and who doesn't, and we use that to predict, then, out in the full set of Medicare claims, and so we have a predictive model. And beneficiaries are very responsive. Those without supplemental, there's a huge spike at day 20, and those with supplemental there's a much smaller spike. So there is quite a bit of responsiveness to the cost-sharing.

I'll also say that, well, that could mean these discharges are premature or overdue, and when we sort of push on that, many of these beneficiaries are being discharged home, many of them home without home health care, there's no increase in readmissions or mortality. So that leads us to conclude this overdue and there's a lot of waste here. We could see, you know, much earlier discharge for many of these patients. And it leads me to wonder -- and I could say more in round two -- this is just kicking in at day 21. Imagine a cost-sharing arrangement that's much earlier in the stay.

DR. JAFFERY: You know, that's interesting. That's helpful. So that's discharge from the SNF, not

choosing the initial --

DR. GRABOWSKI: No, no, no, and we don't really have cost-sharing there, right, to help us.

DR. JAFFERY: Right. Great. Okay.

So thinking about the three-day waiver, you talked in the report about how in 1988 and 1989 the spending doubled, but then, now we haven't really seen any big changes with some of these others, particular with ACOs, being able to utilize the three-day waiver. Do you have any sense of why that would be so different now?

DR. CARTER: Why there hasn't been such responsiveness when providers are given the option to waive the three-day requirement?

DR. JAFFERY: Yeah. It sounds like in 1988 it was pretty dramatic.

DR. CARTER: Yeah.

DR. JAFFERY: In a single year it doubled and then they repealed.

DR. CARTER: Right, but some of that could have been nursing home patients being requalified, which is different than kind of initial PAC decision, if you will. I mean, I think ACOs and BPCI participants are using the

prior hospital stays as speed bumps. So even if they can take advantage of the waiver, many are not, and it's for the same reasons that there are requirements in place. Well, I mean, I think there are a couple of reasons. One is the prior hospital stay was really a way for the program, back in '65, to reinforce, this is a continuation of a post-hospital extended services benefit. That was the way post-acute care was seen.

DR. JAFFERY: Okay. That's interesting. I mean, we've been trying to implement it, and we haven't implemented it, and there are challenges to doing it robustly. But that's helpful.

And the last question has to do with the idea of eliminating day limits on SNF stays. And do you have any sense if that would have any impact, and if so, what on Medicaid spending?

DR. CARTER: That's a good question. I haven't looked at that. I know that very few, something like 3 percent of SNF stays go more than 100 days, and less than 1 percent of IRF stays and less than 1 percent of LTCH stays. Something like at the 99th percentile the length of stay is 280 days. And so if you think those might be Medicaid, you

know, not all beneficiaries are poor but it would impact what the Medicaid program, you know, exposure for -- if the program is now paying for that, yeah, so that would go down.

Now, of course, we know that lots of Medicaid programs that, in theory, pay for what's not covered by Medicare, but that isn't always true. So the coverage is uneven, I would say.

DR. CROSSON: Great. Amol.

DR. NAVATHE: So my question is really a continuation of this last thread, which is if we looked at Slide 13, for example, for duals specifically, would it look different, because of the reasons that you were saying, that there's variation in how much follow-through there is on the Medicaid side?

DR. CARTER: It probably would. We haven't looked at it, but we could come back with that.

DR. NAVATHE: Seemingly, as a population we continually care about, it would be nice to see that.

DR. CROSSON: Dana.

DR. SAFRAN: Thank you. A couple of questions for you. One is -- and I'll hold for round 2 but I am

struggling with just how far do we want to go in making the beneficiary side equivalent, and so that's sort of the theme under which my questions are coming from.

First question is, for the three types of PAC care that do not currently require a hospital stay, do we know what percentage of the time a hospital stay occurs for those? So for home health, for example, I'm assuming it's very, very rare. You know, I'm thinking about your --

DR. CARTER: I think your question is that slide.

DR. SAFRAN: Okay. Yep. Okay. Thank you. Sorry, I missed that slide.

DR. CARTER: That's okay.

DR. SAFRAN: Okay. And then a second question is, when you were talking about the possible equalizing of the copayments, whether it's done on a per diem or episode basis, it was up on the screen and it was in the paper in percentage terms, but is that how you imagine that it would actually be done, percentage of the underlying cost as opposed to a dollar amount?

MS. SAN SOUCIE: So the slide you're talking about with the percentages, we would use the weighted average of the payment, of the average PAC payment for the

stay, and then calculate a fixed percentage of that, so it would come out to a set dollar amount that it would be. In the home health work that they did, or in the 2012 work that they did to assess a home health copayment, it was a set $150, but it equaled about 5 percent of the average home health payment. Does that make sense?

DR. SAFRAN: I think it does. Let me just make sure I'm getting it. So the beneficiary would understand ahead of time, this is the dollar amount that's required for this setting. This is the dollar amount that's required for this other setting.

MS. SAN SOUCIE: Yeah. So if the average PAC payment was $5,000 and you were doing 10 percent of that, it would be $500, and that would be set for everyone.

DR. SAFRAN: Great. Got that. Thank you.

DR. CASALINO: [Off microphone.]

MS. SAN SOUCIE: If it was per stay it would not depend on the length of stay, correct.

DR. SAFRAN: Okay. I'm going to hold the rest for second round.

DR. CROSSON: Okay. Pat.

MS. WANG: Thank you for laying this out so

clearly.

Focusing on the three institutional settings and putting home health to the side for a minute, the vast majority -- and this focuses on the requirement for prior hospital stay -- the vast majority of the stays in IRF and LTCH are preceded by a hospital stay, which maybe we could speculate is because an IRF and an LTCH are themselves hospitals, and so the medical diagnosis and complexity of the patient, you know, would more naturally follow from a prior hospital stay.

I'm wondering if you can share more thoughts about SNF, because there was a reference in the paper to, I guess during a demonstration period there was an assessment that if the three-day stay requirement were to be lifted, spending would increase dramatically, or did increase dramatically. That's also described on the slide.

Can you speculate about why that is so different, why that would be different than the other institutional IRF, LTCH stays? If you eliminated the three-day prior stay requirement for SNF, why would spending increase dramatically?

DR. CARTER: So what you're referring to is what

actually happened when catastrophic got rid of the prior hospitalization requirement, and I will say that there were other coverage changes made at the same time. So that doubling of use and spending isn't just the lifting of the three-day hospital stay requirement.

But I do think this has to do with long-stay patients requalifying for covered Part A stays, which is obviously very different from the IRF and LTCH situation, where you don't have the same facility treating both types of long-stay and short-stay patients. So I think that's at least one big factor that's going on here.

MS. WANG: Do you think that the phenomenon of requalifying folks for a Medicare SNF stay would increase, versus today where maybe folks from a nursing home are admitted for some reason or another and then come back and restart their SNF benefit? Because that does, I think, happen today.

DR. CARTER: Yeah, I'm sorry. I didn't quite catch what the question was.

MS. WANG: The question is, if you eliminated the three-day inpatient stay for SNF, would the thing that you just described, the fear that patients would be requalified

and kind of cycled through the SNF benefit more frequently, would occur more than it does today? Because today, if somebody is living in a nursing home and they're admitted to the hospital and then they come back to the nursing home they are actually restarting their SNF benefit. You know, it's a very important factor.

Can you say more about what you think would actually happen, because this is sort of a behavioral assumption here, that, you know, more people would be -- that SNF spending would increase if you removed that little, you know, sort of --

DR. CARTER: Right. So I'm thinking -- so patients qualify for the SNF care because of those prior hospital stay requirements. If that's lifted then beneficiaries that are in SNF would only need to meet the other coverage requirements for SNF, which is you need a skilled service, which can be either skilled nursing or a skilled therapy service. And so that could be quite easy for nursing home patients to qualify, given kind of the bar they would have to get over, if you will. So I think the other requirements for SNF care would, I think, fairly straightforward to meet for many nursing home residents.

MS. WANG: Okay. Thank you.

DR. CROSSON: Larry and then Kathy and Jaewon.

DR. CASALINO: You may have just answered what I was about to ask.

I still remember when I was first in practice as a young physician, the first time I saw a patient who I thought I can avoid a hospitalization if I can get this person into a skilled nursing facility for a few days, and when I was told I couldn't do that, I was flabbergasted.

So I think from a physician point of view -- and you see this with ACO complaints -- the necessity for a three-day hospitalization really gets in the way.

Are you saying that you think if the three-day period of hospitalization requirement was taken away -- you're not saying it would be fraud by requalification within SNFs. It's just the bar would be so low to requalify?

DR. CARTER: Well, I think you'd have to decide on sort of what would be the coverage and benefit requirements for institutional PAC providers.

Right now, the IRF requirements and LTCH requirements to meet coverage are very different, and

LTCHs, you need to have an average length of stay in that institution. The IRF requirements are you're expected to be able to tolerate and benefit from intensive therapy, which is often translated into three hours of therapy.

Under a PAC PPS, we're thinking there's going to be some uniform coverage delineation that's probably not going to be those things, but that would need to be decided about what is going to be the uniform coverage and benefit.

One of the big differences also, IRFs and LTCHs are already hospitals, and so the idea that they need to go to a hospital for care, I mean, it just happens less frequently because they're already hospitals. They have the nursing, the 24/7. They can identify when a patient is dehydrated and manage that patient, whereas SNFs don't have that kind of coverage.

DR. CASALINO: I'm sorry. I'm still not sure I understand. It sounds like you don't see a way around eliminating the three-day requirement because you think there would just be too much requalification of patients within SNFs?

DR. CARTER: No, I'm not saying that. No. I'm just trying to talk through what the options would be.

I think you could either eliminate it or you could make it uniform, and that would be a really big change for the home health users.

DR. CASALINO: Do you see any other options?

DR. CARTER: Well, we had on the slide you could require it just for institutional and not for home health, and that would be -- that is going away from aligning benefits that we thought should be aligned under a PAC PPS.

But if you thought that the change to requiring a hospitalization for home health, which would eliminate coverage for two-thirds of home health, was too big a step, then you might do a sort of two-tiered requirement. That was on the slide, and that's something that you guys can talk about.

DR. CASALINO: I'm sorry. Just one last time. But the reason not to eliminate it, is there any reason not to eliminate it besides the fact that it would be so easy for so many SNF patients to get kind of requalified -- or long-stay patients -- I'm sorry -- to get requalified as SNF patients?

DR. CARTER: Right, right. I guess it depends on what you think post-acute care is. If you think it's post-

hospital, then that sort of implies there was a hospital stay, but we have a situation now where that's not true. And so you might want to think, well, why don't we live up to the term or have different requirements.

DR. CROSSON: Kathy?

MS. BUTO: So I was wondering. To me, the issue of whether we should consider a lower copay level for home health versus the institutional providers somewhat turns on the question of whether the institutional provider patients set is really interchangeable with home health patients. In other words, would they be probably sensitive and choose home health because there's a lower copay?

My sense is that there's some overlap between home health patients and institutional patients but not total. In fact, I think you were saying in our conversation before that two-thirds come from the community to home health.

So I think in making a judgment about differentiating or not somewhat depends on whether you think setting the home health copay is going to really drag patients from institutional settings or not. I just wonder if we can try to look at that question a little more

specifically and in that look at who's coming from the community and for what reason because that may influence whether we think there should be a lower copay if we don't think there's much overlap, for example, because you've already decided that the payments ought to be lower.

So I just lay that out and ask the question of what do we know about that overlap that would help us make that decision.

DR. CARTER: Well, we do know a little bit about the use of PAC with alternative payment models, and so there has been some substitution of home health for SNF use.

I mean, Amol, maybe you can talk about in the BPCI, that has been definitely lower, shorter SNF stays but also not using SNF and replacing with home health. I'd have to go back and look at the evaluations to know kind of what that estimate is.

I think we've seen similar but smaller effects from ACOs.

DR. CROSSON: On this point?

DR. NAVATHE: Yeah. Just as an example, in CJR for hips and knees, our pre-participation rate of sending

patients to SNFs was about 60 percent and post was about 25 percent. That switch happened virtually overnight.

MS. BUTO: And was influenced by the copay?

DR. NAVATHE: No.

MS. BUTO: Okay. I'm just trying to understand.

DR. NAVATHE: No. Influenced by the payment model.

MS. BUTO: Okay. Anyway, I just think it helps us to decide whether lowering the copay for home health would make a huge difference and would create some kind of a perverse incentive or not to know that sense of interchangeability.

The second question I have is we've been talking about the three-day prior hospitalization stay. In a sense, I agree with at least what you were laying out, Carol, which is we've always thought that pretty much guarantees that SNF stays are post-acute care, at least it strongly suggests.

If you eliminate it, we may get more sort of community recommendations or admissions that are less clearly post-acute, so that's an issue.

I wondered. For IRF and LTCH, there's an

inpatient deductible. Had you thought about applying a deductible across all settings, or would you consider that too big a barrier to access? Because it's already there for IRF and LTCH. Is a deductible something like that kind of constraint?

DR. CASALINO: Deductible and no three-day requirement?

MS. BUTO: Right. Deductible instead of a three-day requirement and a deductible for home health, instead of the structure that we have now.

MS. SAN SOUCIE: We thought that the current situation in IRF and LTCH, the majority of -- or a big proportion of patients who are paying cost sharing are paying the inpatient deductible. That's that $1,300 you see on the bottom left- and right-hand corners. And so we thought that was similar to kind of a per-state copayment. That's the amount they're paying for the care, and so we see them as kind of similar, but we would apply the per-state copayment. So you would just pay the cost sharing once and not have additional amounts on top of that.

MS. BUTO: So you're thinking of it more as a per-stay copayment rather than any kind of constraint on

who's using the institutional care in that case. Okay.

DR. CARTER: But that might influence, then, whether you thought there should be different copayments for institutional. If you're thinking, oh, copayments are kind of like deductibles, first, you've got a copay that's for every stay. It's not dissimilar from a deductible.

MS. BUTO: Right.

DR. CARTER: So if you wanted a speed bump for institutional, you might have a higher copay. But that undermines the idea of having a uniform copay.

MS. BUTO: Interchangeable, yeah.

DR. CARTER: So that's just something for you guys to think about.

MS. BUTO: That's helpful. Thank you.

DR. CROSSON: Okay. I've got Jaewon, Karen, Warner, and Bruce, and then I think we need to move on to the discussion. Questions? Jaewon.

DR. RYU: Sure. Thank you.

I had a question about the supplemental coverage. On Slide 15, the 9 percent current aggregate cost sharing, is that net of the supplemental coverage kicking it? It's not?

DR. CARTER: It's not. So that's sort of what the bene is liable for, and that's a hard thing for us to get at, actually, as sort of what really was.

DR. RYU: So maybe the next question I was going to ask might be the tough thing for us to get at, but do we know what percentage of that 9 percent in the aggregate is covered under supplemental coverage?

DR. CARTER: We don't. There was a table in the mailing materials about sort of 80 percent of beneficiaries have supplemental. At least for the Medigap plans, most Medigap plans cover the PAC cost sharing, and that's where most benes are enrolled in the plans that have the cost sharing. But that's only a third of beneficiaries.

We know very little, I think, about the employer landscape in terms of what the supplemental policies look like.

DR. RYU: Okay. Thank you.

DR. CROSSON: Karen?

DR. DeSALVO: Thank you.

I have a question about the community admissions to SNF in particular, not the other two institutional post-acute care environments, and I wondered if you all had

looked at modeling the total cost of care for beneficiaries who could have gone through a community admission to SNF and avoided a three-day hospitalization potentially, if there's a way to look at it. I don't know how you might do that, based on acuity, but clinically, you might see a person and say, "I want them to go to SNF, but I need to admit them for three days in order to get them there."

So I just wonder from a total cost of care, there would be savings even if we might spend more on SNF and if there's a way to model that out, potentially.

DR. CARTER: We could think about that.

I know when we were looking at -- and it wasn't the work that we did. It was many years ago when Zach was here, and he looked at counting observation time towards the three-day requirement, and then the Commission had a recommendation that patients would have to have one midnight, but two of the days in observation. We can relook at that work to see how many stays was that and what would the effect have been.

To look at trying to match patients that maybe went that route, that's probably beyond the scope of this project, anyway.

DR. DeSALVO: Maybe there's some lessons inside the ACO work that could be learned from that.

MS. THOMPSON: Perhaps. And that was really where I was going to go in my comments in the second round, but to your point, we're one of the ACOs that actually has taken substantial advantage of three-day waivers. And with that, I happened to pull some of our own statistics on next-gen beneficiary number of 110,000 lives in our ACO.

We have very much used the three-day waiver with no increase in utilization of SNF. It stayed at 7 percent for the first three years in that contract.

So you could, I think, extrapolate in our savings something that could correlate, I think, maybe roughly, but a lot of our savings in this next-gen contract have been around reducing utilization of SNF.

DR. CROSSON: Thank you.

Paul, on that point?

DR. PAUL GINSBURG: Yeah. I just want to reinforce you're talking about highly managed environments. So we wouldn't want to infer this outside of the managed environments.

DR. CROSSON: Okay. Warner?

MR. THOMAS: Actually, my question relates actually directly to Sue's comment. Do we have data that we can compare utilization and post-acute providers between the ACO world and what's happening there and/or even MA and the traditional fee-for-service Medicare? Do we have data that we can compare that utilization? Is there anything we can learn from that, just given my understanding is the utilization of post-acute in the managed area is significant different? I don't know if we have anything there.

DR. MATHEWS: Yeah. Warner, we have some work that we are currently developing getting to that specific question in a very granular way. How does the utilization of post-acute services in the ACO environment differ from ambient fee-for-service in those market where they exist?

There's some literature out there that has made some general assertions about those differences, and we're kind of digging pretty deep. And we hope to roll this out a bit later in the fall.

DR. GRABOWSKI: I just want to answer the other part of his question on Medicare Advantage. There's also some papers, and they all suggest MA utilization of PAC is

way below fee-for-service, and some of that is probably selection. But a lot of that is just greater management of the patient.

DR. CROSSON: Amol and Pat, on this point, do you want to make a point?

DR. NAVATHE: Yeah. On this point, we've been looking at some of the ACO PAC, ACO bundles overlap PAC, a bunch of these different areas. What we can see is that ACOs definitely use infrastructure in different ways to perhaps rationalize post-acute care use, and so we can see they even do things like use post-discharge visits as ways to reduce home health utilization. There certainly seems to be the SNF home health margin that Carol alluded to earlier, which is a significant one. We see a little bit less action on IRF just because it's less common in general. So SNF is definitely the main margin.

I think the short answer is yes. There's definitely activity on that.

MS. WANG: I just wanted to underscore Paul's point. MA plans will absolutely admit directly into a SNF but very much monitor length of stay and utilization. It is very much a managed event.

DR. CROSSON: Okay. Bruce, last question.

MR. PYENSON: Was there any information that was useful to this from the extension of hospitalization at home programs? I think there's folks who are exploring SNF at home.

DR. CARTER: That's a good idea. We can look into that. Thank you.

DR. CROSSON: Okay. We'll move on now to the discussion. Put Slide 16 back on.

Just to reiterate, these are the policy directions that Carol and Carolyn are seeking input on to help them bring forward a set of recommendations that we can consider. So I'd like to ask that the discussion in general be directed towards that end, and David is going to start.

DR. GRABOWSKI: Great. Well, thanks again, Carolyn and Carol, for that great presentation. This is an area that's, I think, bothered me for a long time, and I'm glad. You shed a lot of light on this.

As Paul said in his introductory remarks, as we began Round 1, this is really a 1965 vintage model of cost sharing. It's incredibly outdated, and not only do we have

the chance to harmonize cost sharing across the sectors, but also, in many ways, modernize it.

It makes no sense to me that we have no cost sharing in home health, this cost sharing that kicks in on day 21 in skilled nursing facilities, and then kind of a more traditional deductible, and then copayments later in the stay for IRF and LTCH.

I think going forward, I'll say at the outset I'm supportive of trying to unify the cost sharing across the four sectors.

I think we're going to do that, and we're also going to think about cost sharing as a way to encourage appropriate use of post-acute care. I think we first have to take on the elephant in the room, and that's just the role of supplemental in this marketplace.

Far too many beneficiaries are protected from the costs of post-acute care. Obviously, that's money that the program is not spending. That's money that's coming from outside, so we're not charging the trust fund. But we're not kind of using cost sharing the way, I think, a lot of economists think about it as a way to sort of encourage more appropriate utilization, as somebody said yesterday,

to give patients some skin in the game.

I really think we need to reform supplemental here, whether that's disallowing the Medigap plans from having first dollar coverage. We actually force beneficiaries to spend out-of-pocket up front, or the other idea you have is charging beneficiaries with those supplemental policies more. I don't know that I have strong thoughts on either of those, but I don't think we're going to get as far as we want with this if supplemental is standing in the way. I very much think that's a first step in this agenda.

The second point, I wanted to sort of go through your questions that you outlined. This issue of a prior hospital stay, I am a believer that if we do away with the three-day rule or some prior hospital stay, whether it's three days or less -- and I'm going to come back to that point in a moment -- I do think that's a big of opening the flood gates for those long-stay nursing home residents. I do think skilled nursing facilities will immediately qualify a lot of individuals for therapy care, for SNF stays, and we would see a huge increase in spending.

I do believe we need to put some sort of

guardrails in place.

I like the idea of a prior hospital stay, of requiring a prior hospital stay. I don't think we can do it for home health, just given the large percentage of home health episodes currently that don't have a prior hospital stay. Requiring a prior hospital stay would basically decimate that industry. I mean, as we saw, what, 65 percent of episodes currently are community based.

So I think although I'm a huge proponent of being as unified as possible and as uniform as possible across the four settings, I don't think we can do that here. I think we can only apply this prior hospital stay requirement on the institutional side. That would be first best. If that wouldn't work, come second best would be placing a requirement directly on long-stay nursing home residents, to say once you've been admitted as a long-stay nursing home resident you have to have some sort of hospital stay in order to qualify for SNF, and not placing the same burden on the IRFs and LTCHs.

I wanted to make one other point about this before going to the second question, and you raised in the chapter -- I don't think it came up in the presentation --

whether in calculating the three-day rule we could use ob stays or any sort of days. I like the idea of using ob stays, and I think we could -- and I'm not even certain three days is the right limit anymore. That's another limit policy that we came up with a long time ago when, you know, the average length of hospital stay was much longer. I do believe we could probably rethink the length of stay, and I do think allowing kind of those observation days to count against that limit would be a good idea as well.

The second question, and this may be a point where I'm not understanding this, but under a stay-based model I don't think we need a uniform limit on the number of days covered. I just like the idea that you're covering kind of a stay. Very few kind of beneficiaries, as you noted already, are getting out to that 100 days anyway in a SNF. We do see, in home health episodes, multiple episodes. I don't know that we need to sort of limit this if we're paying on a stay. I don't believe that there needs to be that limit in place.

The final issue is how to structure the copayment, and, Kathy, I very much appreciate your comment about unintended consequences here. If we make it too high

in one setting are we sort of, especially in home health, are we then potentially directing individuals into higher-cost institutional PAC?

I'd like the idea of imposing a copayment or some sort of cost sharing on all four of the settings, but doing it on a proportional basis, where it's not a fix dollar limit but rather some sort of proportional amount, where, in an absolute sense, you're paying less for home health than for the institutional PAC, but in a proportional sense or relative sense you're paying that same share of the overall bill. I think if you impose a fixed amount you're really distorting behavior and really directing individuals towards the institutional setting.

So, once again, this is great work, and I'm very excited we're going down this path, and not only the unified payment but also the opportunity maybe to take on cost-sharing, which has been an area long in need of some attention. So thanks.

DR. CROSSON: Thank you, David. Very clear. I see Jon, Amol, Jonathan, Kathy, Dana, Bruce, Pat, Marge.

DR. PERLIN: Thank you, Carol and Carolyn, for really terrific work, and obviously provocative of great

discussion afterwards. What I appreciate about your work is that it is motivated by our first principle which is right care in the right place, in this instance, for the right length of time.

You know, I just can't help but think of the last couple of weeks when my daughter is studying for her LSATs and they wonder what the heck has that go to do, and these logic tests of which one doesn't fit. So the one that doesn't fit for me is the home health, and I think -- I'm very akin to David on this one in terms of thinking about what we need to think about differently for home health in terms of the right care at the right place at the right time.

You know, if a patient doesn't need to come into an institutional setting after a joint procedure, a total joint replacement, as an example, why, in heaven's name, would you put them in an institutional setting, you know, with all of the concomitant risks of institutionalization, disorientation from environment, infection, and everything else? It seems like a sort of perverse incentive.

Ditto as we think of two points Karen has made a number of times, that as the care model changes, more of

the care is given in the community. Why would you bring a patient in the hospital if they need an IV infusion that could be delivered at home, again, without the sort of nosocomial infection risk or wound care, or any number of other settings?

So I recall what got us to the constraints around home health, but why should it be hardest to use the least expensive setting of the entire set of settings?

I also think that the application of arbitrary hospitalization -- to David's points about the changing length of stay, obs, et cetera -- creates a countervailing pressure. If you have a patient you're worried about, you know, that they need home health, what are you going to do? You're going to drive up the use of hospitalization, and I don't care how tightly we stipulate it, you know, you can find reasons that a patient has a justifiable hospitalization. When we think about the cost I think we have to look not only in the bucket of the post-acute but also in the bucket of the pushback that, you know, would occur in a countervailing manner on the acute side as well, were that required.

So given these issues, in terms of your specific

questions, one, you know, I don't see that the copay should be the same. It should be lower for the least expensive setting. I think David's suggestion of proportionality actually comes right out of economics and it makes sense as well. Certainly you shouldn't discourage the least-expensive, least-disorienting and potentially most clinically attractive setting when possible.

Next, something we didn't talk about, although I know we have in the past, is that we have to get to a uniform set of quality measures in terms of clinical outcomes across all the settings. In this regard, that would include home health.

And finally, I think a principle is right of symmetry in general, save for the obvious difference between institutional and non-institutional care, and in terms of the coverage limit, for the reasons David mentioned, and that may solve itself. So just in terms of this issue, then, of the three day, I don't think we have the evidence. I think there are a lot of changing facts in terms of length of stay and potentially countervailing pressures, and that's the one that deserves further study. Thanks.

DR. CROSSON: Thank you. Thank you, Jon. Amol.

DR. NAVATHE: So thanks, Carol and Carolyn, for taking this topic on and really distilling it, I think, into some really concrete areas for us to engage upon, so thank you for that.

So I have a couple of sort of more well-defined comments and then a broader one. The first one kind of picks up on what David was suggesting regarding the supplemental coverage piece, and I would maybe suggest thinking about presenting this information in a slightly different way, which is if we can get our hands on it it would be nice to be able to look at essentially income level of patient, or of beneficiary, and see what cost-sharing they're likely to face, based on the distribution of how supplemental coverage is not uniformly distributed across income distribution, as well as the interaction with potential Medicaid benefits. And I think that would be a rich thing for us to be able to look at, to think about where this cost-sharing is really going to bite and who it is going to bite for. And so I just wanted to make that one suggestion.

The second piece is I think we -- I want to

commend you guys in thinking about this from a copay-only structure. I think that makes a lot of sense. I think in the literature and in the work that we have done, we kind of ostensibly know, at this point, that individuals tend not to really understand deductibles and coinsurance very well, but they tend to understand copays.

And so to the extent that we're putting a cost-sharing structure, particularly one, for example, for home health where it has never existed before, it would be nice to lead with something that people intuitively understand, as opposed to something that we would expect them to be educated about. So I thought that was very nice.

My broader point is I think what we should be -- the frame that we should be taking -- I think this picks up on what Jon was just saying -- is we should be thinking about what the value of these services are. I think traditionally the way insurance has worked is we have said we should have copays that are proportional to the cost of the service, or to the payments being made. And so we have said if there's a very high cost service we should have a larger cost share, or at least dollar amount larger cost share, and for a lower-cost services we have lower cost

share.

And I think as we are going through this journey of thinking about ACOs and bundles and MA, just a shift toward value, then I think that should also apply to the beneficiary, from the perspective of what we expect them to contribute. And if there are services that are particularly high value then we would want low cost sharing for those, because that means that they are likely to get a lot of value and benefit, and, in fact, decrease cost in the system down the road.

And so if we take it down to the -- try to make it pragmatic, I think what we start to think about is, well, so how high-value is IRF care and SNF care and home health? And I think what we'll quickly realize is that it depends a lot, of course, on clinical scenario. There is this question of is institutional PAC a substitute for short-term acute stays, short-term hospitals? I think in some cases there is a sense that, yes, that may be the case, and, in fact, we can drive length of stay down, for example, in a hospitalization, or maybe even avert a hospitalization altogether, because of SNF and IRF care.

For home health I think it also helps clarify,

because much of what's done in the home health setting actually is helping patients either improve quality of life or in potentially averting a hospitalization or an acute event. And so I think if we use that frame we have to understand that there's quite a bit of variability and this is not an easy one-to-one kind of mapping. But I think we can start to think about it in this frame and say, well, as we go through each of these pieces, do we want a prior hospital stay? I think, in some sense, because of the tight link between the short-term acute hospital and institutional PAC, it suggests that probably there should be some requirement, but at the same time we probably don't want it to be as stringent as it has historically been. So kind of doubling down on what Jon and David have said.

In terms of the uniform day limit, I think the suggestion would be, for example, for home health that it may be a mistake to have a day limit, because there is very unlikely to be, at some point, at day 100 or whatever, that the subsequent home health is going to suddenly stop being of value, from a quality of life for from keeping people out of the institutional setting. And so I think that's kind of a rational implication.

And then uniform copayment, I think because the value of these services likely vary, it implies that probably a uniform copayment doesn't make a lot of sense, and we probably need to think about how it's proportional to the value of the services being provided, presumably thinking, you know, that services in an institutional setting have perhaps a lot more value, because otherwise people would get a lot sicker and have worse events.

So that's kind of the framing that I wanted to bring to this that might help clarify. The parting thought on it is that I guess in some sense we're stuck with thinking about this as average value, because it may be very hard to rationalize this, given that different clinical scenarios may actually be quite different, and that's attention, I think, that we are probably always going to feel.

DR. CROSSON: Thank you, Amol. Jonathan?

DR. JAFFERY: Yeah. Thank you. I will try to be brief. I'm in agreement with what the others have said. I just want to emphasize maybe one or two points.

I think in terms of thinking about the copayment, you know, I think we've started to talk more about this

principle of thinking about what is the care model we want to put out there, and if we believe that there's some benefit to trying to get people to be spending more time closer to independent at home, I think that we don't want to limit ourselves or push ourselves to try to do things that would incent away from the home health. So whether that's a difference between a facility-based and home health type of copayment, or as others have suggested, a proportional one, despite the fact that it gets away from a completely uniform thing I think that makes sense.

In terms of the prior hospital stay, I think this is one I'm still -- before coming to the meeting and doing the reading I was really struggling with this, and I was really hoping that after an hour and a half of discussion I would have some moment of clarity, and it hasn't happened. And I appreciate that, you know, thinking about 1988 -- and I appreciate what Paul said, because, you know, it's a different environment in managed care with MA. But we now have two-thirds of beneficiaries in either MA or ACOs, which have a variable amount of tight management between the two, but still, that's a bit of a difference.

And so, you know, I think you're hearing from a

lot of the doctors and nurses in the room that there is some discomfort with the clinical side of this, in addition to not understanding all the payment and behavioral influence.

So I think I would just end with that. I'm not sure that I have a really strong feeling yet about what the right direction is, or know enough, and so Jon's final point about this particular topic probably needs a little bit more thought and work within the Commission is something I would really support.

DR. CROSSON: Thank you, Jonathan. Kathy.

MS. BUTO: I want to thank you for taking up some of the toughest issues in post-acute care unified PAC. I think these are tough.

I don't have any problem with the first one, requiring prior hospital stay, even for home health. I would not just fall back on, well, that's not who they are right now. Well, that's because it's never been required. But before we went there I'd really like to know more about the community-admitted patients to home health. So it may be that I'm wrong about that, but I honestly think this was designed as a post-acute benefit, it was intended to be

short term, to follow up on hospitalization and recovery from either surgery or some clinical treatment, and was never intended to be just a benefit for people who are at home.

Now having said that, for home health there are other requirements, and what I think we'd have to think about, if we went this route, would we want to loosen up on things like homebound and so on? I think those are as constraining to use of the benefit as anything else, the fact that you can only travel to religious ceremonies and so on. Your ability to -- it almost implies you're very frail, instead of that you are able to return home and rehab there. There is a contraction sort of embedded in that.

So I would just say, qualified, I think if it as a post-acute benefit that's never properly been, I guess, overseen, in a way, or properly provided, but I think we'd need to know more about the community-admitted patients.

On uniform days, until David said it I thought, wow, he's right. If this is a per-episode basis, we don't tell inpatient hospitals how long the benefit will last because they're paid a specific per-episode payment for

each admission. I don't see why we'd want to have, or need, a day limit in this case, unless I'm missing something.

And on the third one, having listened to the conversation, again, I think there's an issue of how much real interchangeability is there with patients. I think in the conversation there's a little bit of a contradiction between the goal of unified PAC, which is to make the site, or not have the site be attractive because of the structure and cost sharing, and to try to make these benefits more available for choice, given the patient could benefit in any number of settings.

And an underlying theme I'm hearing that maybe we should try to skew cost sharing to favor home health. I'm really torn about that, so on that one I initially thought a two-tiered copayment would make sense, with home health being lower. Again, particularly if there isn't a lot of likelihood that institutional patients are going to migrate to home health, just because the copay is cheaper, that strikes me as an okay thing to do, because home health is a much more cost-effective benefit.

But I'm still thinking about that and I don't

like the idea of trying to mix signals to create incentive to take home health, even when you'd be better off in an institutional setting. So I want to make sure we don't go too far in that direction. But it strikes me that the copay should be lower for home health.

DR. CROSSON: Thank you, Kathy.

Dana?

DR. SAFRAN: Thank you.

I add my thanks for your taking on this complex issue. I've been struggling with it, and this conversation has been helpful. And your answers to the questions I had before were also helpful.

I think that I'll start by saying Marge's comments at the beginning really to me underscore the magnitude of the communication challenge we have in front of us if we go this path because this would be a monumental change. And beneficiaries as well as the people hoping to organize their care would need to really understand what we're doing and why.

The second thing is that part of why I've been struggling -- and I think it's sort of come out in a lot of comments in the last 20 minutes or so -- is that on the

provider side, I really understand trying to equalize payment for patients who are clinically the same, regardless of which setting. But I don't think that's the same as saying that we're indifferent about which setting patients receive their care in or that these different settings are good and do well, the same things. So that's part of why I'm struggling with how far do we actually go.

It makes sense for a given patient who could be treated in any of these settings, let's pay the same, regardless of which setting. That makes total sense to me.

It doesn't make sense to me necessarily, then, on the flip side to align our payment approach, cost sharing approach for the patient so that the incentives about which setting they go to are the same. So that's where I'm struggling a bit.

I think, in essence, I land a bit where Jonathan Perlin was. I didn't disagree with anything you said, Jonathan.

[Laughter.]

DR. SAFRAN: But that home health feels different here, and part of why I think it feels different to me is that -- and you said it, Carolyn, in answer to a question

before. There are social factors that enter for a given patient with a given clinical profile. There are then other factors, mostly social ones, that decide like is it this setting or that setting. And that says to me that we should think carefully about how far we go in neutralizing or equalizing the way that cost sharing is between institutional versus home health settings.

So on your specific questions, prior hospital stay, I would say absolutely would not want to see us impose one for home health care. Inducing that much more hospital care really makes me very uncomfortable, unless we're thinking that we would, on the flip side, just be dis-incentivizing that much more home health care. And that doesn't seem like a good idea either. So I'd say no there.

And I don't know about -- I think all the smart things have already been put on the table about is it really helping us to have a hospital requirement for SNF or to the two-thirds of beneficiaries who are already in managed arrangement kind of almost start to take care of that for us. So I don't know for the institutional whether we need that.

Uniform limit on days covered, I don't know that I'd go to uniform for some of the reasons that I have been spelling out, particularly wanting to preserve home health as a benefit that people take advantage of, if it can keep them out of higher-cost settings for longer. But I do think that having some kind of cap on the benefits across all of the settings -- and maybe it's at a dollar amount -- is a good thing to do.

Uniform copayment. Now that I understand that -- and this goes to Amol's point. Part of my worry in my question before was I thought payments were going to be on a percentage basis based on that provider, like coinsurance, and that would be terrible. So I loved your answer that these are flat-dollar amounts, and it doesn't actually matter which provider type.

So I do like the idea of uniform copayments, and since the underlying costs are going to be different, I could be okay with the same percent, regardless of which setting.

So let me stop there. Thanks.

DR. CROSSON: Thank you, Dana.

Bruce?

MR. PYENSON: Thank you very much.

I was struck by something I think David was suggesting, which is that the hospital requirement for SNF might be waived if someone came from the community but would not be waived if someone was a nursing home resident. That would seem to help solve some of the concerns.

On the prior hospital stay required just to connect to the discussion yesterday, I think yesterday we heard that 20 percent of hospital admissions are potentially avoidable because they're ambulatory care-sensitive.

There's other categories of avoidable hospitalizations, such as preference, sense of admissions that are there. So the prior hospital stay required seems connected to another archaic issue left over from the 1960s, which is the failure to recognize that today we have relatively good objective criteria for when a hospitalization is necessary. That seems connected to a solution on this hospital required, prior hospitalization required.

I'm wondering if looking for objective criteria on SNF required or home health required would be a

worthwhile venture. I know there's been some frustration in that, but give where we are with data and the advance of medical knowledge and outcomes, I'd suggest that a utilization management approach be adopted for many to these services and would point out that there are similar kinds of criteria that have been used for things, for example, in DME to get a hospital bed or to get a motorized wheelchair. So I think that would help solve some of the concerns we have, and there seems to be enough interest, enough importance, and enough money in post-acute care to justify the development of those.

DR. CROSSON: Thank you.

Kathy, do you want to comment on that?

MS. BUTO: Yeah. Some of my comments about prior hospitalization are a holdover from the catastrophic experience where -- and other experiences where if you lift a requirement that had its intent sort of associated with a particular kind of benefit, you will see a huge surge and increase in utilization.

I also know that utilization management tools are very difficult to deploy and are very budget dependent. So I would never rely on utilization management to try to

manage this benefit. I just wanted to say that because I think, administratively, it's very hard to do, to manage something where you sort of open the door and there's a huge potential beneficiary population involved and then try to manage it kind of after the fact. So I think that's just really tough to do.

DR. CROSSON: Let me just be clear. At the level of CMS, we've already heard that for MA plans and ACOs in terms of managing --

MS. BUTO: Right. I'm talking about -- yeah.

DR. CROSSON: Yeah, right.

MS. BUTO: As I understand it, MA and ACOs can waive the three-day stay now and are doing so.

DR. CROSSON: Among other ways to manage utilization.

MS. BUTO: Yeah, right.

DR. CASALINO: Jay, may I ask a clarifying question about this?

DR. CROSSON: Yeah.

DR. CASALINO: And then I have some comments for later.

Kathy just said we'd get a huge surge if we took

the three days away.

MS. BUTO: That's my --

DR. CASALINO: Yes. And I saw Amol and David nodding.

But I haven't heard you guys say that. You said that you think that some of the doubling or whatever it was, when the three-day requirement was removed, was from SNFs requalifying patients. Do we know how much there was of just people being admitted straight to SNFs from the community?

There seems to be a little bit of an unspoken assumption here that people kind of like to go into SNFs, and I'm not --

[Laughter.]

DR. CASALINO: I'm not sure that that's really true.

So do we have any data on that? I don't think we should just assume. This is not like you can get an MRI of your knee the first time you sprain it. This is going SNF, which is not the most pleasant environment in most cases. I'm trying to separate the two.

DR. CARTER: So why don't we go back, because

there were two or three payers that looked at the effect of catastrophic.

Now, of course, there were many things going on at the same time besides the three-day, and so I'll see whether those papers tried to tease that apart and whether they looked at the use of community admits versus the nursing home residents. And we'll see what there is there.

DR. CASALINO: It is an important question, right?

DR. CARTER: Yes, I agree.

DR. CASALINO: Because there could be some kind of barriers put in place to SNFs requalifying perhaps.

DR. CARTER: Mm-hmm.

DR. CASALINO: Now, if the idea of people going directly into SNFs from the community and that there be a huge surge, inappropriate surge in that is incorrect. That matters.

DR. CARTER: Yes, I agree. Yeah.

DR. CROSSON: Okay. We have Pat, Marge, Paul, Warner, and Larry. And we have exhausted our time for this discussion.

MS. WANG: So I will be quick.

DR. CROSSON: I'm going to beg conciseness.

MS. WANG: So I'm just going to go.

For the three questions that you have here, in the first one, I would say do nothing. I would leave the requirement in for SNF with the caveat of maybe looking at the average short stay today and sort of maybe making some recommendations of modifying the three-day to something else.

I would not put a requirement for an inpatient stay to be a requirement for another inpatient stay, which is LTCH and IRF. It's not a problem today. Don't fix it if it ain't broke.

I'm with Kathy in trying to understand more about home health and the community it knitted. When I listened to the conversation, I know that I myself, this particular treatment modality is something that seems like has a much broader range of what is being done and for what reason. I would think it would be very helpful to learn more about that.

On the second one, uniform limit on days covered, I take the point that David raised. My only concern is that when a state-based payment is developed that there be

some sort of outlier for length of stay so that we don't create disincentives to keep people who need to stay for 100 days. I mean, those poor people. After that, today, after that limit is exhausted, there's no place for them to go. There is no insurance that is going to cover them. So that's a tough situation to be in.

On the third, for copayment, I think I agree with my colleagues here. I have the most confusion around home health. It does seem like it should be lower, but I would benefit at least from understanding more about the nature of the services there.

On the prior hospital stay, the reason that -- I think it would be helpful to learn more as you dig up the old research. The one thing that I would say that I like about the way the system works now is that it is an extra benefit to join a managed system, whether it's an ACO or an MA plan, and clinicians should understand that when they're counseling their patients. And maybe it creates an indirect incentive to boost participation in value-based managed Medicare as opposed to flat-out fee-for-service.

So, in a way, we are differentiating the benefit as between MAP-niched environments and straight out fee-

for-service, and I like that.

DR. CROSSON: Thank you, Pat.

Marge?

MS. MARJORIE GINSBURG: I will also try to be quick.

I'm beginning to think that maybe PAC, it's time to put that term to rest. We've been focusing everything around acute care, as if that is the centerpiece of health care, which it probably is, but regardless, we're trying to move that away from being the center of health care.

So my first suggestion is we change PACs to community-based care. We move the LTCHs over to the hospital, acute care. I'm not sure what to do with IRFs, but the rest is community-based care, so that's my one point.

The other is right on home care, and I do speak form some experience with this. Home care is a preventive service. the reason why so many people get it, not counting those that came directly from the hospital, is they've got a medical need that can be addressed in the home, and this is, in part, to keep them healthier, to keep them out of hospitals.

I don't think we want to do anything to discourage that, except maybe put a limit on the number of days. I would not put any cost sharing on patients for home care because my fear is they would then turn it down. I don't need that.

The doctor says you need to go into the hospital. You go to the hospital. Even you go to the SNF. But if he says you need home care and if there's anything about it that patients are feeling uneasy about, they can turn it down. And if they're paying a piece of it, I worry that they will turn it down, and I think of it more in terms of that category of prevention that we now provide for free for seniors to get their preventive exam once a year. To me, that's really how we should be looking at home care.

We do have to put some more boundaries around it because it's gone wild, but I think we can do that without any cost burdens on the patients.

Thank you.

DR. CROSSON: Thank you, Marge.

Paul?

DR. PAUL GINSBURG: Sure. I think it's terrific that we've had this discussion, which has forced us to

really grapple with this ignored-for-years cost sharing structure, and I think that's going to be a real benefit of having pursued PAC PPS.

Just one thing on the home health. Marge, I think when you have zero cost sharing, then you get fraud, and that's been our experience with home health. I know the virtue of not having any barriers for something that might be preventive, but when you go to the extreme of having no cost sharing, then you're just opening yourself up to fraud.

MS. MARJORIE GINSBURG: It's not the patients that are committing fraud.

DR. PAUL GINSBURG: I know. But you want the patients to block the fraud.

MS. MARJORIE GINSBURG: And do we really think that they --

DR. PAUL GINSBURG: I mean, I'm going to have to pay $10 a day for this? Get out of here.

DR. CROSSON: Okay, all right. Let's not have a debate on honesty. Go ahead.

DR. PAUL GINSBURG: Yeah. But, actually, the final thing I want to say is that I'm really glad that

David brought up this issue of having some redesign of supplemental coverage to be consistent with the best cost sharing approach we can come up with, and I think we want to do this in other areas too.

When we look for better ACO models, ones that engage beneficiaries, there's likely to be a supplemental coverage component to that, so that the supplemental coverage doesn't block all attempts to engage beneficiaries.

DR. CROSSON: Thank you, Paul.

Warner?

MR. THOMAS: I think it's great work, and it's a tough situation.

I think the idea of prior hospitalization, I think for me works with the institution, though I would not do that around home health. That's just my view. I agree with Marge that I think it's -- and Jonathan actually as well. I think it's a totally different situation.

I think if you want to look to unified payments, I would go back to the word I know you guys have done and looking at it along diagnosis and looking at the type of care and trying to align along diagnosis, regardless of

whether you're in an IRF, a SNF, or an LTCH.

I think we do that in hospitals, in acute care hospitals all the time. It's based upon the type of diagnosis, and you're paid appropriately for that diagnosis, regardless of kind of where you sit in the hospital. I think we could look at the same thing in post-acute.

I think going back to the limit, I would put a limit on home health, but I wouldn't make it an absolute. I would have different milestones where you need additional review and approval because there is overutilization in this area, and we know there's a view.

I think many times, going back to Marge's point, it's needed, but having the right review process would be important.

I would like to encourage us. Whatever is learned from the information in the ACO or the MA world, I think we ought to be looking at that and trying to apply here because I think there is lower utilization in those areas. It would be interesting to see if you can prove it out, but I think there's a lot to learn that could be applied to this area.

The final piece -- and this is maybe a little off topic, but in the home health area, we haven't talked a lot about how digital and telemedicine is going to play in this world, and I think that is a big opportunity and probably going to be a very complex topic. There's going to be more and more digital home monitoring that's going to play out in home health world, and today it will all be out-of-pocket or retail-oriented. But I do think there's going to be opportunities to save other costs by doing those types of things to try to keep people in the home.

And the last comment I'd make -- and I didn't really see the information here, but it would be interesting to look at acute care cost during the same 12- or 24-month period while somebody is in post-acute to see if there's any differential in acute care cost while folks are in these different modalities and try to understand is there any relation to a reduction in the acute care cost by utilization of certain services.

Maybe that's been done. I'm not sure, but there might be some learnings there or reasons that we would want to focus on certain post-acute disciplines versus others if it has a material impact on acute care cost, so just a

couple other thoughts.

DR. CROSSON: Thank you, Warner.

Larry, last comment.

DR. CASALINO: Briefly going from the third to the first, I think a uniform copayment, there's been some discussion of that, but speaking specifically about home health -- and let's say it was a per-stay payment for home health that was maybe lower for other places based proportionately on the cost. It's attractive in a way, but I think there are two problems. If it is very high, it's going to discourage people. If it's per-stay, it's going to have to cover the whole cost, potentially, or some kind of average from a week of home health to six months of home health. So it could be really an obstacle, that kind of per-stay copayment, to people who really just need a week or so of help and that would be paying very much for that compared to someone who needs six months of help and be paying the same amount. I think that is a little bit of an obstacle.

The other side of the coin is once you've made your per-stay copayment, then there's really no incentive to stop with the home health, which can be nice to have

because it helps in lots of ways, and even if you don't really need it anymore, it's nice.

That's not really true with the three institutional sides. Most people don't really want to stay in an institution, but they might want to keep up with home health as long as they could. So I do see some problems with per-stay for the home health.

Home health seems to be what we're all mostly talking about because it is the problem in trying to make something unified, I think. There probably should be some kind of limit on days. I'm not sure that that's a separate issue from the issue of how you actually pay. I think we all agree that it shouldn't be free forever to get home health.

I've already addressed, I think, from a clinician point of view, the three-day stay for SNFs is hard for doctors to understand. I think that Bruce and maybe a couple of other people since have mentioned that maybe the idea of eliminating that for community-based patients but doing something a little different to try to prevent nursing homes from qualifying people for that inappropriately would be something to look at, although I

suppose the argument could be made that that's really discriminating against people who are in SNFs already. Why should they be treated differently from someone in the community?

DR. CROSSON: Thank you, Larry.

Good discussion. Carol, Carolyn, you've got plenty of material to take back and cogitate on, which is what we're here for. So thank you for that. Thank you for the good work, as usual.

MS. BUTO: Jay, could you remind us, or maybe Carol could, what the timing of unified PAC was in the legislation?

DR. CROSSON: Carol, could you answer that?

DR. CARTER: I'm sorry. The question?

MS. BUTO: The timing of the introduction or adoption --

DR. CARTER: Oh, so there's no actual requirement in the legislation. There are just requirements for reports.

MS. BUTO: And our last report is this year --

DR. CARTER: No. Our report is in like 2022.

DR. CROSSON: Okay. Now we will proceed with the

final presentation and discussion for the October meeting, and we are going to be looking at the issue of an aggregate cap, the aggregate cap for the hospice benefit, and Kim is here to present, all by herself. Go ahead.

MS. NEUMAN: Good morning. We're going to discuss Medicare's hospice payment and explore a policy option to modify the hospice aggregate cap, as a way to potentially increase equity across providers, improve payment accuracy, and generate savings for taxpayer and the Medicare program.

The presentation is going to have three parts. First, we'll discuss background on hospice and the hospice payment system, then we'll discuss the hospice aggregate cap and how the cap works, and finally we'll explore a policy option to wage adjust and reduce the cap.

So, first a reminder about the hospice benefit. Hospice provides palliative and supportive services for patients who have a life expectancy of six months of less if the disease runs its normal course. There is no limit on how long a patient can be in hospice as long as a physician certifies that the patient continues to meet this criteria.

In 2017, Medicare spent $17.9 billion on hospice, and Medicare pays a daily rate for hospice care. This rate is paid regardless of whether the patient received services on particular day.

There are four levels of care. Routine home care is the most common level, accounting for 98 percent of days. The other three levels of care offer more intensive services to manage a crisis or special situations.

Over the years, the Commission has expressed a number of concerns about the hospice payment system. First, the Commission has found that the aggregate level of payment for hospice substantially exceeds cost. The Commission recommended a 2 percent reduction to fiscal year 2020 base rates. That recommendation was not taken up and instead the hospice annual was a 2.6 percent increase for 2020.

Second, there's been concern that the payment system has been out of balance by level of care, with routine home care overpaid and the other three levels of care underpaid.

Third, the Commission has been concerned for many years that long stays in hospice are profitable. Until

2016, routine home care was paid a uniform daily rate. Because hospices furnish more services at the beginning and end of an episode and less in the middle, this has meant that long stays in hospice have been more profitable than short stays, and these profit opportunities associated with long stays have led to substantial for-profit entry in the sector.

Finally, hospices with disproportionately long stays that exceed the aggregate cap –- something we will talk more about shortly -- have strong margins.

CMS' changes in 2016 to restructure routine home care payment rates and in 2020 to rebalance payment rates by level of care are improvements, but the aggregate level of payments for routine home care remains above cost and long stays remain profitable.

When the hospice benefit was first created, Congress included an aggregate cap to ensure that the legislation creating the new benefit saved money. This cap limits the total payments a hospice provider can receive in a year. The cap is an aggregate limit on payments, not a patient-level limit. If a provider's' total payments exceed the number of patients served by the provider,

multiplied by the cap amount, the provider must repay the excess to Medicare.

The cap was set at $6,500 initially and has been increased annually for inflation. Currently, as of fiscal year 2020, the cap is about $29,965. The cap is not wage adjusted.

As we'll see shortly, the hospice cap affects providers that have disproportionately long stays. So this next chart is a reminder of what hospice length of stay looks like for the overall hospice population nationally.

On average, hospice length of stay among decedents was 87.8 days in 2016. Many hospice decedents have short stays. Fifty percent have stays of 18 days or less. Some patients, though, have long stays. Thirteen percent of decedents had stays of 180 days or more in 2016.

So here's an illustration of how the hospice cap calculation works. This is a hypothetical example of a hospice with a mix of patients with disproportionately long stays compared to the national data that we just looked at.

This is a hospice with 20 patients, half with stays of 30 days and half with stays of 300 days each. To determine whether the hospice exceeds the cap we compare

the provider's total payments, in the left box, to the aggregate cap amount, in the right box. So let's look at the provider's total payments on the left.

For patients with a length of stay of 30 days, the hospice was paid about $5,600 per patient, and for patients with a length of stay of 300 days, the hospice was paid roughly $46,000 per patient. Adding it all up, the hospice was paid in total $520,000 for the 20 patients.

In the right box, we have the calculation of aggregate cap, which is just the number of patients, 20, multiplied by the cap amount in 2016 of about $27,800, which yields an aggregate cap of about $556,000.

And so when we compare the left, the provider's payments, to the right, the cap, we see that this hospice, with half of its patients with 300-day stays, would be under the cap.

So now let's look at some statistics on hospices that are above the cap. In 2016, we estimate that about 12.7 percent of hospices exceeded the cap. Payments in excess of the cap were equivalent to about 1 percent of total payments to all hospice providers. Margins for above-cap hospices would have been very high without the

cap -- we estimate about 20 percent. After the return of cap overpayments, above-cap hospices' margins were still strong, at 12.6 percent.

In terms of characteristics, above-cap hospices have substantially longer stays and higher live discharge rates than other hospices. They are also disproportionately for-profit, freestanding, urban, small, and recent entrants to the Medicare program.

So next let's talk about wage adjustment. Hospice payments are wage adjusted but the aggregate cap is not, and because the cap is not wage adjusted it is stricter in some areas of the country than others. For example, for a provider with a wage index of 1, the aggregate cap in 2016 was equivalent to an average length of stay of routine home care of about 173 days. However, it was equivalent to a shorter average length of stay in areas with a higher wage index and a longer average length of stay in areas with a lower wage index.

And so this means that providers with the same utilization patterns in two areas of the country could fall on opposite sides of the cap, due to wage index differences. And we do see more hospices in high-wage

index areas exceed the cap than those in low-wage index areas. About 20 percent of hospices with a wage index above 1 exceeded the cap in 2016, compared to 9 percent of hospices with a wage index below 1.

In light of all of this, the Commission could consider a policy option to wage adjust and reduce the cap. Wage adjustment could improve the equity of the cap across providers. Reducing the cap could improve payment accuracy and reduce excess payments to providers with disproportionately long stay and high margins. To the extent that some providers have entered the hospice sector pursuing a strategy focusing on long stays, this could also lessen the attractiveness of that business model. Also, reducing the cap could generate savings for taxpayers and the Part A trust fund, which could help address the Commission's concern about the aggregate level of payments.

So we conducted a simulation to explore the potential effects of a policy that would wage adjust and reduce the cap. We simulated a 20 percent reduction to the cap. This figure is illustrative. Other amounts could be considered. The simulation uses 2016 data and assumes no utilization changes. Because the 2016 data does not

reflect CMS' 2020 rebasing, we simulated the rebasing before simulating the effect of the policies to modify the cap.

So I'm going to summarize what we find when we simulate the policy option. There is more detail in your paper.

Overall, the share of hospices exceeding the cap increases, but many hospices would remain well below the cap. Under the policy option, we estimate that about 26 percent of hospices would have exceeded the cap in 2016. This estimate is based on constant 2016 utilization and does not reflect the possibility that some providers might adjust their admissions patterns so that they don't exceed the cap. And as you'll see on the next slide, these hospices that exceed the cap are those that have the longer stays.

At the same time, many hospices would remain below the cap. For example, in our simulation half of hospices would have been 41 percent or more below the cap under the policy option.

So this next chart shows the simulated effect of the cap policy option on payments to providers in 2016.

Overall, our simulation estimates that total payments would decline 3.2 percent in 2016. As you can see in this chart, the reduction payments occurs among hospices with the longest stay and the highest margins. Those are the hospices on the bottom two lines of the chart. The other hospices, on the three lines above the bottom two, there's virtually no effect.

So when we look at the effects of the policy to modify the cap by provider characteristics, what we find is that the effect by category of hospice depends on the prevalence of providers in that category with disproportionately long stays. So as a category, for-profits and freestanding hospices would experience reduced payments. We find little effect on nonprofits and hospital-based hospices, provider categories with the lowest margins.

In summary, wage adjusting and reducing the hospice cap is an immediate targeted step that could be considered to improve equity across providers, increase payment accuracy and reduce excess payments for providers with disproportionately long stays and high margins, and likely generate savings for taxpayers and the Part A trust

fund.

We expect that beneficiaries would continue to have good access to hospice care, many providers would remain substantially below the cap, and to the extent that some providers have entered the sector to pursue strategies focusing on long stays, it would lessen the attractiveness of that business model.

So that concludes the presentation. I look forward to your discussion and would be glad to answer any questions. It would be helpful to get your feedback on the policy option to modify the cap and whether you would like to consider developing it further into a potential recommendation for further consideration in December.

DR. PAUL GINSBURG: [Presiding.] Thank you very much, Kim. Let's start with clarifying questions for Kim. Yeah, Larry.

DR. CASALINO: Yeah, Kim, very nice work. Very clear, and this really makes a lot of sense to me.

Two quick questions. One is, one of the characteristics of the hospices that had the highest profit margins and a disproportionate number of long stays was that they were small. That's not what I would have -- I

don't know much about this area but that is not what I would have predicted. Do you have any sense of who these small ones are, and why they fit into this disproportionate long-stay category?

MS. NEUMAN: Well, the hospices that exceed the cap, as you know, are small, and they have a bit of a different patient mix. They have fewer non-cancer patients and more patients with -- I'm sorry, fewer cancer patients and more patients with non-cancer diagnoses. And then, within any diagnosis category, they have longer stays within those categories. So it's both their mix of patients is different and then they have long stays for any type of patient.

DR. CASALINO: And physicians have to refer. Do you have a sense of who the physicians are that are referring them, compared to physicians who are referring to different types of hospices?

MS. NEUMAN: We have not looked at the referring physicians.

DR. CASALINO: Okay. And the second question I had was, the 18-day median for hospice stays I think probably is way too short, right? I mean, my main idea

about hospice is that most physicians refer too late, not too soon, right?

So have modeled, or could you model -- if that increased to a more appropriate number, whatever that number might be, but it's probably a lot longer than 18, maybe multiples of 18, would that be likely to be putting many hospices -- and everything else stays the same, say -- would that be likely to be putting many hospices over the cap?

So just conceptually, we'd like to not have hospices have too many disproportionately long stays that are unnecessary, but we would like them to have more stays that are of an appropriate length, and what would be the effect if that happened? We want to, quote/unquote, punish the one but not the other, right?

MS. NEUMAN: Right. And you can see on this slide here, where we did the sort of hypothetical example, we put half of these hospice patients at 30 days. So there were no 2-day or 3-day stays, which is actually a big chunk of what happens in hospice. So it's kind of the sentiment that you were just expressing. You could play with this and try other kinds of numbers, but that was kind of the

thinking here is to bring the shorter stays up.

DR. PAUL GINSBURG: Jon.

DR. PERLIN: This is really just an extension of Larry's question. In terms of understanding what drives the longer length of stay at the smaller hospices, I just want to understand what you know about their locations. Do we know if they are more isolated, either being rural or in, you know, sort of urban areas that may be lower income and bereft of SNFs for alternatives?

MS. NEUMAN: So hospices that exceed the cap are located more in urban areas than rural areas. There is geographic concentration. It happens in more states than others, and it tends to happen more in the southern coast, I would say, is where we see more access cap hospices.

DR. PERLIN: The question I'm trying to tease out is what is it being a substitute for? I mean, because clearly you don't go to a post-acute care by choice. You don't go to a hospice by choice. So these are individuals, then, that have some sort of care dependence, say, and need, and yet our working assumption is that they're not really who we are thinking of as the most appropriate of hospice patients. So I'm just trying to get at this

question, what piece of infrastructure is it that they're not accessing?

MS. NEUMAN: We hear anecdotally that sometimes, for certain patients, certain providers may view it as a substitute for long-term care or other kinds of supports, but I can't speak to it broadly, just anecdotally.

DR. CROSSON: [Presiding.] Kim, I apologize. I'm just jumping in here. But maybe for the benefit of some of the other newer Commissioners you might talk about the changes in diagnoses that have occurred over the last decade or so, in terms of who is going into hospice, particularly for the longer term.

MS. NEUMAN: So there has been a big shift over the last 15 or more years in terms of patients in hospice. It used to be that it was largely cancer patients, but we have shifted over time to a mix that is majority non-cancer on diagnoses, and, in general, probably is more reflective of the overall decedent population than solely the cancer model that existed.

DR. CROSSON: With a particular emphasis on chronic neurologic disease -- would that be fair to say?

MS. NEUMAN: The largest sort of big category now

is chronic neurologic disease.

DR. CROSSON: Thank you.

DR. RYU: Do we attribute that to anything in particular? Is that just better education for the care delivery system around types of patients that might benefit from hospice, or is it a different mix of beneficiary disease burden? Do we know what is driving that?

MS. NEUMAN: I think it's a combination of things. I think there is a better understanding that hospice is appropriate for a range of patients, so I think that that is certainly part of it. And I think that, as well, this group of patients has longer stays and so they are an attractive group from a business model perspective.

Mr. Cassidy. [Off microphone.]

MS. NEUMAN: Substantially. Substantially longer.

DR. CROSSON: Okay. Dana.

DR. SAFRAN: So that last bit was actually very, very helpful, so thank you for that.

I guess if you could go back to Slide 6. You know, what you told us and shared in the written materials about the policy is this applies to people expected to live

less than 180 days, or half a year, and for the most part that's what we see. I mean, I don't know if 13 percent beyond 180 days is what you'd expect by chance, in a population, you know, that clinically you are assessed to live, you know, less than 180 days. But it doesn't probably look like it's that far off.

So coming at this fairly new to the topic, does leave me wondering whether we really need a sort of systematic policy solution like a wage index, or whether we need a solution that addresses sort of bad actors, specifically. So I just wonder kind of if you could speak to that a little bit, of why you've come to sort of the policy lever tool that would go across as opposed to kind of -- it sounds like you kind of can identify specific entities that are bad actors, and is oversight of those maybe a better approach here?

MS. NEUMAN: So there's two pieces to the policy option. One is the wage index, as you mentioned, which puts everybody on equal footing.

And then the second piece is that we see certain providers whose distribution looks quite different from this, and so what the cap does is it reduces payments to

providers whose distribution looks dramatically different from this. And so, in a way, it is sort of a blunt targeted approach, and it effectively does not affect the vast majority of providers. It would just hone in.

DR. CROSSON: Okay. Questions? Amol.

DR. NAVATHE: So, on Slide 13 and then, I think, Table 7 in the paper, I just want to make sure I'm understanding correctly. The simulated effect is the percent change, correct? It's not the net margin that we would end up seeing? So, if I'm understanding that correctly, I just want to confirm that the lowest quintile group of hospices here would end up with a negative margin. If they start with a negative margin, they would end up with a negative margin.

MS. NEUMAN: Right. They're at minus 5.4 percent, and the policy does not affect their payments.

DR. NAVATHE: Okay. Thank you. I'll save my comments for later.

DR. CROSSON: Karen?

DR. DeSALVO: Thank you.

Kim, two questions. One is about whether you can tell anything about the actual clinical services being

delivered not only in that tale of the longer stay but in some of the newer diagnoses, particularly related to palliative care, because clinical practice has changed a lot in the last decade as well as referral patterns to treat people, not just that's a hospice service, but that there's also a palliative care side. I'm just wondering if there's something to tease out that some of those providers are delivering a different kind of service, and maybe that's the reason for the longer length of stay.

MS. NEUMAN: So the data that we have for hospice is we know how many nurse visits they get, how many aide visits, social worker visits, physician visits, those kinds of things. So it's been a while since we've looked at the difference for cap versus non-cap in those services, but the last time we looked at it, we didn't see that big of a difference.

To the extent that there's different kinds of palliative care that's being provided, that's sort of not those kind of tangible things like nurse visits, aide visits. We don't have a window on that.

DR. DeSALVO: Okay. I'm just thinking that, for example, there may be some service providers that are doing

more procedures, paracentesis or thoracentesis, ways to palliate symptoms, and that prolongs life, compared with a hospice model form the past that would be more about you're right at the end of life. And this is going to be more true comfort care and family support.

It may or may not be relevant, but I think part of the reason to ask is both of these ideas that we -- we want people to get both palliative and hospice and not just go in for hospice, so raising the floor but also recognizing that there's got to be some upper limit of what's realistic, but trying to understand if there's something different about clinical practice.

The other question I had was about tradeoffs, which has kind of come up in what Jon Perlin said. Is there something of value to understand a comparator population? Where even if there is a very long hospice, hospice stay, the alternative would have been a series of inpatient admissions or other admissions that -- just thinking from a cost, not even so much about quality and quality of life, but that we should be taking into account.

Part of the reason I'm asking is, again, we want to encourage right type of care at the right time when the

beneficiary chooses that, and so we wouldn't want to dampen what seems to be an appreciation for the opportunity of palliative and hospice care by squishing it too much, to use a technical term, and to understand again globally that there is a little bit of an extra cost, 12 percent, but on the other hand, what we're gaining for beneficiary quality of life and total cost of care is greater than in one particular area and then take a strategy that's more targeted.

So what I'm asking, is it possible to kind of do a comparator population and say if there wasn't 180 or 300 days of hospice stay, what would that potentially have looked like in terms of inpatient admissions to do something similar?

MS. NEUMAN: So there's some literature on that end. The Commission has sponsored research looking at the effect of hospice on Medicare expenditures, and it's tricky methodologically to say what would have happened in the counterfactual, they weren't in hospice.

But what the evidence suggests is that for patients in the first month or two right before death, hospice saves money. When stays are longer, there's a

point where the savings turns to extra cost, and the study that the Commission sponsored found that in aggregate, the evidence suggests that overall the net of the savings and the cost haven't -- t here's not evidence overall that it's saved, even though it saves for particular patients.

One other thing, just one comment, just to sort of put this in context, while the cap was thought of at the beginning of the legislation as a means of generating savings, today when we look at the data, it's functioning kind of differently. It's functioning almost as a payment accuracy tool. It's honing in on providers that would have the highest margins, and it's pulling back some of those payments. So that's kind of more the spirit of the presentation here of whether we want to go further down that road of using it in a payment accuracy kind of context.

DR. CROSSON: Okay. Thank you.

Amol?

DR. NAVATHE: I apologize for being confused about this, but on this slide, the simulated effect, is that a percent change, or is that a percentage point change?

For example, for highest quintile, would their margin, simulated margin, be zero, or would it be 15 minus 15 percent of 15?

MS. NEUMAN: Their payments would go down by 15 percent.

DR. NAVATHE: Percentage point. Okay.

MS. NEUMAN: So if they didn't change their cost, which we would never make that assumption -- that's why we didn't simulate a margin because we don't want to assume what's going to happen to their costs. We just are saying what's happening to their payments.

If they didn't change their cost, it would be you could add those two together.

DR. NAVATHE: Right, okay. Got it. Thank you.

DR. CROSSON: Okay. So we'll move on to the discussion. We can put the last slide on, Kim, 16.

What Kim is asking for here is people's perspective on the two policy options, wage adjustment, geographic wage adjustment, and then in addition, reduction of the cap for the purposes that she described fairly recently to target certain facilities and certain patterns of marketplace behavior.

Then, also, I think a qualitative sense from the Commission is to what degree do we believe that these things should be changed, and should we move forward in this cycle to recommendations?

Okay. And Paul is going to begin.

DR. PAUL GINSBURG: Yeah. Thank you.

I want to express my enthusiastic support for both of the recommendations. I was particularly influenced as far as lowering the overall cap your comments about the fact that the few hospices that have this that are constrained by the cap or closed by it, their patterns look very different from the bulk of hospices. It's not just that they have a little higher all throughout the distribution, but as you say, they are very different. I very much doubt these are the innovators and the pioneers -- or not the pioneers in a good sense -- in the industry.

So I think that lowering the cap would serve a function of reducing abuse.

DR. CROSSON: Thank you.

David, Jon, Sue. David, Jon, Sue.

DR. GRABOWSKI: I'm also enthusiastic about both of these recommendations, both -- wage adjusting seems like

a complete no-brainer that we're disproportionately penalizing. That makes no sense to me. I like the idea of lowering the cap.

The only addition I would make here in the chapter, you mentioned the problem of live discharges. I really think that needs to be monitored because we can imagine hospices that are nearing the cap beginning to discharge more and more patients in order to keep them below that, so just monitoring those rates. And I don't know if that's a quality measure, if that's some sort of trigger for penalties, but something around live discharges, that needs to be monitored alongside the average length of use.

Thanks.

DR. CROSSON: Jon?

DR. PERLIN: I'm really challenged in this area, and I still feel like I don't personally have enough information to understand exactly the problem we're trying to solve.

Don't get me wrong. If there are high outlier entities that are abusing the intended purpose, that is an issue.

A table that's missing for me is a table that shows not the distribution, not the length of stay by decedent, but a table with length of stay by institution and the sort of deep dive into what the characteristics of the patient and the environment around that institution are to be able to get at that.

I'm really glad, Jay, that you brought up the comments about the types of patients and the change and the diagnoses over time because, clearly, I think of chronic neurologic disease. Obviously, we think about dementing illnesses and frankly the burgeoning population there and clearly a large a substantial needs for the Medicare program and its beneficiaries.

I hate to do things that maybe discourage into the appropriate use while trying to solve the inappropriate use. I'm reminded of Jack Rowe's work at Aetna, where the uptake of hospice was low until they offered intervention to patients who would be appropriate for hospice, which is that they could revert back into general care. That questions the fundamental philosophical underpinning of the structure of our particular Medicare benefit.

But I think one would have to look to the

evidence and say, "Gee, I wonder if that as a premise itself shouldn't be under some degree of discussion," and that what we want is not only efficiency but the best possible care. So I just offer that out because I think it makes this question.

When I look at this in my hat as a health care administrator, it strikes me as indirect, getting at it through wage, though David, as an economist, may be able to comment to me that's absolutely the right approach.

I wonder if retrospectively there isn't an appropriate reclassification of patients if, in fact, this is serving as a substitute. Not all hospices -- there are a variety of hospice services, but something akin to re-class as home health or something else where a population that has that, so that you can just rectify that in reverse.

Final point, given the obvious inability in not the instances of potential abuse of the system but, frankly, the reality that sometimes even the best clinicians can't estimate accurately the length of remaining life.

Thanks.

DR. CROSSON: Thank you, Jon.

Sue?

MS. THOMPSON: I too am really challenged by this chapter because of the importance that palliative care as well as hospice plays in doing the right things for patients. I think some of the most important work that we do in the Medicare program and I think the advancement, as described by Karen, in terms of more intervention on the palliative side is improving the quality of life.

My mother with pancreatic cancer lived an additional six months pain free because of a stent that was placed. So I'm a huge advocate of the work, and she lived longer than six months with a diagnosis of pancreatic cancer. There's very good work that goes on here.

At the same time, what I really struggle with are the bad actors in this arena, which are making it very, very difficult for organizations that are practicing ethically and professionally, and I'm all about MedPAC going after policies that will address abuse of -- and playing with their panels of patients and avoiding taking on cancer diagnoses and abusing the system, and that's a fine balance.

This obviously is the question that's on the table, but I'm quite supportive of continuing this work, Kim, and I thank you for bringing it forward.

DR. CROSSON: Thank you. Thank you, Sue.

Larry. Larry, then Bruce.

DR. CASALINO: Yeah. I agree that wage adjustment is a no-brainer. I think that's why we haven't been talking about it very much. So that makes sense for sure.

Having read this and for most of the discussion, I also thought that the cap seemed like a good idea, but a couple things concern me. One is it seems like these are bad actors, but we could be wrong. Maybe they specialize in care of ALS or something, and so they have lots of very long-stay patients but appropriately. That seems unlikely, but it might be nice to be a little more sure about that if we can be.

If it's bad actors, I think then the question is, What's the best remedy? Is a cap going to really get them very effectively and not get other people that it shouldn't get so much, or is it realistic to think that Medicare can actually police the bad actors? And if that was done well

-- and I'm saying this is realistic to believe that -- then would there still be a need for the cap? So I think those questions could use a little bit more work.

I just say as a technical point, the table Amol kept referring to, I had kind of the same problems. That last column is a little hard to understand. Do we make it that they had a 15 percent margin and now they have a minus 15 percent margin, or is it just that they're losing 15 percent of their payments? I think a lot of people might be confused by that. So that could probably be just made more explicit because that's going to be a table that would get a lot of attention, potentially.

DR. CROSSON: Okay. Bruce?

MR. PYENSON: I support the policy option for both the wage adjustment and the reduction in the cap.

I'd remind fellow Commissioners that our recommendation for last year was perhaps less refined. We called for an overall cut in hospice reimbursement because of the high profitability of the industry overall, though recognizing that there were hospices that were losing money and others that were making a lot of money.

So, looking at Slide 13, I think this is a more

refined policy option than we've already recommended, and I think fairer for the stability of the industry.

So I hear the concerns, but in the past, this seems to be an improvement over what we've recommended in the past. So I'm very comfortable with them.

DR. CROSSON: Thank you, Bruce.

Dana?

DR. SAFRAN: Thanks. This is difficult. So the thing I want to underscore is the importance of continuing this work. You know, end-of-life care for this population, both in terms of cost and the impact on quality of life is probably one of the most things that we can focus on.

I'm mostly supportive of the two policy levers you've suggested here. The one thing I would just like us to be really careful about before we say the wage index is a no-brainer is that it wouldn't be expected to have unintended consequences on the wages set for hospice workers, and, therefore, the ability to attract the quality and training of workers that are currently serving there.

So I don't pretend to understand the wage index implications well enough to know whether that's a possibility, but I would just ask you to look at that

before we pull the trigger on recommending that.

Otherwise, I'm comfortable with these but I really want to kind of continue to underscore that I think our most important policy lever here could be figuring out how we identify those who are sort of systematically abusing this benefit, and address that. Jonathan's idea of retrospective is important, and certainly the point about having a table in this that really calls out what you seem to indicate, Kim, is a distribution that you can see at the site level and how different the distributions look for some entities versus for others I think is important.

I wonder whether some of the qualitative work that the staff often does, of actually going out and talking to folks might be useful here. You know, go talk to some of the entities that look like bad actors, and go talk to some of the actors that look like really good ones, and maybe that would be helpful.

But I want us to keep our focus on the fact that as, I think Larry was the first of us to say it, one of the biggest problems across the board is getting people into hospice sooner, and so I don't want us to make moves that will undercut the progress that's being made there.

Thanks.

DR. CROSSON: Kim -- sorry, so Kathy and Warner. Kim, could you just basically briefly describe how the applicable wage index is set here?

MS. NEUMAN: Sure. So we use the hospital wage index, and so right now it is used to adjust the payments that the hospice providers receive. So a provider in Manhattan is going to get a higher payment rate than a provider in a rural area. But the cap amount is the same amount. So that would be the only place where we would be adding it.

DR. PAUL GINSBURG: So if a hospice wanted to raise the wages of its employees it would have no effect on the wage index.

MS. NEUMAN: Correct.

DR. CROSSON: Okay. Amol.

DR. NAVATHE: So thanks for this great work. I also am supportive, I think, of the changes, generally speaking, and of continuing this line of work. Thanks for that clarification, Jay, on the wage index part, because I thought that was very helpful.

Two points. I think one thing is just looking at

the table on Slide 13 again, I'm struck that there's the negative margins on the low side as well, and I think you made comment in the paper that the cost structure is this new cost structure. And so it made me sort of think about to the extent that we would follow Jon's recommendation, for example, to look at the environment and the characteristics of the patients of the highest quintile outliers, it might also make sense to look at the lowest quintile, essentially, to try to understand what the characteristics are there and if they're intrinsic with the patients or settings or intrinsically different from others, given that right now they have a negative margin, and so the incentives there are obviously different.

And then, accordingly, this hasn't been included in the scope of what we've talked about here, but if this work on wage index and cap should also be pared with some further recommendations on rebalancing the fee structure to more closely emulate the new cost structure, which is not part of the CMS updates that are upcoming. So I just wanted to see if we could add that to our scope of thinking.

DR. CROSSON: Thank you, Amol. Kathy, and then

Warner and Karen.

MS. BUTO: Yeah, I support both recommendations. I just have a quick question, which is, is any of this possible to be done administratively or does it require legislation?

MS. NEUMAN: The cap is written into statute, so it would have to be modified.

MS. BUTO: The wage index could be done -- wage indexing the cap is also implicated by legislation?

MS. NEUMAN: The statute says $6,500, and then it has an inflation factor in it. So I'm not clear if they could wage adjust on their own.

DR. CROSSON: Okay. Warner.

MR. THOMAS: This may be a little bit off-topic but it just seems -- and I was reflecting on this conversation, the one we had on post-acute, and, you know, it seems like when we're trying to create payment policies that have broad implications that we constantly kind of bump up to it's because of bad actors. And so then we're trying to make kind of broad payment changes.

And I don't know what sits in the purview of MedPAC or not around the situation of, you know,

significant outliers. But I just wonder at some point should we be taking up the discussion around significant outliers and how that should be addressed, and should there be, you know, a much more detailed review on entities that are in the -- decide if it's the top or bottom 10 percent, or whatever the number is, about a much more significant review. Because I think we keep trying to have broad policies here, and whether it's home health, which we were just talking about, that, you know, we want to put utilization caps because there's a lot of overutilization, but there's lots and lots of organizations that are doing it right that that can be impacted.

And I worry about the same thing with hospice. I mean, we're going to put a policy in that, you know, frankly, may impact the bad actors, but going to David's point, there might be the discharge right before the cap and then readmission after.

And so it's just more of a question. I don't know whether it sits in the -- where that sits in the agenda of MedPAC, but it just strikes me, in some of our conversations we're trying to put things in that have broad implications, but we're really trying to deal with, you

know, a small percentage of organizations that are not adhering to the policies appropriately.

DR. CROSSON: Thank you, Warner. Karen.

DR. DeSALVO: That's a good segue, because that would be my hope is that we don't create such a broad policy that we disincentivize people getting into palliative care and hospice when it's right for them, and that they don't get the kind of, you know, quality of life that we want them to have. And this famous, you know, Slide 13, you might even read it like that. You know, if the -- again, not understanding all the patients that fall into the bucket, but maybe people are getting in too late, and what we really want to do is try to keep encouraging that to improve.

And so, again, I don't know if that's the purview of MedPAC, but in addition to the things that you've recommended, which I am generally supportive of and I certainly would like to see us continue this work, but it would be -- if it's possible to think about a more targeted strategy, to Bruce's point, rather than sort of a broad approach. This is more finessed, and I appreciate that, but maybe we could get an option that was even more

finessed, that looked at outliers, as opposed to trying to maybe send a negative message and disincentivize the whole care opportunity.

DR. CROSSON: Okay. Thank you, Karen, thank you, Kim, and thank you to the rest of the Commission for the good discussion.

I'll just bring up one topic and that's that several Commissioners have commented on not the issue of the hospice benefit per se as it exists, but perhaps as it should exist, with more of a consideration for palliative care. And I think in the paper, Kim, I think you wrote, as I remember, an example of where that's beginning to take place.

And I just want to make sure that nothing that we've said here with respect to these recommendations is in any way antithetical to that set of developments, which is, I think, late now and important. It needs to have moved forward more quickly.

So at that rate I think you've had some good information provided to you, and thank you again for the presentation.

DR. CROSSON: We now have an opportunity for

public comment period. If there are any of our guests who wish to make a comment about the issues before the Commission this morning, please come forward to the microphone. I'll give you an instruction in one second.

So please identify yourself and any organization that you are part of or speaking for, and we'd ask you to confine your remarks to two minutes. And when this light comes back on, the two minutes will have expired.

MS. ACS: Thank you. Good morning. My name is Annie Acs. I am the Director of Health Policy and Innovation with NHPCO. That's the National Hospice and Palliative Care Organization. On behalf of our President and CEO, Edo Banach, I'd like to offer comments on the proposed policy options regarding modifications to the hospice aggregate cap under the Medicare hospice benefit.

NHPCO is the largest membership organization representing the entire spectrum of not-for-profit and for-profit hospice and palliative care programs and professionals in the U.S., compromised of almost 4,000 hospice locations with more than 57,000 hospice staff and volunteers, as well as 46 state organizations. NHPCO is committed to improving end-of-life care and expanding

access to hospice care, with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

With this in mind, we would like to submit the following comments to MedPAC today.

As stated today, the original intent of the aggregate cap was to ensure savings to Medicare when the benefit was first established. The outstanding question is whether Medicare has achieved any savings since the cap was first introduced. Without this understanding, it is unclear whether reducing the cap by 20 percent would impact spending positively or negatively. We cannot support proposed changes until we understand whether the cap currently functions to produce savings for Medicare.

The vast majority of hospice providers do not exceed the annual aggregate cap limits. We are concerned about the unintended consequences of reducing the aggregate cap limit by 20 percent and the wage indexing of the cap on beneficiary access and quality of care delivered by hospice providers, especially to those who are located in underserved areas and across the nation, including rural

areas.

We would like to work with MedPAC to further analyze the impact of wage adjusting the cap and possibly indexing the cap based on quality. Any proposed policy change to the hospice benefit, including modifications to the aggregate cap limit, must be first tested to determine the extent to which beneficiary access to high-quality care is hindered.

On behalf of NHPCO, I thank you for your service. We continue to offer our assistance to MedPAC in your important role in advising Congress.

DR. CROSSON: Thank you for your comments.

Seeing no one further at the microphone, we are adjourned until November 7th.

[Whereupon, at 11:05 a.m., the meeting was adjourned.]