

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C. 20004

Thursday, January 14, 2016
9:44 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[9:44 a.m.]

1
2
3 DR. CROSSON: Okay. I think we have got a pretty
4 busy morning here. Let's reconvene. Let me welcome our
5 members of the public here who have come to listen to our
6 morning discussions. I hope you find them interesting.

7 The first topic is a discussion of the Medicare
8 Advantage program. We're going to hear from Scott Harrison
9 and Andy Johnson.

10 DR. HARRISON: Good morning. Andy and I are here
11 to present a couple of draft recommendations that emerged
12 from our Medicare Advantage discussion at last month's
13 meeting. I will present the recommendation on improving
14 inter-county equity. Then Andy will present the risk
15 coding intensity recommendation.

16 Last month I presented our findings on the status
17 of the MA program. Let me summarize.

18 MA enrollment grew 6 percent in 2015, and
19 currently at least 30 percent of Medicare beneficiaries are
20 enrolled in MA plans; 99 percent of beneficiaries have
21 access to at least one MA plan.

22 There has been improvement in some measures of

1 plan availability, including a growth in the average
2 rebates that provide extra benefits. Rebates now average
3 \$81 per member per month.

4 There has been progress toward financial
5 neutrality with Medicare fee-for-service. The average plan
6 bid is below fee-for-service. If there were no quality
7 bonuses and risk coding differences, the benchmarks would
8 average 103 percent of fee-for-service, and MA plans would
9 be paid an average of 99 percent of fee-for-service in
10 2016. And the quality of care measures have been mostly
11 stable.

12 One new point not on the slide: In response to
13 Herb, Carlos dug into the latest plan margin data and found
14 that for 2013 total Medicare margins for plans that offer
15 Part D drug coverage averaged 4.2 percent. But there are
16 some inter-county benchmark inequities that could be
17 addressed, and there are coding differences unaccounted
18 for. Last month we presented draft recommendations
19 addressing these issues.

20 One draft recommendation addressed inter-county
21 benchmark inequities caused by two special provisions in
22 the 2010 reform law. Both provisions change or limit the

1 benchmarks in perpetuity for certain counties based on old
2 benchmarks that are no longer appropriate.

3 There is a double quality bonus that increases
4 the benchmarks for some legislatively selected counties.
5 Normally the benchmarks for plans with four or more stars
6 are increased by 5 percent of fee-for-service spending in
7 the county. But in the 236 double bonus counties, the
8 benchmarks for those same plans are increased by 10 percent
9 of fee-for-service spending. Counties are deemed eligible
10 for the double bonuses based on the benchmark formula for
11 2004.

12 A recent academic study found that in double
13 bonus counties, quality did not improve, but the number of
14 plans serving those counties increased.

15 Now, another provision in the law generally caps
16 a county's benchmarks at its 2010 benchmark updated
17 nationally to the current year. In 2016, the caps reduce
18 the benchmarks of over 1,400 counties, and most of these
19 reductions limit the quality bonuses. In fact, these caps
20 limit benchmarks in 52 of the double bonus counties.

21 So the law includes a double quality bonus that
22 inequitably raises quality bonuses for plans in some

1 counties, and it includes a benchmark cap that inequitably
2 lowers benchmarks, especially quality bonuses, for plans in
3 other counties. Eliminating both of these inequities at
4 the same time would result in very little change in
5 spending for the program and would improve inter-county
6 equity.

7 If the double bonuses were eliminated for 2016,
8 Medicare spending would decrease by about 0.6 percent. And
9 if the benchmark caps were eliminated for 2016, Medicare
10 spending would increase by about 0.5 percent.

11 If both of these policy changes had been made for
12 2016, the resulting net impacts would be relatively small.
13 The overall effect is that Medicare payments to plans would
14 decrease by about 0.1 percent.

15 Last month, during our public comment period, a
16 commenter said that the recommendation would result in
17 large losses for plans, especially for small not-for-profit
18 plan sponsors or organizations. However, the comments
19 isolated the effects of removing only the double bonuses
20 for certain plans in certain counties and did not take into
21 account the offsetting gains from removing the caps and the
22 overall effects for organizations. One of the specific

1 plans he said would lose a substantial amount in one county
2 would actually gain substantially overall.

3 So we did a little analysis, and this slide shows
4 the estimated effects of the recommendation on the 182
5 parent organizations that submitted bids for 2016. Sixty-
6 three percent of organizations would see an increase or
7 decrease in payments of less than half a percent. These
8 parent organizations enroll 83 percent of all projected MA
9 enrollment for 2016.

10 Two percent of enrollees are in plans that would
11 see payments decrease by 2 percent or more. The largest
12 reduction in Medicare payments to any organization would be
13 under 3 percent.

14 At the same time, 1 percent of MA enrollees are
15 in plans where payments would increase by 2 percent or
16 more, and the largest increase in payments would be 3.9
17 percent.

18 The effects are likely to be greater for smaller
19 and regional plans because the smaller and regional plans
20 by definition serve fewer counties than other plans, and
21 the effects of serving double bonus counties are less
22 likely to be offset.

1 Focusing on only the for-profit/not-for-profit
2 issue, net losses in revenue are slightly higher for not-
3 for-profit plans. Not-for-profit plan revenue would
4 decrease by 0.2 percent, and for-profit plan revenue would
5 decrease by 0.1 percent. Of the organizations that would
6 see the largest decreases in revenue, about half are not-
7 for-profit and half are for-profit. However, of the
8 organizations seeing the largest increases from the
9 recommendation, all are not-for-profit.

10 So the draft recommendation reads: The Congress
11 should eliminate the cap on benchmark amounts and the
12 doubling of the quality incentives in specified counties.

13 We expect that overall this recommendation would
14 result in some small savings for the program, as the cost
15 of eliminating the caps is slightly more than offset by the
16 elimination of the double bonuses.

17 Also, we expect some redistribution of plan
18 payments; some plans, depending on the mix of counties they
19 serve, would see increased payments and some would see
20 decreased payments. As a result, plans may find some
21 markets more or less attractive than they are now. Also,
22 plans may have a new incentive to improve quality in

1 previously capped counties. Beneficiary access to plans
2 thus may increase or decrease based on plan reactions to
3 the new benchmarks.

4 I look forward to your discussion of the
5 recommendation, but now I'm turning it over to Andy for the
6 presentation of risk coding intensity.

7 DR. JOHNSON: Thanks, Scott. I am going to start
8 by discussing health risk assessments in Medicare
9 Advantage.

10 The Commission has expressed strong support for
11 the use of health risk assessments and home-based care. We
12 recognize that assessments are a valuable tool that plans
13 use in care planning. When assessments are combined with
14 follow-up care, they play an important role in care
15 management, and we support their continued use in that
16 capacity. In current payment policy, assessments produce
17 diagnoses that affect Medicare's risk-adjusted payment to
18 MA plans.

19 Last month, the Commission discussed a draft
20 recommendation that would remove health risk assessments
21 from risk-adjusted payment when they are the sole indicator
22 of a diagnosis. This change is motivated by concerns about

1 the reliability of assessment-based diagnoses and about the
2 appropriateness of Medicare payments for conditions that
3 are documented on an assessment but have no follow-up care.

4 We analyzed MA encounter data from 2012 and found
5 that about 30 percent of all assessment-based conditions
6 were not treated by any other physician, inpatient, or
7 outpatient encounter. Although no treatment was provided,
8 we estimated that these assessment-only conditions
9 generated about \$2.3 billion in Medicare payments.

10 Since our last meeting, we have begun to analyze
11 MA encounter data for 2013. We found that the number of
12 assessments administered to MA enrollees increased by
13 nearly 50 percent and that the number of assessment-only
14 conditions increased by 10 to 17 percent.

15 We also used the 2013 encounter data to update
16 our contract-level analysis of assessment-only conditions.
17 For each contract, this graph shows the amount of Medicare
18 payment per enrollee generated by assessment-only
19 conditions. As you can see in the black area on the right
20 side of the graph, several MA contracts increased the per
21 capita number of assessment-only conditions documented in
22 2013.

1 Now I'd like to address a few comments about the
2 draft recommendation.

3 First, the draft recommendation would remove
4 diagnoses from risk-adjusted payment when they documented
5 only through an assessment. However, if an assessment-
6 based condition is also documented on another physician,
7 inpatient, or outpatient encounter, the condition would be
8 used for risk-adjusted payment.

9 The draft recommendation addresses assessments
10 administered in any setting, not just the home. The main
11 issue being addressed is not the location of assessment
12 administration, but that assessments do not indicate
13 whether any treatment was provided for the conditions that
14 are documented. Some Commissioners have raised concerns
15 about the integrity of some use of assessments. Many of
16 the conditions documented on assessments are serious, and
17 if the diagnosis is accurate, some follow-up care would
18 normally be expected. The draft recommendation focuses on
19 the set of conditions that are documented on an assessment
20 but have no other medical care.

21 Next, commenters, including some Commissioners,
22 have expressed concern that the draft recommendation would

1 reduce the incentive for providing assessments or for
2 providing home-based care. Plans and others in the
3 industry have found that assessments are a valuable tool in
4 care planning and coordination, and some have also found
5 that assessments may lead to reduced utilization and plan
6 spending. Therefore, the incentive to administer
7 assessments would continue even without their use in risk
8 adjustment, and the incentive would be better matched to
9 their benefit.

10 Another comment from Commissioners is that
11 conditions that appear to be documented only through an
12 assessment may actually be treated with services that are
13 not covered by Medicare. The issue here is that, by law,
14 services not covered by Medicare must be funded through the
15 rebate that Medicare pays to plans for bidding below the
16 benchmark or through premiums charged to enrollees. The
17 HCC risk adjustment model determines payment only for
18 Medicare-covered services. Therefore, excluding
19 assessment-based diagnoses from HCC risk adjustment has no
20 impact on the funding for non-Medicare-covered services.

21 Finally, many have commented that fee-for-service
22 diagnostic coding is imperfect and that MA plans should not

1 be penalized for coding more accurately. Using two years
2 of fee-for-service and MA diagnostic data directly
3 addresses this comment. A given diagnosis would only need
4 to be documented once during a two-year period. Fee-for-
5 service coding would be improved by reducing variability
6 across years, and MA plans would be under less pressure to
7 document each diagnosis in every year.

8 We are now going discuss implications of the
9 draft recommendation addressing coding intensity.

10 CMS has applied the minimum coding adjustment
11 required by law since the law took effect in 2014. For
12 2017, the minimum required adjustment is about 5.7 percent.
13 Under current policy, CMS reduces all MA risk scores by the
14 adjustment amount. In other words, it is an across-the-
15 board adjustment.

16 The draft recommendation would address
17 differences in coding intensity in three parts. The first
18 two parts would modify the risk adjustment system by
19 removing diagnoses from assessments and using two years of
20 fee-for-service and MA diagnostic data. The third part
21 would apply an across-the-board adjustment to account for
22 the remaining impact of coding differences. Our analysis

1 suggests that the first two parts of the draft
2 recommendation would account for up to 5 percent difference
3 in coding intensity. Assuming that the overall impact of
4 coding differences is 5.7 percent, under the draft
5 recommendation the across-the-board adjustment would be 0.7
6 percent.

7 A benefit of this approach is that the effective
8 adjustment that each plan would receive is more closely
9 related to the amount of coding intensity that each plan
10 produces. For example, a high-coding plan with MA coding
11 intensity that is 12 percent higher than fee-for-service
12 may receive an effective adjustment of 8.7 percent, and a
13 low-coding plan with MA coding intensity that is 3 percent
14 higher than fee-for-service may receive an effective
15 adjustment that is 1.7 percent. In aggregate, the
16 adjustment for coding intensity in this example is still
17 5.7 percent.

18 However, in your mailing material and during last
19 month's presentation, we provided evidence that the overall
20 impact of coding differences is likely higher. We
21 concluded that after taking all factors into account, MA
22 risk scores in 2017 would be about 9 percent higher than

1 fee-for-service due to coding differences. Under the draft
2 recommendation, it would be up to the Secretary to make the
3 revisions to the risk adjustment system and determine the
4 size of the across-the-board adjustment. The draft
5 recommendation would affect high-coding plans more than
6 low-coding plans.

7 This slide presents the draft recommendation
8 addressing coding intensity. The draft recommendation
9 reads: The Congress should direct the Secretary to develop
10 a risk adjustment model that uses two years of fee-for-
11 service and MA diagnostic data and does not include
12 diagnoses from health risk assessments from either fee-for-
13 service or MA, and then apply a coding adjustment that
14 fully accounts for the remaining differences in coding
15 between fee-for-service Medicare and Medicare Advantage
16 plans.

17 We expect that the draft recommendation would
18 result in some savings to the Medicare program, as evidence
19 suggests that the overall impact of coding differences is
20 larger than the minimum adjustment required by current law.

21 We do not expect the draft recommendation to have
22 any impact on beneficiaries' access to care or the quality

1 of care they receive. However, to the extent that plans
2 use aggressive recruitment techniques for assessments or
3 use assessments to identify new conditions without
4 providing follow-up care, beneficiaries may experience some
5 relief.

6 We do not expect the draft recommendation to
7 significantly influence plans' willingness to participate
8 in the MA program. However, as discussed on the previous
9 slide, there would be a differential impact on plans. We
10 believe the reduction in program spending would mainly
11 affect plans that use assessments to identify conditions
12 without providing follow-up care and plans that have higher
13 coding intensity resulting from other coding efforts.
14 Plans with coding similar to fee-for-service Medicare would
15 likely receive a coding intensity adjustment that is
16 similar or lower than current law.

17 This concludes our presentation. We look forward
18 to hearing your discussion. Thank you.

19 DR. CROSSON: Okay. Thank you very much.

20 We'll now take clarifying questions.

21 MR. ARMSTRONG: Jay, actually this is for you.

22 In the chapter, there were recommendations on a whole

1 series of other topics in the MA program. Are we not going
2 to take action on those? Maybe I'm confused by this, but -
3 -

4 DR. CROSSON: Sorry. What are we --

5 MR. ARMSTRONG: The employer MA bid.

6 DR. MILLER: That's all stuff that has been -- I
7 think that was documenting previous --

8 DR. CROSSON: Previous --

9 MR. ARMSTRONG: Okay. Thank you.

10 DR. CROSSON: Clarifying questions?

11 DR. NERENZ: On Slide 3, please. I know that
12 we've talked about this before. Could you just remind us,
13 what are the characteristics of a double bonus county?
14 What do you have to do to qualify?

15 DR. HARRISON: So in 2004, you were considered an
16 urban floor county. An urban floor county is a county in a
17 metropolitan area of 250,000 people or greater. So you had
18 to be in one of those metropolitan areas. You had to have
19 Medicare managed care penetration of 25 percent.

20 DR. NERENZ: As a minimum? [off microphone]

21 DR. HARRISON: As a minimum. And you had to be
22 below -- and moving forward, in the current year you have

1 to have below average fee-for-service spending.

2 DR. NERENZ: In that county?

3 DR. HARRISON: In that county.

4 DR. NERENZ: Thank you.

5 MR. THOMAS: A clarifying question on the whole
6 chapter or just the first recommendation?

7 DR. CROSSON: Clarifying questions on the
8 chapter, and then we'll take the voting recommendation by
9 recommendation.

10 MR. THOMAS: Okay. On the health risk
11 assessments, do you have any idea whether the -- because
12 you indicate that the percentage of folks that do not have
13 another interaction with a provide after the health risk
14 assessment, do you have any sense of whether that's
15 changing? I know we looked at '12 data. Do we have any
16 sense in '13 or '14 that that's changing, you know, better
17 or worse?

18 DR. JOHNSON: The change from 2012 to 2013 was
19 that the number of HCCs identified that did not have
20 another encounter went up by about 10 percent if you looked
21 at the same model that was in use for the 2012 data.

22 MR. THOMAS: I believe there was about thirty --

1 was it 37 percent of folks that were not seen? Did that
2 improve?

3 DR. JOHNSON: We did not have time to conduct
4 that analysis.

5 MR. THOMAS: So we're not sure if actually that's
6 getting better, that we're actually seeing people, you
7 know, better follow-up from the HRAs as -- it seems like
8 obviously the HRAs are becoming more prevalent. There's
9 more organizations that are using them. I guess the
10 question is: Are we seeing better follow-up after those
11 HRAs, you know, today versus, you know, 2012 or 2013?

12 DR. JOHNSON: That's something we'll continue to
13 look at as we dive into new years of data, but we right now
14 only have that set of analysis for the first year of
15 encounter data.

16 MR. THOMAS: Because it seems like the
17 implication is there's just not follow-up after, and I
18 guess I'm just trying to understand if that's gotten
19 better.

20 DR. JOHNSON: Sure.

21 MR. THOMAS: The second question is: Do we have
22 any idea what percentage of folks in fee-for-service

1 Medicare have health risk assessments?

2 DR. HARRISON: I have no idea.

3 DR. JOHNSON: There are some who have assessments
4 that come through the annual wellness visit, but that's the
5 only avenue in fee-for-service. So there are some, but I
6 think the proportion is lower in fee-for-service than MA.

7 MR. THOMAS: Okay. And then for folks that have
8 a health risk assessment but have no follow-up, so that 37
9 percent, something like that, do we know what percentage of
10 them are on medications? Because, obviously, part of the
11 whole health risk assessment is medication management and
12 looking at that. Do we have any idea if there's--if they
13 have like no other expenditures or are they on multiple
14 medications that may get managed through the health risk
15 assessment?

16 DR. JOHNSON: I haven't looked into any of the
17 medication use, but if that was medication under Part D,
18 then that would be a separate payment model and still would
19 not affect the HCC model, which determines payment for just
20 the A and B services.

21 MR. THOMAS: Okay. But, they could be on
22 medications that are covered through -- not through Part D.

1 DR. JOHNSON: It's possible, yeah.

2 MR. THOMAS: And, then, a last question. Do we
3 have any -- and maybe I missed it, because there's
4 obviously a lot of information -- do we have any idea on
5 the two-year period of looking at how to capture what
6 impact we think that has, you know, positively or
7 negatively? I know there was a comment that this actually
8 may be better because plans don't have to kind of capture
9 this data in every year.

10 DR. JOHNSON: Right.

11 MR. THOMAS: But as we look at kind of the two-
12 year period, do we have any idea of what impact that has?

13 DR. JOHNSON: There was one set of analyses done
14 that's in our June 2012 report chapter that looked at
15 diagnoses that were present in one year and whether or not
16 they were present in the following year, and that showed
17 that across different HCCs, the follow-up varied by HCC,
18 but there was a lack of consistent coding in both fee-for-
19 service and Medicare across years. Overall, we think that
20 the -- using two years of diagnostic data would make coding
21 in fee-for-service and MA more similar, and in your chapter
22 it says about one to two percent.

1 MR. THOMAS: Okay. Thank you.

2 DR. JOHNSON: Yeah.

3 DR. CROSSON: Kathy.

4 MS. BUTO: I want to pick up on something that
5 Warner was saying. If there was a prescription or
6 assessment that an individual needed a Part B drug
7 administration, typically, there would be a follow-up,
8 since those are physician-administered drugs, correct?

9 DR. JOHNSON: That's right.

10 MS. BUTO: I just want to make sure that we're
11 clear on that. It's not like the patient would go off and
12 get a script filled and there wouldn't be a follow-up
13 encounter.

14 DR. JOHNSON: Right.

15 DR. CROSSON: Rita.

16 DR. REDBERG: Can you clarify who orders the home
17 risk -- the health risk assessment?

18 DR. JOHNSON: Most often, it's a plan initiated,
19 either through a program that plans run themselves or
20 contract through a third party, and often, we've heard
21 there are some telephone banks that are set up to call and
22 offer an assessment to beneficiaries.

1

2 DR. REDBERG: So, it is not requested by the
3 physician. I had assumed it was requested by the physician
4 until I read this Harvard Health Blog about a woman who got
5 a call soon after her doctor's visit saying that they could
6 come do a home visit.

7 DR. JOHNSON: Everything that I've read --

8 DR. REDBERG: It seems very inefficient to me to
9 do that.

10 DR. JOHNSON: Right. Everything that I've read
11 is that it is not initiated by the physician or the
12 patient.

13 DR. REDBERG: Maybe we could revisit that.

14 DR. CROSSON: Scott.

15 MR. ARMSTRONG: Yeah, just in response to that,
16 it varies. I mean, there are systems where this is part
17 of, you know, a relationship our beneficiaries have with
18 their care delivery teams, where clinicians, sometimes
19 physicians, actually are going to the home and doing the
20 assessment itself. So, it really does kind of depend upon
21 the system that you're talking about. I think you're
22 speaking to, you know, in general, that is the approach,

1 but there are real exceptions in certain systems.

2 DR. JOHNSON: And to add to that, an assessment
3 is provided as part of the annual wellness visit, so if
4 those are being provided by the physician, that would be a
5 separate type of interaction.

6 DR. REDBERG: Right. But, then, I mean, that
7 Harvard Health Blog that was in the -- I mean, she got a
8 call to have a health risk assessment soon after her annual
9 wellness visit.

10 DR. JOHNSON: Yes.

11 DR. REDBERG: It would be inefficient and
12 confusing, I would say, at best.

13 DR. CROSSON: Other clarifying questions?

14 [No response.]

15 DR. CROSSON: Okay. So, I think what I'd like to
16 do is just start out with a bit of a comment, and then
17 we'll take the two recommendations separately. So, we'll
18 go around, vote, and then go around and vote on the second
19 one.

20 I think, and this is for the Commission but also
21 for our participants in the audience, I want to make a
22 couple of things clear. First of all, the Commission is

1 committed to a robust Medicare Advantage program and has
2 always been. It's an important choice for beneficiaries
3 and more beneficiaries are choosing Medicare Advantage
4 every year at this point.

5 That said, we believe pretty strongly that the
6 Medicare program should pay the same amount of money from
7 the Federal Treasury for the care of beneficiaries through
8 the Medicare Advantage program and through the fee-for-
9 service traditional Medicare program, assuming that
10 Medicare is paying for individuals with comparable risk,
11 and that, of course, is a lot about what the risk scoring
12 process is about.

13 In addition to that, within the Medicare
14 Advantage program, we believe that Medicare payments should
15 be equitable and fair across plans, while we understand
16 that they are and have been for the last number of years
17 adjusted for quality, and we support that. But as I said,
18 we also support the notion that those payments for quality
19 are, in fact, distributed in a fair and equitable way among
20 plans.

21 So, the recommendations that you have in front of
22 you as a Commission and that you're going to hear us

1 discussing and voting on are predicated on those
2 principles.

3 So, if we could turn to page six --

4 DR. CHRISTIANSON: I think they're both on 12.

5 DR. CROSSON: I'm sorry. Are they both on 12?
6 Okay. We can go back to 12, then, save a few keystrokes.

7 So, we're going to entertain discussion and then
8 vote on draft recommendation one, that Congress should
9 eliminate the cap on benchmark amounts and the doubling of
10 the quality increases in specified counties. Comments,
11 starting with Craig.

12 DR. SAMITT: So, I appreciate all the hard work
13 on this chapter, especially with several controversial
14 topics.

15 I have reservations about draft recommendation
16 number one as well as a recommendation to follow. My
17 reservations really very much stem from your remarks, Jay,
18 about the desire for a fair and equitable approach to
19 quality bonus payments, and, so, let me divide the two
20 parts of the recommendation, which one of my reservations
21 is that we have bundled them together. You know, they're
22 both relevant to quality bonus payment, but I believe that

1 the foundational issues for the two are separate.

2 I very much believe that if an organization is
3 delivering quality results, they should reap the benefits
4 of that in an equitable way, and so the first part of the
5 recommendation is very true to what you've described, that
6 it would be fair and equitable to reward both plans equally
7 for performance.

8 However, I have concerns about the double quality
9 bonus. The intent of that program was to protect
10 potentially disadvantaged plans that were in urban areas
11 that had high MA penetration and below-average fee-for-
12 service spending. And, so, there was an intent there,
13 because there was a feeling that these plans or these
14 counties were already disadvantaged to start, which
15 warranted the creation of a double bonus.

16 And, so, the removal of the double bonus, to me,
17 feels as if it could create instability in payment rates in
18 these counties that were previously disadvantaged and
19 potentially create access issues or benefit issues for
20 beneficiaries.

21 So, my reservation is that the double bonus
22 component of this recommendation could have some

1 significant access exposure and benefit exposure to
2 beneficiaries, which is our intent to protect. So, that
3 would be the reservation that I would articulate.

4 The recommendation is that if it's the intent of
5 the collective Commission to support this recommendation in
6 total, I would at least hope that we would institute a
7 transition plan without absolute removal of the double
8 bonus. It looks as if, in terms of the net financial
9 effect of this recommendation, it is slightly favorable.
10 So, for those plans that have a two percent or more impact
11 of this net effect, that those supplemental net resources
12 be applied to create a transition plan to protect them as
13 we move to a different state for the double bonus.

14 DR. CROSSON: Other comments? Scott.

15 MR. ARMSTRONG: First, let me also just
16 acknowledge, Jay, some of your introductory comments. This
17 whole area around reconciling and balancing Medicare
18 Advantage payments from the Federal Treasury to fee-for-
19 service beneficiaries in our fee-for-service system is hard
20 and complicated. And then the county-to-county comparative
21 analysis and our responsibility to pay attention to that
22 also is difficult.

1 And, I struggle often with, well, what are the
2 best payment policy levers to reconcile some of those
3 issues, and the connection between our payment policy
4 discussions and trying to get to those results sometimes
5 seems a little circuitous.

6 I have, much like Craig, reservations about these
7 recommendations for some of those reasons. First, I would
8 say I think there are two parts to this recommendation, and
9 I don't think we need to belabor this, but it should be
10 stated that the proposal to lift the cap on the quality --
11 on the benchmarks so that the quality payments can be made
12 is good policy and that we should be, you know, fully
13 incentivizing plans that are achieving those great outcomes
14 and providing those kind of services to our beneficiaries,
15 the full payment and not having a cap that compromises that
16 full payment.

17 The second part of this recommendation around the
18 double bonus payments in certain counties, I actually maybe
19 would sway a little bit from where Craig was. I think the
20 argument for why double bonus payments were built made
21 sense at some point historically. I actually find it a
22 hard policy argument to make, to continue to implement

1 those double bonus payments in those counties.

2 But, like Craig, I am concerned about really
3 understanding the implications. And, I think staff has
4 done a good job of helping to put into context of our
5 overall spend how much this would really affect plans and
6 so forth, but it may be, as Craig was suggesting, that
7 attending more to what the implications net of these policy
8 changes might be and looking at a transition plan of some
9 kind, I think is a really smart suggestion.

10 DR. CROSSON: Cori, and then Mary.

11 MS. UCCELLO: So, I support both parts of this
12 recommendation. I think the way things are now, they cause
13 distortions in the market. Removing them will lead to a
14 more equitable system.

15 And, in terms of the double bonuses, something
16 else I think about is as those double bonuses are resulting
17 in greater payments and potentially greater extra benefits
18 and rebates to beneficiaries who are in those plans, those
19 extra payments are paid by taxpayers and beneficiaries who
20 are not getting those extra benefits. And, so, I think
21 there are some equity issues there, as well, and I think
22 that this recommendation addresses those.

1 DR. CROSSON: Mary.

2 DR. NAYLOR: So, first, I want to thank the
3 staff, not just for this report, but for all of these
4 reports. I have no idea -- well, I have a pretty good
5 sense of how you spent your holidays. This was really
6 extraordinary.

7 DR. MILLER: [Off microphone.] There were
8 holidays?

9 [Laughter.]

10 DR. NAYLOR: All right. Yeah, that was my point.
11 That was my point. More to come. But, in addressing a
12 number of questions, and so to all of you.

13 So, I really strongly support the recommendations
14 as they're stated. I think bundling the first two, as Jay
15 has suggested, around a real frame of achieving equity
16 makes enormous sense and it's very consistent with how this
17 Commission has worked in the past. Thinking about how
18 we're going to, on the one hand, really recognize the
19 quality improvement efforts of many, many counties by
20 removing the cap, and then the other, really now that we've
21 addressed the underlying issue, not continue a policy of
22 paying twice for quality bonuses. So, I think that makes

1 enormous sense. I also think it's so aligned with our
2 quality efforts, and especially the draft recommendation
3 number one gets us to there.

4 In terms of a transition plan, I think the
5 additional data that you have is really compelling, that
6 I'm not sure that we need it. Table 8, and you actually
7 summarized that in one of yours, but where 182 plans, and
8 of the 182, only five will have -- only five, but five will
9 have increased payments and nine decreased payments around
10 two percent. And, it seems to me that we're really talking
11 about very small numbers of plans that will be affected,
12 you know. So, I think you've really looked very critically
13 in terms of the impact of this and the vast majority are
14 there and will have a minimal effect.

15 But, I -- and, like every other policy
16 recommendation, we'll come back. We should come back as a
17 Commission to look at long-term what's happening here.
18 But, for right now, this makes every bit of sense and I
19 support the draft recommendations.

20 DR. CROSSON: Jack, and then Bill.

21 DR. HOADLEY: So, I'm going to echo, really, a
22 lot of what Cori and Mary both said. I'll be brief. But,

1 I do think we're moving in the right direction on these. I
2 think the equity issues, you know, it makes sense. From my
3 perspective, if we were looking at these at the current
4 policies as something that we were proposing to introduce,
5 we would probably not see them as useful changes to a
6 program, and so we're really just sort of undoing some
7 policies that may have made sense at some point in the past
8 but don't seem to now. And, as Cori said, when there are
9 inequities and when there are additional services paid for
10 in some places, it does come out of somebody else's pocket.

11 And I also, like Mary, was very taken by the new
12 analysis, which I really appreciated, of sort of the impact
13 and the fact that such a small number of enrollees -- I
14 think it's about three percent total of enrollees -- are in
15 plans with gains or losses of two percent or more. And,
16 so, for the most part, you know, the vast majority of
17 enrollees are in plans where this is a negligible financial
18 impact. So, I think the -- you know, to me, that does not
19 strike me as a big enough disruption to need a transition.
20 And if we did do a transition, it would be only for a very
21 small -- only for that very small subset of plans, the sort
22 of nine plans that are the big losers, but even those are

1 only at sort of the two percent level. So, I think we're
2 in pretty good shape the way we are.

3 DR. CROSSON: Bill.

4 DR. HALL: So, I would echo what others have
5 said. This is an incredible work, dedication. I also am -
6 - it's breathtaking to me that you were able to get this
7 all together. And, I speak in favor of both
8 recommendations.

9 As far as number one is concerned, it does put
10 some uniformity into a system that hasn't had that for a
11 long time, and I think this will, on balance, will be an
12 advantage to the entire MA program.

13 On recommendation two, in terms of health risk
14 assessment, I just sort of throw out maybe a cautionary
15 note here, not in opposition to what we're saying. So,
16 we've extended the period of observation for results of the
17 assessment for two years. That still may be too short.
18 If, for example, a Medicare recipient joins my plan and
19 they come in and they're comatose because their diabetes
20 has progressed to the point where it's not really even
21 going to be realistic to expect them to live for a period
22 of time, I will institute therapy that will be very

1 concrete, easily identifiable, and requiring some action.

2 On the other hand, the much more common situation
3 -- for every one of those, I'll see a thousand people who
4 will come in with very premature evidence of diabetes, but
5 I do know that over five to ten years in their lifetime
6 that it will become a very serious condition, and it's much
7 more cost effective for me to find that condition at a very
8 early stage.

9 This whole business of prevention and early
10 diagnosis is very much of a moving target. I mean, some
11 people think that we might even have early diagnosis for
12 Alzheimer's disease; others don't believe that. So, I
13 think we have to keep our eye on this whole progress. This
14 is a recommendation that could easily change with medical
15 progress over, let's say, a five-year period of time.

16 DR. CROSSON: Thank you, Bill.

17 Just a general reminder. We're actually on
18 recommendation number one, although your comments referable
19 to number two are taken. Thank you.

20 Comments? Did I see -- Rita, and Kathy, I
21 thought I saw you first.

22 MS. BUTO: [Off microphone.] No, I was --

1 DR. CROSSON: Oh, you were changing your mind.

2 MS. BUTO: No, no, no, no. I was going to make a
3 comment on the HRA, but I support recommendation one. I,
4 like Cori, I guess, and Jack, don't really see a strong
5 justification for a transition, but if that would make this
6 approach smoother, I would support it. I just don't -- I
7 don't see there's a strong, compelling case for that.

8 DR. CROSSON: Rita and then Warner.

9 DR. REDBERG: I support the recommendation. I
10 had some comments on the quality measures, but it's not
11 directly relevant to our recommendation, so I can say them
12 later.

13 DR. CROSSON: The quality measures relevant to?

14 DR. REDBERG: Like the star ratings and the
15 things that were later in the chapter on --

16 DR. CROSSON: I wonder -- it isn't, Rita,
17 actually. I wonder if you could talk with staff about that
18 at the break.

19 DR. REDBERG: Sure.

20 DR. CROSSON: Okay. Warner?

21 MR. THOMAS: So I understand the concepts behind
22 the recommendations, and for one, I understand that the

1 chart and the impact. The impact, once again, seems
2 relatively minor.

3 The comment I would make is more of a broader
4 one, and we have several recommendations that are being
5 considered as well as ones that are already in place that
6 are being enacted. And I guess my concern is what are the
7 sum of all those changes and the impact on the MA plans in
8 total?

9 As we look at Draft Recommendation No. 1, we have
10 the information in the chapter of what the impact is, and
11 it seems like it's relatively negligible on plans, although
12 we know there's certain counties and a double bonus that
13 are going to be very significantly impacted.

14 My comment is more on, do we understand the
15 aggregate of these changes well enough versus acting on
16 each one of them individually? So that's just a general
17 comment.

18 DR. CROSSON: Other comments?

19 [No response.]

20 DR. CROSSON: Okay. We're going to proceed to
21 vote in a minute.

22 I think I'd make this comment about the

1 transition issue. I think I agree with Mary and Jack and
2 Cori -- I think Cori. Did I do that --

3 MS. UCCELLO: You mentioned it, but I'm okay.

4 DR. CROSSON: Yeah, yeah.

5 [Laughter.]

6 DR. CROSSON: I remembered your name. I just
7 couldn't remember everybody who commented.

8 Are you keeping score?

9 DR. MILLER: I would move on.

10 [Laughter.]

11 DR. CROSSON: That the notion here for kind of a
12 broad-based transition doesn't appear to be there.
13 However, I think, Jack, you said 2 percent. It's actually
14 2 percent or greater. So I think it would be a reasonable
15 thing to take a look at where that "greater" is, and
16 although it may involve only a small number of plans to
17 consider and to put into our final write-up of this, were
18 this to be enacted, that that issue should be considered
19 seriously. For that, somebody would have to make a
20 judgment as to what is a significant impact or the like,
21 but I think that's not unreasonable.

22 Okay. So we're going to take a vote. We'll do

1 it by raising hands, and as with the other 12 votes that
2 we're going to take today and tomorrow -- yes, there are 12
3 more -- I will ask first for those who are in favor of the
4 recommendation, those who are opposed to the
5 recommendation, and those who choose to abstain from voting
6 on the recommendation.

7 So all those in favor, please raise your hand.

8 [Show of hands.]

9 DR. CROSSON: Opposed?

10 [No response.]

11 DR. CROSSON: Abstentions?

12 [No response.]

13 DR. CROSSON: Thank you very much. We are ready
14 to move on to the next recommendation, and we'll start the
15 discussion on Draft Recommendation 2. On Draft
16 Recommendation 2? We already heard from Bill Hall. Going
17 once?

18 Oh. Whoa! Let's go down this way. Alice?

19 DR. COOMBS: I strongly support Recommendation 2.

20 Scott made the point earlier about a physician
21 being engaged and ordering HRA, but specifically having
22 gone through this a couple of times, Andrew, and looking at

1 that chart that you persuasively convinced us and the
2 diagnosis that obtained in that chart really spoke to if
3 the people have these diagnoses, they should actually see
4 somebody and not be without care from a provider, a
5 clinician.

6 So I support that, and I think that chart is very
7 persuasive, that alone. So that was speaking specifically
8 with patients who had those diagnoses, assessed on an HRA,
9 that wasn't with a physician present.

10 DR. CROSSON: Kate?

11 DR. BAICKER: I'm also very supportive, and I
12 think the fixes that you've implemented, like having a 2-
13 year looking window, make a lot of sense in dispelling any
14 potential problems, and presumably, if the goal of
15 prevention is to detect these things earlier, it is so that
16 you can then do something about them. And so we would
17 expect to see -- even as available preventive treatments
18 arise, we would expect to see them implemented if there had
19 been a real diagnosis.

20 I had some concern at some point about
21 incentivizing plans to then have a visit for the purpose of
22 documenting what occurred in the HRA for the future risk

1 assessment -- the risk adjustment to be able to incorporate
2 that position. That seems like a relatively minor concern,
3 given the list of conditions that we're seeing at play
4 here. So I feel as though all of the first-order concerns
5 have been addressed.

6 DR. CROSSON: Cori.

7 MS. UCCELLO: I agree with both of those
8 comments, and I think some of the comments we've received
9 from outside, I think it's just worth emphasizing again
10 that this is not disallowing health risk assessments. To
11 the extent that plans and physicians think that those are
12 still useful, they can still be done, and perhaps this will
13 provide incentives to do those in a more targeted way. And
14 that would be a good thing.

15 DR. HOADLEY: So I agree with all of the comments
16 made so far. I think the list of conditions that have been
17 identified is quite compelling.

18 The other thing I found quite compelling is the
19 graphic you showed again today on the concentration of
20 these HRA-only HCCs in a relatively small subset of plans.
21 If that graph had shown much more of a constant pattern,
22 then I'd be more persuaded that there's a phenomenon going

1 on where there's a certain kind of service that's kind of
2 being provided at the assessment that doesn't need follow-
3 up. But it's a subset of plans that seem to just much
4 disproportionately doing these, and that suggests that it's
5 not something we should be encouraging.

6 DR. CROSSON: Other comments? Mary?

7 DR. NAYLOR: I just want to join in what seems to
8 be the movement here started by Alice.

9 I really think that this is a very important
10 recommendation for beneficiaries, and I loved the way that
11 you went at length to separate how valuable the health risk
12 assessment is and all that can be accomplished there from
13 its use to do diagnosis of schizophrenia or something
14 without any follow-up.

15 And I think it really places a spotlight on we're
16 about not just diagnosing problems, but making sure that
17 people get the care, the follow-up that they need in order
18 to address them. And the fact that we have 63 percent at
19 least, maybe more now, of plans that are really doing that,
20 we have available to us best practices that enable us to
21 really build and grow on that.

22 So I'm strongly supportive of this

1 recommendation.

2 DR. CROSSON: Thank you. Let's move over this
3 way. Warner?

4 MR. THOMAS: Just, first, a clarifying question
5 on the recommendation because up there, it says eliminating
6 HCCs from health risk assessments. Is that all health risk
7 assessments, or is it health risk assessments that do not
8 have some sort of follow-up from a physician or other
9 clinician?

10 DR. JOHNSON: The follow up would be at the HCC
11 or condition level. So, on an assessment, you could have
12 two diagnoses, one that gets followed up on with the
13 physician and that would go into the risk adjustment for
14 payment and one that is not addressed at all in another
15 situation. And that would not be included in the risk
16 adjustment.

17 MR. THOMAS: Okay. So we're not talking about
18 eliminating all conditions. We're talking about
19 eliminating ones that do not have the appropriate follow-up
20 with the physician?

21 DR. JOHNSON: Correct.

22 MR. THOMAS: Okay. So a couple of comments, one

1 -- and I guess I'm maybe the lone person on this situation,
2 but I guess what concerns me about this recommendation is I
3 think we want to have health risk assessments done on
4 people, and I think that at least the data I've seen
5 indicates that we're seeing more follow-up from physicians
6 than kind of when we first started, so there is a better
7 connection between health risk assessment and follow-up
8 with physicians. And this is still a relatively new
9 situation over the past couple of years.

10 And I've read the anecdotes in here, and I don't
11 dismiss them, the gift cards and the beneficiary that's
12 upset the people that are calling them, trying to do a
13 health risk assessment.

14 But on the other side of that, I could quote and
15 be happy to -- anecdotes from patients who are very
16 thankful that nurses have come to their -- nurse
17 practitioners. These are trained certified clinicians that
18 have come to their house to do these health risk
19 assessments, to provide care for them, some that don't
20 leave their home.

21 So I kind of feel like we're taking a situation
22 where there may be some issues that are problematic and

1 tossing the whole approach out, and I'm concerned about
2 that from a policy perspective.

3 I don't deny the comments that are in here about
4 the -- and I'm sure there are some plans that do not use
5 this appropriately, and I'm sure there's some of these
6 assessments that are not done and have the right follow-up.
7 I understand that, but it seems to me that we're taking a
8 pretty broad approach to it, when I think there's a lot of
9 good work done here, and maybe what we ought to do is
10 provide more guidance that there has to be the appropriate
11 follow-up within a certain time frame or within the year to
12 really incent folks to do the assessments and then do the
13 follow-up.

14 And I guess to some extent, you could say that's
15 kind of what we're doing here, but that's not going to be
16 the tone of the chapter, per se. I mean, the tone, as I
17 read it, is, hey, this has really been a flawed model and
18 it's problematic.

19 So I have those kind of general concerns with the
20 recommendation.

21 DR. BAICKER: Can I ask a follow-up question for
22 Warner? Is that allowed?

1 DR. CROSSON: Yeah. Go ahead, Kate.

2 DR. BAICKER: There's a long pause there.

3 DR. CROSSON: I'm sorry. No, no. Are you
4 questioning Warner or us or who? The staff?

5 DR. BAICKER: I wanted to try to understand --

6 MR. THOMAS: Kate, I told him no questions.

7 [Laughter.]

8 DR. BAICKER: I'll ask, but you don't need to
9 answer.

10 MR. THOMAS: That's right.

11 DR. BAICKER: I didn't get the impression that
12 anything in here discouraged use of HRAs, changed the
13 financial incentive to do an HRA, changed anything about
14 the availability of those HRAs. It is only if a condition
15 is diagnosed in the HRA and there's no follow-up care for
16 the condition. Then that condition doesn't go into the
17 next year's risk adjustment.

18 If that's not why people are doing the HRAs, I
19 wouldn't see why this recommendation would change any
20 prevalence of HRAs, so I don't feel as though I'm entirely
21 understanding the concern, and I'd like to hear more about
22 that.

1 MR. THOMAS: So I think part of it goes to tone,
2 right? So it would be nice to have several examples of how
3 HRAs have been effective, one. It would be nice to have
4 discussions around how HRAs have been effective in
5 medication management, and going to Kathy's point, yeah,
6 you would think that these are nurse practitioners that are
7 doing this. I mean, they do write scripts and work in
8 conjunction with a physician around medication management.

9 So I think there's other comments here that would
10 be very helpful to make sure, as outlined in the chapter,
11 because to me, the tone is pretty negative against these
12 types of assessments and could be a lot more balanced.

13 I really think the tone we ought to strike is
14 that, hey, there's a lot of folks out there that get these
15 assessments that really need to have follow-up, and the
16 incentive here should be let's get the follow-up. You can
17 get there if you read between the lines, but I think it
18 would be helpful to be a lot clearer that that's the
19 situation.

20 I also would just ask generally, is if there's
21 nothing else -- you know, going back to home-based care,
22 and I think Scott has brought this up previously. We want

1 more home-based care, and if there's a health risk
2 assessment done on somebody and it's really the only thing
3 done with them, once again, getting back to are they on
4 medications -- that's why I was curious about -- if there's
5 nothing wrong with them, I guess that's one thing.

6 But if they are on medications and that sort of
7 thing, at least they are getting a health risk assessment.
8 At least somebody is seeing them, which I think is
9 positive.

10 And the comments in the chapter about maybe what
11 we ought to be saying is we do want to have an assessment
12 of the home; we do want to make sure that this information
13 gets back to physicians. I mean, there are physician
14 comments about the things they'd like to know.

15 So I would just kind of come back to maybe we
16 should focus more of our comments on those areas because I
17 don't think generally these are bad, but I think you could
18 read the chapter and get the impression that, hey, this is
19 just a real problematic thing and needs to be tossed out.
20 So that's what I'm concerned about as I read the chapter.

21 I think there's a lot of great work done here.
22 We focus on the 36 percent, but there's 64 percent that do

1 have a follow-up that are having the connection, and I'm
2 just more worried that that's being lost in the discussion.

3 DR. MILLER: And that's where -- I'm sorry, but
4 that is sort of what I extracted out of your comment, that
5 we need to connect the dots.

6 We talked to beneficiaries, as you know, and we
7 reported it before. And I can't remember. It's an actual
8 disposition in the chapter, but we heard both: "It was
9 good. I had a nurse at my house," "I felt like I was being
10 called constantly, and I didn't want anybody at my house."

11 Jack's point, I think is really important that
12 most -- and I wanted to say this at the point that Jack
13 said it. Most plans appear to be doing it and following
14 up. That's what the data says. We're a little worried
15 about what direction it's moving in, but most plans are in
16 fact doing that.

17 And I think the notion of anecdotes that make the
18 other case and put that across, we can take responsibility
19 to make sure that the chapter does do that. That is what I
20 extracted from your comment, and I will try to do that.

21 MR. THOMAS: And I would just say as an
22 additional point, I mean, I would think that we should be

1 promoting, that more of this should be done in fee-for-
2 service Medicare. I mean, frankly, I think that's a
3 problem with fee-for-service Medicare is that we're not
4 doing enough health risk assessment work and assessing how
5 someone is doing appropriately, and that it is strictly on
6 kind of a fee-for-service basis where there is not an
7 incentive to be reaching out to folks.

8 Now, you could look at this that, yeah, people
9 are calling up and saying, "Hey, we want to come in and do
10 a health risk assessment," and I understand that some
11 people can view that as being badgered, and they shouldn't
12 be. I get that from a beneficiary, but there is also --
13 there's a lot of folks that need to be seen, that we need
14 to be more proactive to get out and help them. I would
15 think that should be captured for the fee-for-service side
16 of the equation as well.

17 DR. CROSSON: Point well taken. There is nothing
18 here in either the recommendations or the deliberation that
19 suggest that we are opposed to health risk assessments, and
20 to the extent that that could be emphasized better, then I
21 think that's appropriate.

22

1 Craig and Kathy and then Scott.

2 DR. SAMITT: So I learned a big lesson this year,
3 which is to never miss a MedPAC meeting because the last
4 time we were discussing this, I think we were focusing on
5 addressing the bad actors or focusing on codes potentially
6 that wouldn't count toward the risk adjustment if they were
7 found only in the HRA, and now, all of a sudden, it's a
8 much more broad-based recommendation.

9 I can support the recommendation, although
10 admittedly, I would say it feels to me very heavy-handed as
11 opposed to the more tailored or focused approach that we
12 had been talking about previously. But my bigger
13 reservation is really not so much about this fix, but
14 potentially about the broader risk adjustment model.

15 As I am interpreting this, what I am hearing is,
16 to get appropriate risk adjustment and therefore resources,
17 you need to generate a visit. And that doesn't feel like a
18 very contemporary view of where we want the industry to go.

19 We talk about the fact that we want to shift from
20 volume to value, which means we need to think of
21 alternative ways to more efficiently care for members,
22 focus on wellness, avoid unnecessary visits or procedures

1 or what have you, and yet we're creating a forum that
2 really demands that the member, the patient, go to a
3 facility where lots of bad stuff can happen.

4 So it feels to me backwards, and I wonder if the
5 lesson here is, instead of all of these continued
6 individual fixes to manipulate the risk adjustment model,
7 we need a more clinically relevant risk adjustment program
8 that truly does get a complexity of illness and doesn't
9 drive what is sort of counter to where we think the
10 industry should go from a value perspective. So that would
11 be my concern, and I don't know when we can address this,
12 but I think we have to pick up the discussion of risk
13 adjustment more broadly to see if we should encourage sort
14 of a complete rethinking or revision of how we do this.

15 DR. CROSSON: I mean, you make good points here.
16 As you know, it's a little beyond the scope of what we're
17 doing right now.

18 As Scott pointed out earlier, the whole process
19 of trying to make payments in fee-for-service and payments
20 in Medicare Advantage equitable is not easy. It's very
21 complicated because it involves trying to determine the
22 nature of the needs, legitimate needs of the individuals

1 who are either in fee-for-service or enrolled in Medicare
2 Advantage.

3 The risk adjustment process is, admittedly, an
4 imperfect way to do that. If there are better ways to do
5 that, that we should consider as a commission, I think we'd
6 certainly be open to that.

7 Sorry. Go ahead.

8 DR. MILLER: Yeah, and just before -- so one
9 advertisement or commercial. Jim, is it April that we're
10 thinking of coming back on the risk --

11 DR. MATHEWS: Yes.

12 DR. MILLER: Right. So April we're -- all this
13 always depends on what we can get done. I'm a little upset
14 about this whole holiday thing I missed.

15 [Laughter.]

16 DR. MILLER: I'll go back over some of that.
17 But, you know, it always depends on what we can get done,
18 but Andrew and others are working intensively with the
19 encounter data because there's whole different ways of sort
20 of thinking about the risk system, and we are trying to get
21 that staged up for April.

22 and then just one clarification. You said "visit

1 to a facility," and you may be talking about other things
2 like email and those types of things, which are a broader
3 issue in a direction we're going in. But in this instance,
4 if somebody gets the care in the home, it counts. The code
5 counts. And so there's no reason it should discourage --
6 if a lot of this is happening, somebody's homebound, that
7 type of stuff, this should not encumber that.

8 Now, if you're saying, you know, Skype and those
9 types of things, plans actually have a lot more flexibility
10 to use that with their rebate dollars and their
11 supplemental benefit dollars. That doesn't -- you know, on
12 the fee-for-service side, that bridge has not been crossed
13 yet, that type of thing.

14 MS. BUTO: I want to support the recommendation.
15 I really was listening to what Craig was saying. You know,
16 risk adjustment in my mind -- I have a very simple mind
17 about risk adjustment -- is designed to provide adequate
18 payment in relation to resources used. If there isn't a
19 follow-up visit or follow-up care, then resources are not
20 being used in the way at least it was intended to recognize
21 and pay more to the plan for those resources. So, you
22 know, I get that there's preventive care and so on and so

1 forth that can forestall unnecessary utilization. I think
2 that the plans have a lot of incentives to do health risk
3 assessments to avoid unnecessary care.

4 Having said that, I liked what Craig said because
5 I think the visit, whether in the home or some facility,
6 probably does not capture care anymore. Whether it's
7 Skype, email, or other things, I don't know the extent when
8 we come back in April plans are given credit for that as a
9 follow-up to an HRA when they should be. If that's the way
10 that there's sort of ongoing management, phone calls, et
11 cetera, that's real resource use and it ought to be
12 recognized in some way.

13 So I think it needs to be refined, but as the
14 recommendation stands now, I support it.

15 DR. CROSSON: Thank you. I'm sorry. Scott, you
16 were next.

17 MR. ARMSTRONG: So being kind of at the caboose
18 of the train, most of what I wanted to say has been said,
19 so I'll be very brief, and there are a couple points I want
20 to make.

21 I will support this. I feel more comfortable
22 supporting it now having had the benefit of hearing from

1 other Commissioners, and that's the great thing about
2 MedPAC. I do support in particular the use of the two
3 years of data for actually making some of these
4 calculations.

5 A couple of points, though, I would add briefly.

6 First, it has been made -- I know I have said
7 this before. There certainly are a small number of plans
8 that are abusing the system here, and we should confront
9 that. But I worry that we are creating a broad policy that
10 affects them all in a way that will potentially have some
11 of these other issues, but I don't know a better
12 alternative. So it is a minority of plans that are
13 abusing, appear to be abusing this, and it should stop.

14 Second, this point about is this a policy that
15 may somehow inhibit the kind of evolution and innovation of
16 care delivery that we want I also think is really an
17 excellent point. I feel a concern that this particular
18 policy will have too much of an impact on it, but just for
19 the record, I want to affirm that MedPAC has consistently
20 reinforced the importance of home health services and other
21 services outside of the medical clinics or the use of early
22 detection, health risk assessments, proactive preventative

1 care and so forth. And I do worry, whether it's the tone
2 or the actually policy, anything we do to inhibit that
3 forward progress we should be paying close attention to
4 that.

5 Then, finally, I liked Craig's point about the
6 risk adjustment methodology, and I'm glad -- I hope we can
7 find time to tee it up and that future generations of
8 MedPAC Commissioners will fix this, my hope is.

9 [Laughter.]

10 MR. ARMSTRONG: But I would just point out that I
11 feel as we're trying to strike this balance between in our
12 role the payments we make to Medicare Advantage versus fee-
13 for-service and the role risk adjustment plays in trying to
14 help us believe they're equitable and so forth, we tend to
15 come into this with a presumption that when there's an
16 imbalance, it's because we're overpaying or overcoding or
17 overdocumenting on the MA side rather than being comparably
18 concerned about undercoding, underdocumenting on the fee-
19 for-service side. And I know that doesn't necessarily
20 solve the overall spend problem, but my hope is as we get
21 into this that would be part of our evaluation.

22 DR. CROSSON: Just parenthetically, I hope it

1 doesn't take another generation of MedPAC Commissioners, or
2 yet unborn, to resolve the problem.

3 [Laughter.]

4 DR. CROSSON: Warner, you have the last word, and
5 then Jack, and then we're getting behind so we're going to
6 call for the vote.

7 MR. THOMAS: So I'll be brief. I'm glad to hear
8 that we're going to take the risk assessment on, because I
9 think that is at the crux of what's happening here. I
10 would echo Scott's point that I think there are --
11 obviously, there are some folks that don't adhere to this
12 appropriately, and to me it seems like we're taking a broad
13 approach. And I also wonder if this recommendation, this
14 work, ought to be combined with the whole assessment of the
15 risk adjuster versus being dealt with separately, but, you
16 know, maybe we're too far down the road to deal with that
17 issue. I just think there's so much connected and related,
18 I think that's an important thing for us to think about.

19 You know, finally, as I look at the situation,
20 getting back to the risk adjuster -- and I think Kathy's
21 point, we want to make sure people are paid appropriately.
22 And we have to understand with a Medicare recipient, I

1 mean, you might go one, two, three years before there's a
2 major kind of health event, and we understand these
3 insurers -- I mean, they're insurance companies, we get
4 that. But if they just got the premium for that year, it
5 probably doesn't work out. You need to insure them -- I
6 mean, I'm looking at folks that are in this business -- you
7 know, one, two, three years. You need to get the premiums
8 for one, two, three years in order to make it work. And so
9 just because somebody has an event two or three years from
10 now doesn't mean they don't have that condition today. And
11 I would actually come back to fee-for-service. There's a
12 lot of things that people have that need to be addressed in
13 the fee-for-service world that are not because of the way
14 that system is set up. And I'm just concerned as we look
15 at this.

16 So I'll leave it there.

17 DR. CROSSON: Thank you.

18 DR. HOADLEY: And I just wanted to remind us all
19 that one of the comments that Andrew made in the
20 presentation is that we have a current policy of doing an
21 across-the-board adjustment to help make up the
22 differential and what these pair of policies in

1 Recommendation 2 would do is to substitute for the across-
2 the-board, at least some part of the across-the-board, a
3 more targeted adjustment, and that I hope gets at that
4 point of, you know, the bad actors versus sort of the
5 impact on everybody. This actually might be a gain for the
6 plans who have been doing things right.

7 DR. CROSSON: Okay. Thank you. A good
8 discussion.

9 So we're focused now on Draft Recommendation 2.
10 I won't read it. You have it up in front of you. All
11 those in favor of Draft Recommendation 2, please raise your
12 hand.

13 [Show of hands.]

14 DR. CROSSON: Opposed?

15 [Show of hands.]

16 DR. CROSSON: Abstentions?

17 [No response.]

18 DR. CROSSON: Okay. Thank you very much.

19 Scott, Andrew, thank you very much for your
20 presentation and your excellent work.

21 We'll wait one minute for the audience to
22 rearrange itself.

1 [Pause.]

2 DR. CROSSON: Okay. The second topic for this
3 morning is payment adequacy for hospital inpatient and
4 outpatient services. We have presenting Jeff Stensland,
5 Dan Zabinski, and Ariel Winter.

6 You have the floor.

7 DR. STENSLAND: All right. Good morning. This
8 session will address issues, as Jay said, regarding
9 Medicare payments to hospitals.

10 First, we are going to briefly review the payment
11 adequacy indicators that were discussed in detail during
12 our December meeting.

13 Second, we'll discuss changes in how Medicare
14 could support hospitals serving poor patients and hospitals
15 with high uncompensated care costs.

16 To summarize our payment adequacy findings from
17 last month, first, access to care is good in most markets.
18 Occupancy is 61 percent on average.

19 Access to capital remains strong, with low
20 interest rates for most hospitals.

21 Quality is improving. We see lower mortality and
22 lower readmission rates in recent years.

1 Medicare margins are low for the average
2 provider, but Medicare payments do cover the marginal cost
3 of treating Medicare patients.

4 The relatively efficient providers were able to
5 roughly break even serving Medicare beneficiaries in 2014;
6 however, as we discussed last month, there are payment
7 policy changes in 2015 and 2016 that are expected to reduce
8 Medicare margins. We expect negative Medicare margins in
9 2016, even for the relatively efficient providers.

10 While Medicare margins are expected to be
11 negative, hospitals will still have a financial incentive
12 to see Medicare patients due to the marginal revenue
13 exceeding the marginal cost.

14 So, given these mixed-payment adequacy
15 indicators, the draft recommendation discussed last month
16 was to retain the update in current law, which is projected
17 to be 1.75 percent.

18 Now, most of the discussion last month was
19 regarding the special payments Medicare pays to hospitals
20 that serve poor patients. First, let's start by reviewing
21 the four special Medicare programs that exist now. In all
22 cases, Medicare dollars are tied to Medicaid patient

1 volumes.

2 First, there are \$3.3 billion in traditional DSH
3 payments. This provides an add-on to Medicare rates for
4 hospitals with high shares of Medicaid patients and poor
5 Medicare patients.

6 Second, there is a \$6.4 billion pool of
7 uncompensated care dollars. This stems from a legislative
8 change that was supposed to tie Medicare payments to
9 uncompensated care costs rather than simply the traditional
10 DSH formula. By uncompensated care, we mean bad debts and
11 charity care. However, CMS had decided to use Medicaid
12 inpatient days and Medicare SSI days as a proxy for
13 uncompensated care. The net effect of this is that most of
14 the \$6.4 billion is distributed as a payment to hospitals
15 for each of their Medicaid days. So the Medicare trust
16 fund is paying for Medicaid.

17 In addition, one-third of the non-profit
18 hospitals with the highest Medicaid and SSI shares received
19 \$1.2 billion in discounts from pharmaceutical companies and
20 their Medicare drugs. These discounts result in Medicare
21 payments being substantially above the hospital's drug
22 acquisition costs.

1 Finally, Medicare made roughly \$1.1 billion in
2 bad debt payments for dual-eligible patients when the
3 Medicaid programs declined to pay the dual-eligible
4 beneficiaries' cost sharing.

5 So the key point here is that there is a large
6 amount of Medicare dollars tied to Medicaid inpatient days.
7 Currently, there are no Medicare payments tied directly to
8 a hospital's cost of uncompensated care. In other words,
9 the Medicare program helps with the cost of cases where the
10 hospital has paid the Medicaid rate, but the Medicare
11 program does not provide any direct help for the cost of
12 cases where the care is completely uncompensated.

13 Now, there's several problems with Medicare
14 subsidizing Medicaid, and we've talked about these over the
15 past several years. First, the Medicaid program already
16 has special UPL payments and Medicaid DSH payments to help
17 cover hospitals' Medicaid shortfalls. Having Medicaid and
18 Medicare covering the same Medicaid shortfall would be
19 duplicative.

20 Second, when Medicare tells states it will
21 increase its payments to hospitals if Medicaid rates
22 decreases, it encourages state Medicaid agencies to

1 underpay for Medicaid.

2 Third, Medicaid shortfalls are the difference
3 between Medicaid costs and Medicaid revenues. A shortfall
4 could be due in part to low Medicaid fee-for-service rates,
5 but it could also be due in part to high costs. In
6 general, higher cost hospitals will have higher shortfalls
7 per discharge.

8 Fourth, at some hospitals, there may not actually
9 be any Medicaid shortfall after Medicaid supplemental
10 payments are considered.

11 Now, some have argued that it's fine to tie all
12 the Medicare low-income subsidies to Medicaid shares and to
13 ignore uncompensated care. The argument is that hospitals
14 with high Medicaid shares are the same hospitals that have
15 high uncompensated care, but as this table shows, that's
16 not true.

17 The first row shows DSH hospitals. We see that
18 qualifying for the DSH program, especially given Medicaid
19 expansion, is not that difficult. Eighty percent of PPS
20 hospitals are DSH hospitals.

21 Now, most of those provide more than the national
22 median of uncompensated care, but 46 percent of them

1 provide less than the median.

2 The second row is 340B hospitals. It's more
3 difficult to get into this category. You must be a non-
4 profit or government hospital and meet a high DSH
5 threshold. Thirty-five percent of PPS hospitals meet these
6 criteria. They have 4.3 percent uncompensated care on
7 average, which is above the national median, but there's
8 also about 40 percent of these 340B hospitals that provide
9 less than the median level of uncompensated care. And this
10 is simply because Medicaid days are a poor predictor of
11 uncompensated care.

12 So over the past year and most recently in
13 November and then again in December, the Commission has
14 discussed how hospitals receive significant discounts on
15 their Part B drugs through the 340B program. The Office of
16 the Inspector General estimated that all covered entities
17 in the 340B program received an average discount of 34
18 percent on Part B drugs in 2013. We believe this is
19 reasonably close to the discount received by hospitals.
20 The 34 percent savings is equivalent to hospitals saving
21 over \$1 billion on drugs provided to Medicare patients.

22 Now, last month, we described how a change in

1 Medicare payment rates to 340B hospitals could accomplish
2 two things. First, we could reduce beneficiaries'
3 coinsurance. Second, we could generate some savings that
4 could be redistributed back to hospitals that provide the
5 most uncompensated care; in essence, redirecting some of
6 these savings to help pay for hospitals' uncompensated
7 care.

8 Now, I also want to stress that the 340B program
9 itself would not change. The criteria to be a 340B
10 hospital would be exactly the same. Discounts provided by
11 drug companies to the hospitals would be exactly the same.
12 This is just involving the Medicare payment rates.

13 Another key question is how the uncompensated
14 care pool of dollars should be distributed. As we
15 discussed last month, in 2016, the uncompensated care pool
16 had \$6.4 billion in it. The policy change I just talked
17 about would add \$300 million to the hospitals'
18 uncompensated care payments.

19 However, CMS currently distributes the funds
20 based primarily on Medicaid days, which they argue is a
21 proxy for uncompensated care, and this results in Medicare
22 paying DSH hospitals \$174 for each Medicaid day.

1 We found that Medicaid is a poor indicator of
2 uncompensated care. A better alternative is the Schedule
3 S-10 in the Medicare cost reports, which has hospitals
4 directly report the cost of their charity care and bad
5 debts. We discuss this in detail in your mailings.

6 The effect of using the S-10 would be to
7 materially increase payments to some large hospitals that
8 provide lots of uncompensated care relative to their
9 Medicaid days and also those hospitals which tend to be
10 large public hospitals, and that it would also increase
11 payments a bit to rural hospitals.

12 So this leads to the draft recommendation, and
13 this is largely the same as last month. The Congress
14 should direct the Secretary of Health and Human Services to
15 update inpatient and outpatient payments by the amount
16 specified in current law, reduce Medicare payments for 340B
17 hospitals separately payable 340B drugs by 10 percent of
18 the average sales price, direct the program savings from
19 reducing Part B drug payment rates to the Medicare-funded
20 uncompensated care pool, and distribute all uncompensated
21 care payments on the data from the Medicare cost reports
22 worksheet S-10. The use of the S-10 uncompensated care

1 data would be phased in over three years.

2 So the rationale behind the recommendation is as
3 follows. First, balancing the beneficiaries' good access
4 to hospital care with the potential for declining Medicare
5 margins and the lack of fiscal pressure applied by private
6 insurers, an update equal to current law is warranted.
7 Redirecting the 340B program savings to hospitals providing
8 uncompensated care is a more direct way to help hospitals
9 serving the uninsured and others generating uncompensated
10 care. Reducing payment rates on 340B hospitals by 10
11 percent will also reduce beneficiary cost sharing, and
12 phasing in the use of the S-10 over three years will
13 improve targeting of uncompensated care dollars, create
14 incentives for better S-10 reporting, and prevent large
15 swings in hospital payments in a single year due to the
16 phasing in.

17 So the package has a combination of impacts.
18 First, it's budget neutral from the perspective of the
19 Medicare program. Hospitals would still be expected to
20 receive a 1.75 percent update to their base rates, just as
21 they are in current law. However, the beneficiary would
22 see a slight reduction in Part B cost sharing. As prices

1 go down, beneficiary Part B coinsurance goes down. For
2 beneficiaries with supplemental insurance, this may
3 eventually mean a slightly lower supplemental premium. For
4 the 19 percent of 340B patients that do not have
5 supplemental insurance, this will directly lower the
6 coinsurance bill to them.

7 The primary impact on hospitals would be a
8 redirection of funds from hospitals with high numbers of
9 Medicaid inpatient days toward hospitals that provide large
10 amounts of inpatient and outpatient uncompensated care.

11 Now, recall that we're only redirecting part of
12 the savings from the discounts. Roughly, two-thirds of the
13 discounts would stay with the current hospitals. One-third
14 of the discounts would be redirected to hospitals with high
15 uncompensated care costs.

16 Now, this slide quantifies the net effect of the
17 draft recommendation relative to current law. First, the
18 payment rate increases will be the same as in current law,
19 projected to be 1.75 percent. Second, the recommendation
20 will reduce Medicare payments for Part B drugs at 340B
21 hospitals. The payment is now estimated to be 158 percent
22 of the 340B hospital's acquisition costs. The Medicare

1 payment to 340B hospitals will fall to an estimated 143
2 percent of the acquisition cost. We expect that the
3 hospitals will still see the program as profitable.

4 Second, beneficiary cost sharing will decline
5 from about \$700 million to about \$630 million for
6 separately payable drugs based on 2014 data.

7 Now, program payments for 340B drugs will
8 decrease by about \$300 million, but the uncompensated care
9 pool will increase by exactly the same amount, \$300
10 million. So the net program spending on the combination of
11 340B drugs and uncompensated care will not change. We're
12 just redistributing those hospital dollars.

13 Finally, part of the recommendation is just to
14 use the S-10 rather than Medicaid and SSI days to
15 distribute the uncompensated care pool, and this will have
16 two changes. Right now, Medicare is paying DSH hospitals
17 \$174 for each Medicaid day. That will drop to zero.

18 However, those same funds will be distributed
19 based on reported uncompensated care, meaning charity care
20 plus bad debt costs. The net result is Medicaid trust fund
21 dollars will end up paying for about 20 percent of the DSH
22 hospitals' uncompensated care costs.

1 Now, I just showed you the average effect across
2 the whole industry, and this slide shows the effects on
3 different types of hospitals. So let's start by looking at
4 the first column, which shows the average change in
5 payments for all these different types of hospitals.

6 The average hospital loses \$30,000. This is due
7 to the reduction in the beneficiary's cost sharing.

8 Next, look at 340B hospitals in the second row.
9 They actually see a slight increase on average of \$170,000.
10 This is because the benefit of using the S-10 to distribute
11 dollars to these hospitals more than offsets the effect of
12 redistributing away a portion of their discounts that they
13 currently receive through the 340B program.

14 Rural hospitals have a \$240,000 increase on
15 average. This may be because they provide much of their
16 uncompensated care in an outpatient setting. CMS is
17 currently distributing uncompensated care dollars based on
18 Medicaid days, which is an inpatient-only measure. The S-
19 10 factors in both inpatient and outpatient uncompensated
20 care, and that could help the rural providers.

21 Third, government hospitals see the largest
22 increase in payments. This is because these hospitals

1 often provide -- report providing large amounts of
2 uncompensated care, often to the uninsured.

3 In the second column, we see that in every
4 category, meaning each row on this table, some hospitals
5 will gain and some hospitals will face reduction. Payments
6 are increased for more than 50 percent of government
7 hospitals and for more than 50 percent of rural hospitals,
8 but only 29 percent of for-profit hospitals would see an
9 increase in their payments.

10 The last three columns show you that the S-10,
11 using the S-10 to distribute uncompensated care dollars
12 will materially change payments for more than 10 percent of
13 hospitals. Therefore, the draft recommendation is to phase
14 in the changes over three years to limit any one-year
15 swings.

16 Finally, I should say a few words about the
17 practicality of using the S-10, since the industry often
18 brings up these questions. First, many hospitals report --
19 hospitals have to report the uncompensated care data on
20 their S-10, and many have told us that eventually the S-10
21 should be used to distribute uncompensated care dollars.
22 However, many hospitals do have concerns about its

1 accuracy.

2 But as you recall that as we discuss in your
3 paper, we compared the S-10 to audited data from hospitals
4 and found that the S-10 was a closer match to the audited
5 uncompensated care data than the Medicaid proxy. So while
6 the S-10 isn't perfect, it's better than what's being
7 currently used.

8 However, we do want to work on those
9 imperfections. Specifically, we think CMS should use two
10 types of auditing. First, there's a handful of hospitals
11 that appear to have errant data on their S-10, and they can
12 be identified with automated screens. And we've done some
13 of this. It's not that difficult.

14 Second, there are some large public hospitals
15 reporting very high levels of uncompensated care, and these
16 are places like Stroger in Cook County or Parkland in
17 Texas, Grady in Atlanta, Charity in New Orleans or Bellevue
18 in New York. And we expect that these hospitals generally
19 are providing high levels of uncompensated care as they
20 report. However, because their numbers are big and they
21 will be critical to how much other hospitals receive from
22 the fixed pool of \$6.7 billion, their data should be

1 audited by CMS.

2 So, in summary, to improve the quality of the S-
3 10 and to prevent any errant distribution of the S-10
4 dollars, we're suggesting three things. First, audit the
5 aberrant data, and this might be 10 or 20 hospitals that
6 you will be looking at and primarily four key variables.

7 Second, as a precaution, you should also audit
8 the 10 or 20 hospitals with the biggest numbers because
9 this can really affect how much money is left for everybody
10 else.

11 And third, as our third precaution, as we're
12 phasing this in over three years, so we have three years
13 before it's fully effective.

14 And now I'll turn it over to your discussion.

15 DR. CROSSON: Thank you, Jeff, Ariel, and Dan.

16 We're going to start with clarifying questions.
17 Clarifying questions starting with Herb.

18 MR. KUHN: Thank you all for this information.
19 It's very helpful.

20 So two slides I have questions on regarding the
21 redistribution of the dollars. So if I could start with
22 slide 5?

1 So, on the one column where we say the share of
2 PPS hospitals, it looks like there is probably three times
3 as many DSH hospitals as there are 340B hospitals, roughly,
4 kind of in that category.

5 So, as we look at the redistribution, it looks
6 like we're going to be redistributing a lot of this money
7 away from 340B hospitals to ultimately DSH hospitals. Is
8 that essentially correct, the way the redistribution is
9 going to work? Because we have so many fewer --

10 DR. STENSLAND: Well, there's two things
11 happening.

12 MR. KUHN: Yeah.

13 DR. STENSLAND: There is one, is there is some
14 money coming. Part of the discounts that 340B hospitals
15 are receiving, that \$300 million, the \$300 million comes
16 out from the 340B hospitals. Some of it goes back to the
17 340B hospitals, especially those providing a lot of
18 uncompensated care, and some will go to other hospitals,
19 other DSH hospitals providing uncompensated care. That is
20 one redistribution.

21 The second thing that's happening is we're using
22 the S-10 data. So what happens with the S-10 data is

1 actually it tends to take all the money that people are now
2 getting for their Medicaid days and to a lesser extent the
3 SSI days and redistributes that money, and that money is
4 more going the other way because that money primarily
5 disproportionately goes back to the 340B hospitals, so
6 that's why on average, they actually see an increase.

7 MR. KUHN: Okay. That's helpful. When you look
8 at the 80 percent, 35 percent, I was just trying to get a
9 sense, but, I mean, overall we're probably seeing more
10 money go from 340Bs to non-340Bs, but on a little bit more,
11 probably not the order of magnitude of 3:1, but there is
12 probably more movement in that direction, would you say?

13 DR. STENSLAND: Adding all the policies together,
14 the mean difference is, I think -- what did I say, a
15 hundred and something?

16 MR. WINTER: 170.

17 DR. STENSLAND: A \$170,000 increase to the 340B
18 hospitals. So adding it all together, there's more money
19 flowing to 340B hospitals than is flowing out of 340B
20 hospitals.

21 MR. KUHN: Okay. Thank you. That's helpful for
22 clarification.

1 Then on Slide 12, I'm just curious about -- this
2 is a very helpful chart, and I appreciate it. I'm
3 interested in the line on rural hospitals. So if you look
4 at kind of the expansion of the 340B program, as we all
5 know, in PPACA they added critical access hospitals. So we
6 went from basically a base of 1,000 hospitals to 2,000
7 hospitals, if I understand right. So on the impacts here,
8 the dollars are a little greater, but do we know how many
9 hospitals, you know, rural hospitals versus others, are
10 being impacted by this change in rural? Is it helping 600
11 critical access hospitals? Is it 500? Do we have any
12 sense of that?

13 DR. STENSLAND: Yeah. So it won't affect
14 critical access hospitals at all because this is just
15 affecting PPS payments.

16 MR. KUHN: Okay.

17 DR. STENSLAND: And the critical access hospitals
18 are paid for their 340B drugs based on their cost. And,
19 interestingly, because it's based on their cost, the
20 discounts are taken out of that cost. So, in essence, the
21 critical access hospitals are already getting lower
22 payments for their 340B drugs when they're getting a

1 discount. But this will help -- this will affect all the
2 DSH rural hospitals.

3 MR. KUHN: Yeah, DSH rural hospitals. So kind of
4 what everybody calls the "tweener hospitals," basically,
5 that crowd is what we're talking about here.

6 DR. STENSLAND: Right. And 60 percent of those
7 will see an increase in their payments, and particularly
8 the ones that probably will benefit the most are those that
9 provide a lot of uncompensated care in their emergency room
10 or that offer to accept the people without insurance,
11 especially if they don't have OB, because what you have now
12 is we're distributing everything based on Medicaid days,
13 and if you're a hospital that doesn't have a lot of
14 Medicaid inpatient and you don't provide obstetrics, you
15 might not have a lot of Medicaid days, so you're not
16 getting a lot of money now. But if we switch it to
17 covering for all your different types of uncompensated
18 care, inpatient and outpatient, bad debts, charity care,
19 that generally helps the rurals, especially those with a
20 lot of -- a disproportionate share of their care going on
21 the outpatient side.

22 MR. KUHN: Thank you.

1 MS. BUTO: Okay. So just a couple questions.
2 Does our policy only affect 340B payments for Part B drugs,
3 right? Hospitals get 340B prices or discounts for Part D
4 drugs as well, and those are just up to the D plans to deal
5 with, whatever best deal they can come up with.

6 The other question I had is about the
7 uncompensated care pool that we're adding to. That's the
8 pool that pays for the shortfall when a state under
9 Medicaid doesn't cover coinsurance, right, for Medicare
10 beneficiaries? Or is that bad debt, a whole separate deal?

11 DR. STENSLAND: That's a whole separate deal. So
12 there is the \$6.4 billion uncompensated care pool, and
13 that's what we're affecting. There's another \$1.1 billion
14 that Medicare paid for cases where the state declined to
15 pay the coinsurance of their Medicaid beneficiaries. That
16 \$1.1 billion isn't affected at all by this.

17 MS. BUTO: Okay.

18 DR. STENSLAND: So that whole bad debt thing
19 isn't affected.

20 MS. BUTO: I don't think -- I mean, as I
21 understand -- maybe that's in statute -- the states are
22 allowed to not have to pay that amount if their rates are

1 lower than Medicare -- lower than Medicare plus the
2 coinsurance, I think, right? They don't have to pay the
3 coinsurance.

4 DR. STENSLAND: I think if the Medicaid -- if the
5 Medicare rate is here and the Medicaid rate is here, but
6 after you subtract -- and if you say that the Medi -- after
7 you take out the beneficiary's cost sharing, just the
8 program payment is above the Medicaid rate --

9 MS. BUTO: Is still higher, yeah.

10 DR. STENSLAND: -- then the Medicaid state can
11 say, well, you already got more than our rate just from the
12 program payment, we're not going to pay you any
13 coinsurance.

14 MS. BUTO: Right, okay. Thank you.

15 DR. HOADLEY: So back on Slide 5, given the
16 questions you were just answering from Herb, here we're
17 talking about the share of PPS hospitals, or the critical
18 access hospitals were already excluded from this chart?

19 DR. STENSLAND: Correct.

20 DR. HOADLEY: And this is share of hospitals.
21 Would it be similar if we were looking at share of patients
22 or share of beds or something, more volume? Or is it

1 possible that it would be quite different?

2 DR. STENSLAND: It would be a bigger share
3 probably of patients that are in the DSH and the 340B
4 programs both.

5 DR. HOADLEY: Okay.

6 DR. STENSLAND: Because they tend to be bigger
7 hospitals, and you think like -- a lot of those little
8 physician-owned specialty hospitals, ortho hospitals, and
9 that kind of thing, they probably aren't -- those are often
10 the ones not in this kind of program.

11 DR. HOADLEY: Okay. That's helpful. And on the
12 recommendation, the three-year phase-in is only applying to
13 the use of the S-10 uncompensated care, not to any other
14 part of the recommendation. Is that right?

15 DR. STENSLAND: Yes.

16 DR. HOADLEY: Okay. Thank you.

17 DR. CROSSON: Other clarifying questions?

18 [No response.]

19 DR. CROSSON: Okay. Seeing none, we're going to
20 proceed then to the discussion. I'm going to start off,
21 and then we'll have a broader discussion.

22 I think it's probably useful to point out, not

1 just to the Commission but to the audience -- and could we
2 put the recommendation up? Thank you -- that within this
3 recommendation, we have done two things. We have made a
4 recommendation to increase payments to hospitals by 1.75
5 percent, which is about roughly \$3 billion of additional
6 Medicare program spending. We also have -- and we're going
7 to discuss, I think, for the majority of our time in the
8 discussion -- a set of recommendations with respect to the
9 amount of money and the way the money is being paid from
10 the Medicare program to 340B hospitals.

11 As you heard in the presentation, even though
12 there is a redirection of money among hospitals, the net
13 reduction that is called for in the recommendation across
14 hospitals is \$70 million. This is money that will be paid
15 to the beneficiaries or will be a reduction in the amount
16 of out-of-pocket payment that accrues to beneficiaries
17 paying for Part B drugs. A \$3 billion increase to
18 hospitals and \$70 million redirected from hospitals to
19 beneficiaries. That's the net financial impact of this
20 recommendation.

21

22 Now, having said that, a lot of the difficulty

1 with the recommendation and in some cases confusion on the
2 part of members of the hospital community relates to the
3 other parts of the recommendation, those having to do with
4 340B. So I thought it would be useful both for the
5 Commissioners who I think have probably heard this enough,
6 but also some of you who have come to listen to the
7 discussion, to go back and revisit how we got here, because
8 not all of you have attended all of the MedPAC meetings,
9 and we've been discussing this issue since early November.

10 We were initially asked by Congress to review the
11 340B program. In the initial processes of doing that, we
12 recognized that, in fact, the 340B program was administered
13 by HRSA and not CMS. And yet this is a Medicare
14 expenditure, and, therefore, it was our intention from
15 early on in the discussion to look at the impact of the
16 340B program on Medicare and on its beneficiaries.

17 In early November, we had an initial discussion
18 about potentially recovering for the Medicare program 10
19 percentage points of the estimated discount, which at the
20 time we thought was in the range of 23 or 24 percent, and
21 moving that money back to the federal treasury, as well as,
22 as is incorporated in the current recommendation,

1 recovering 10 percentage points and using that to reduce
2 the out-of-pocket payments for beneficiaries, many of whom
3 are of limited means.

4 At the time we discussed it in November, there
5 was concern among Commissioners that this was an across-
6 the-board, if you will, reduction -- that is, the portion
7 that was to be recovered for the Medicare program and,
8 therefore, could have an unintended negative consequence
9 for hospitals that were the most financially vulnerable.

10 So in December, we came back and discussed the
11 recommendation that you see in front of you, and that does
12 recover for the beneficiaries a portion of the out-of-
13 pocket payment costs that they are subject to, and I'll
14 talk about that a little bit more in a minute. But rather
15 than recovering the some \$300 million for the federal
16 treasury, we have a recommendation in front of us that
17 redirects that money back to hospitals based on
18 uncompensated care.

19 So just to raise a couple of questions I know
20 have come up, because some of them have been directed to
21 me, one of those is: Do we have jurisdiction, if you will,
22 to make any recommendations regarding 340B? And our answer

1 is: Yes, we do. This is, in fact, a Medicare expenditure.
2 And, therefore, it is appropriate for MedPAC to analyze and
3 to make recommendations about that expenditure and also the
4 impact on beneficiaries. These are Medicare-supplied
5 dollars.

6 Another question that has come up is: On the
7 beneficiary saving piece, does this money actually accrue
8 directly to beneficiaries? And the answer is: In part.
9 About one out of five beneficiaries would actually see a
10 direct savings. Many of the other beneficiaries, however,
11 pay in a competitive marketplace for Medigap plans. And,
12 therefore, since part of this reduction will flow to
13 Medigap plans who are competing with each other for
14 beneficiaries, it is not unreasonable to assume that
15 Medicare beneficiaries could face lower Medigap premiums.
16 That would certainly be our hope.

17 And, finally, the question of why we redirect the
18 savings based on uncompensated care rather than Medicaid,
19 and I think you heard this well outlined in the
20 presentation. But, fundamentally, we believe that
21 redirecting this portion of the money as well as the
22 uncompensated care pool based on uncompensated care is a

1 better choice than doing it based on Medicare days for the
2 reasons well outlined, and that is, simply, that the
3 Medicare program should not be subsidizing the Medicaid
4 program, and that's the reason for the recommendations.

5 So, with that, let's open the recommendation, and
6 we'll take the entire recommendation together for
7 discussion. David, that was not much of a hand wave, but -
8 -

9 DR. NERENZ: I was waiting to see if anybody else
10 would step up. I will.

11 [Laughter.]

12 DR. NERENZ: I'll jump in. This has been a real
13 tough issue for me since we started talking about it. In
14 fact, back in November I didn't have any gray hair at all,
15 and now you look at the effect.

16 [Laughter.]

17 DR. NERENZ: This is really --

18 DR. MILLER: Factually incorrect [off
19 microphone].

20 DR. CROSSON: And there are no pharmaceuticals
21 involved in this?

22 DR. NERENZ: No, no, no.

1 [Laughter.]

2 DR. NERENZ: No, seriously, I've really agonized
3 over this, and I think I find myself in a different spot on
4 this to all of those who I respect so much around this
5 table, but here we are.

6 I have had concerns about this. I've expressed
7 them at each of the three prior meetings. Nobody is going
8 to be surprised if I say it, so I'll try in fact not to
9 repeat, just touch on a couple of main points.

10 The first one, just largely for background, you
11 know, the 340B program, as everybody knows, is very
12 contentious, a lot of back-and-forth discussion, largely
13 pits the drug companies against the hospitals. There are
14 claims and there are counterclaims and there are studies
15 and there are counterstudies. All of them I believe are
16 deeply flawed. All of them make it hard for me to draw any
17 conclusions. But the point -- I don't sit here starting
18 with the idea that there are some fundamental problems with
19 340B that we should be dealing with. In fact, I would
20 strongly prefer that we not. This is one of those policy
21 issues I think we probably would not wish to touch with a
22 ten-foot pole. At least that would be my personal

1 preference, but we are.

2 Now, right there I will say I fully understand
3 and agree that we are within our jurisdiction. We are
4 talking about a Medicare payment issue. I know that. I
5 understand that. My concern, though, is that as we just put
6 the term 340B on the slide and we talk about specifically
7 taking Medicare dollars from 340B hospitals, if we're not
8 over the line, we're really close to it, and it's a very
9 fine and very difficult to see line. Even using a term
10 like "taking away" implies that we have some feeling that
11 there's money to be taken away or should be taken away.
12 And Herb said the same thing back in December. He probably
13 said it better than I just did. But I'm just a little
14 worried about that. So I start with just wishing we were
15 not talking about that part.

16 Now, the S-10 part, I also understand that
17 rationale. A couple concerns there. If we could put up
18 Slide 12, this is, I understand, the combined effect of
19 both things. We saw this in December. It's got some
20 interesting features, and it has a little bit of a
21 Powerball feature to it, meaning there's one big winner and
22 then there's a whole bunch of other losers. And so,

1 clearly, in the bottom left, the government hospitals are
2 the big winners. Everybody sees that. But I know we've
3 looked, say, at the 340B line and said on average there's
4 an increase, but these are partially overlapping
5 categories. My guess is if the government hospitals were
6 taken out of the 340B line, it has to tip negative. It's
7 got to.

8 Also, you know, we don't show private as a
9 category. That's got to be negative. We were talking
10 about redistributing a fairly -- a finite pool of money.
11 So maybe you've had a chance to look at this, maybe not,
12 but I just think that there are patterns of winning and
13 losing here that are not fully expressed, because you only
14 can put so much in a chart. And even the subtleties, you
15 know, we look at 340B, we say, well, on average we go up
16 170,000, but we move one line to the right, most -- the
17 majority -- 340B hospitals lose. Now, how can that be?
18 Well, it's because of the government effect.

19 So I think what's going on here is that you've
20 got one well-defined set of big winners and then a bunch of
21 others that, you know, I think lose on net, but then, you
22 know, they just get mixed in these categories. So I don't

1 like and I don't understand even completely all of the
2 patterns of what's going on here.

3 Okay. So then even a little more explicitly, I
4 understand and agree with our principle that Medicare
5 should not subsidize Medicaid. I appreciate that. But
6 let's just walk through a quick example, and I'll use
7 Medicaid expansion and its effect on hospitals.

8 Let's go to a hospital pre-expansion, in any
9 given state you want to imagine. It serves a lot of
10 uninsured people so it's got a big charity care number.

11 Now, Medicaid expansion occurs, and people who
12 were uninsured become insured. But the payment rate is not
13 that high, so the hospital now loses money on each event
14 because Medicaid is paying some number of pennies on the
15 dollars. In the hospital accounting, charity care goes
16 down, Medicaid underpayment goes up.

17 Okay. Now, let's just -- instead of that being a
18 transition, let's just compare states. In states that have
19 done Medicaid expansion but they're not paying all that
20 well, those hospitals are showing relatively more Medicaid
21 underpayment, and we say we will not subsidize that. The
22 states that did not do Medicaid expansion still have a lot

1 of uninsured in their hospital, and in this proposal we're
2 saying, oh, well, we'll subsidize that.

3 So what we're doing is we're taking dollars from
4 states that have done something and moving it to states who
5 have done nothing, and we've gone from -- we're taking
6 money away from Medicaid expansion states, and we're moving
7 it to hospitals in non-expansion states. Now, I don't know
8 that we really want to do that. Or maybe we want to do
9 that. But I think that's an inevitable consequence.

10 And the same dynamic goes, say, at the city or
11 county level, that there are some counties who have created
12 insurance programs for indigent folks. I haven't studied
13 this, but I think one characteristic is they don't have
14 very rich payment rates. And so the same thing occurs.
15 We're willing to -- we don't want to have money go to
16 places that are underpaying because those underpayments are
17 also in the same part of the S-10 form. It's Medicaid and
18 other public program underpayments. But for counties who
19 do nothing, we'll say, okay, we'll give you lots of money
20 to cover that.

21 So, again, at a couple different levels of
22 government, we say we're going to take money away from

1 those that have done something and we're going to move it
2 to those who have done nothing, and that bothers me.

3 Then, finally, on the beneficiaries -- and the
4 point has been made -- you know, it sounds nice and it tugs
5 the heart to say, you know, we want the beneficiaries,
6 particularly the low-income, to share in some of this. But
7 only 19 percent will. Those who are dual eligibles have
8 these co-pays paid -- or not paid, actually, by the
9 Medicaid program. So if there is any relief, it accrues to
10 the Medicaid program. So now we've come back and are
11 providing relief to the Medicaid programs that way. Or
12 it's Medigap, and I think it's debatable whether that
13 benefit accrues ever to individual beneficiaries. So I
14 like the sound where it says we're going to help
15 beneficiaries, but not very much, I don't think.

16 So we're not talking about something that
17 produces net savings to the Medicare program. We've got
18 these complex effects of winning and losing states, public,
19 private, I'm not fully comfortable with. The returns to
20 the beneficiaries are kind of weak, I think, and I'm not
21 sure we need to be doing this at all.

22 So the top line of the recommendation, fine,

1 great. 340B and S-10, not so much.

2 DR. CROSSON: Thank you. Other comments?

3 Warner.

4 MR. THOMAS: I think David did a good job
5 outlining the, I think, some of the issues. I think the
6 concern I have once again is, you know, if we look at the
7 reallocation of dollars, and we indicate that it's
8 relatively small, and it seems like part of that, we're
9 really trying to reallocate to less fortunate facilities
10 that have more uncompensated care. But, yet, we have a
11 letter, and I'm not sure who all the members are, that each
12 of us received from the America's Essential Hospitals, that
13 I would imagine a lot of their members are these folks that
14 are potentially going to do better, but yet they cite many
15 different reasons that they find the recommendations
16 problematic.

17 I think at the end of the day, if we want -- I
18 definitely can get my head around the issues with the
19 beneficiary, and I think if that's what we're trying to
20 accomplish here, we're trying to help the beneficiary, then
21 I would say, let's look at ways that we can help the
22 beneficiary directly.

1 I agree with David. I mean, if you take its \$70
2 million that at the end of the day is really going to be --
3 go back to the beneficiary, if only 19 percent of them are
4 getting that, it's a very, very small amount of money that
5 actually will go to a beneficiary because the other 81
6 percent will go to the Medigap plans, and I have a very low
7 confidence that those dollars are going to come back to the
8 beneficiary.

9 So, I, too, have a tremendous amount of
10 reservation about the second recommendation. I think there
11 is -- I could go into more details about it, but I think
12 David has done a good job outlining that. And, once again,
13 I think if we're trying to get back to the issues of
14 helping the beneficiary, then let's take that specific
15 issue on directly and not mix it in with a bunch of other
16 issues.

17 The other comment I would make is that, you know,
18 we're talking about this reallocation of dollars, and I
19 understand, Jay, your comment that we're increasing
20 hospital payments by \$3 billion, but we're doing it in the
21 context of, even with the 340B program, even with all these
22 reductions, hospitals are still running negative margins on

1 Medicare. They just are. I mean, if you look at the chart
2 we're given, they're running negative margins on Medicare,
3 and it's projected to get worse next year, not better.

4

5 So, I just -- I have trouble looking at hospitals
6 that have qualified for this program because they're
7 disproportionate share, they have more uncompensated care.
8 It's not like they just choose to be in this program. They
9 have to qualify to be in the program, and yet we're
10 targeting those folks and reallocating their dollars in the
11 context of what's going on.

12 So, that's just my comments about it.

13 DR. CROSSON: Thank you.

14 Herb.

15 MR. KUHN: So, I, too, thank Warner and David for
16 their comments, and I won't repeat what they've said.

17 I'd just like to come back to this issue of
18 whether this is an issue that the Commission ought to be
19 involved in. And I think everybody here is well meaning
20 and has good thoughts about this, but let me just give you
21 my bias on this, and probably part of my bias stems from my
22 time at CMS.

1 But, I do, as I said at the last meeting, I do
2 feel like there's a bit of mission creep here as we get
3 into a Health Resources and Services Administration program
4 here. And the thing that I think kind of worries me a
5 little bit more here is the fact that, you know, when you
6 look at how things work at HHS, yes, there's a lot of
7 interdependencies with a lot of these programs, and there
8 certainly is an interdependency here between a Public
9 Health Service program and the Medicare program. But, I
10 wonder if the actions we're taking would make that Public
11 Health Service program less effective as part of that. And
12 when I mean less effective, what's ultimately the
13 beneficiary impact or the people those facilities are
14 serving that are out there. And, you know, if you go back
15 to the original intent of the 340B, it was to stretch
16 scarce resources as we go forward, and that's just an area
17 that concerns me, as well.

18 So, I think there is a solid argument, this is
19 the Medicare side, but I just look at the interdependency
20 of those two programs and I do worry about the impact on a
21 Public Health Service program and how these actions might
22 go in that direction.

1 DR. CROSSON: Thank you, Herb.

2 Other comments? I see Kathy.

3 MS. BUTO: Okay. I support the recommendation in
4 full, and probably also coming from my CMS experience, and
5 that is that this is -- I believe in the presentation we
6 talked about the fact that 340B drugs are now making up
7 more than or almost 50 percent of all payments for Part B
8 drugs, and I think that we have to look at whether that
9 trend, which is accelerating, is really appropriate in the
10 Medicare program. So, that concerns me.

11 There has been some suggestion, though, I
12 understand, criticism, of a GAO report and other reports
13 that have looked at the trend and which drugs are purchased
14 and whether they're the more expensive rather than the more
15 cost-effective drugs.

16 So, the program has distortions in it, and we
17 know enough about the extent to which the discounts are
18 much greater than the Medicare payment, that unlike other
19 areas of the program, we may not have the same level of
20 detail. I think the Commission could act in this way, in a
21 fairly prudent way, to essentially reduce that by some
22 small -- ten percent, as we suggested.

1 We're going to be looking at drugs in other
2 contexts, in the physician's office, Part B drugs paid that
3 way, Part D drugs. It's not as if this is the only area of
4 distortion we're looking at. And, it strikes me it's
5 perfectly reasonable for us to look at this.

6 I also have to say about the S-10, and I don't
7 know very much about the S-10 -- maybe Jack or others know
8 more about it -- my experience at CMS was until payment was
9 based on a schedule, the accuracy of that schedule did not
10 tighten up. As soon as payment is made based on the
11 schedule, there will be great degree of attention paid to
12 the accuracy. I agree with the staff's recommendation that
13 in the meantime, audits are really advisable. But, the
14 schedule will get much better if payments are going to be
15 based on it.

16 So, again, I support the recommendation.

17 DR. CROSSON: Warner.

18 MR. THOMAS: This may be more of a round one
19 question, so I apologize. What are we trying to accomplish
20 in recommendation two? What is the -- I'm just trying to
21 understand, in the approach on 340B and in the
22 redistribution, what is the -- you know, what is the

1 problem, what is the issue we're trying to meet? Do we
2 feel like there needs to be a distribution here? Is that
3 what we're trying to solve? Do we feel like there's more
4 dollars that need to go back to the beneficiary? Is that
5 the issue? Is it a -- I'm -- do we just feel like the
6 program is growing too much? Is that the issue we're
7 trying to solve? What do we see as the issue?

8 DR. CROSSON: Warner, I think I tried to address
9 that with the opening remarks.

10 MR. THOMAS: Yeah.

11 DR. CROSSON: I think, again, we were asked to
12 review the 340B program by Congress. In the course of
13 doing that, we asked ourselves the question about the
14 impact of the 340B program on Medicare and its
15 beneficiaries. And as a consequence of that, examining the
16 fact that, in the end, this money that's being supplied is
17 Medicare money and it is perfectly reasonable for Medicare,
18 and for us as the Advisory Commission on Medicare, to ask
19 how that money is, in fact, being expended and whether, in
20 fact, we believe that it's being expended in the best
21 possible way. Out of that came the recommendations.

22 MR. THOMAS: Okay.

1 DR. CROSSON: Kate, I'm sorry I missed you.

2 DR. BAICKER: So, I do support this direction,
3 and I think it's -- the point that David raised is well
4 taken, that we don't want to subsidize Medicaid, so basing
5 uncompensated-ish funds on Medicaid days doesn't make a lot
6 of sense, especially given the mismatch.

7 We also don't want to differentially subsidize
8 states that choose to expand Medicaid or don't choose to
9 expand Medicaid, and some ways that that's handled in
10 alternative formulations would be to base the distribution
11 on the sum of Medicaid days and on insured days and then
12 you're neutral with respect to the population that's
13 covered by Medicaid with the assumption that they would
14 otherwise be uninsured. I don't feel like that's something
15 that has to happen here and now, but that's something one
16 could consider as an alternative for the distribution of
17 those funds.

18 It does seem clearly in our purview to think, are
19 we paying more for items of service than they cost to the
20 provider of those, and if so, do we think that that's a
21 reasonable way to spend Medicare dollars. So, this seems
22 like a very reasonable question for us to ask, as far as

1 I'm concerned.

2 As for the beneficiary sharing in the reduction
3 of that excess of payment over cost, that seems like an
4 important component of ensuring that the payment system is
5 fair. I have more faith that Medigap premiums would
6 reflect the expenditures, both through standard market
7 mechanisms and through regulation. I have no reason to
8 think that they would be able to secrete away some extra
9 profits and that they would not be returned to
10 beneficiaries in the form of lower Medigap premiums, with
11 the caveat that that's not going to happen instantaneously
12 nor one for one. But, I think the part that we have set
13 aside as we want to be sure beneficiaries share in any
14 savings, I think the vast majority of that is going to flow
15 back to beneficiaries. So, I have a little more faith on
16 that dimension.

17 So, with that in mind, the package makes sense to
18 me and I see the change in the payment for 340B hospitals
19 in particular not as addressing the 340B program, but just
20 aligning where Medicare resources are flowing to be less
21 distortionary of the types of services that are used, the
22 sites of care where people get those services. Our general

1 principle is we don't want to be differentially subsidizing
2 certain types of treatment that are not more effective for
3 beneficiaries. So, the package makes sense to me.

4 DR. CROSSON: Thank you, Kate.

5 Jack.

6 DR. HOADLEY: So, I generally want to associate
7 myself with the comments just made by Kathy and Kate, and I
8 think overall -- I mean, I think this is a challenging
9 topic and I think we've all thought hard and have listened
10 hard to the different arguments. But, I do come down
11 thinking the package makes sense.

12 I think on this last point, the beneficiary
13 savings, I, too, am -- I guess I have more optimism that
14 those savings -- now, one of the impacts is that the
15 individual beneficiary who used that drug won't see the
16 magnitude of savings, but that was their choice, in a
17 sense, in buying protection through a Medigap policy.
18 Every beneficiary, hopefully -- again, it won't be
19 immediate, but there will be at least either a reduction of
20 future increases or an actual decrease to reflect this over
21 time and it will affect the beneficiaries as a whole, not
22 the individual one who got those drugs.

1 The ones who have chosen not to insure themselves
2 will see the direct impact, and the impact can be huge, as
3 the IG report says. The differential -- you know, we
4 talked about the average differentials, but for some drugs,
5 it's well above that. I think there's even examples where
6 the copay is actually larger than what the hospital is
7 paying.

8 And, I do think, you know, we did start, as Jay
9 recounted, thinking that maybe this was a case where we
10 should be recapturing savings for the program, and in the
11 end we settled on an approach that said we'll opt not to
12 recapture savings from the programs, but we'll move those
13 dollars around to achieve other goals.

14 I am somewhat concerned about one of the points
15 David made about some of the complicated effects this has
16 relative to Medicaid. It really all stems back to the
17 Medicaid payment rates being lower and sort of how that
18 plays through, and that may be something -- I know MACPAC
19 has looked at those issues, and whether that's something we
20 should take a look at, sort of how Medicare policy layers
21 on top of Medicaid in those cases almost is a separate
22 issue, because that's just being exacerbated by some of the

1 potential changes in policies.

2 But, I do think, you know, it overall does feel
3 like a reasonable direction to go, and so I'm supportive of
4 the recommendation.

5 DR. CROSSON: Thank you, Jack.

6 Other comments?

7 [No response.]

8 DR. CROSSON: Seeing no hands, we will proceed to
9 voting. Just to be clear, this is one recommendation with
10 multiple parts, so we're voting once. And as before, we'll
11 call for hands for those in favor, those opposed, and those
12 who choose to abstain.

13 All those in favor of the recommendation, please
14 raise your hand.

15 [Show of hands.]

16 DR. CROSSON: All those opposed.

17 [Show of hands.]

18 DR. CROSSON: Abstentions.

19 [No response.]

20 DR. CROSSON: Thank you very much. Jeff, Ariel,
21 Dan, wonderful work, wonderful presentation.

22 We will now proceed to the public comment period.

1 All of you in the audience that wish to make a comment,
2 please come and stand at the microphone so we can see how
3 many individuals we have.

4 [Pause.]

5 DR. CROSSON: Bruce, I see you're the first one.
6 I think you probably know the drill, but I'll go through it
7 anyway. We are pleased to have your comments. The
8 Commission values them. We are going to listen intently.
9 We would ask you to limit your comments to two minutes, and
10 when that light comes back on, that means the two minutes
11 have expired.

12 And I just emphasize one thing that we do often.
13 This is not the only, nor is it, in fact, the best way to
14 provide information to the Commission and to the staff.
15 There are multiple avenues, through e-mail, through
16 letters, through direct contact with Mark and his staff, as
17 well as information that can be sent to the Commissioners,
18 to do that well ahead of the process of voting.

19 Having said that, Bruce, you have the floor.

20 DR. SIEGEL: Thank you, Jay, and thank you,
21 Commissioners, for allowing me the time to speak. My name
22 is Bruce Siegel. I'm the CEO of America's Essential

1 Hospitals. We represent 275 hospitals that care for the
2 neediest.

3 Our safety net hospitals provide exceptional care
4 to those in need and vital services to entire communities.
5 They do this with an aggregate operating margin of
6 negative-three percent, compared with positive-six percent
7 for all hospitals nationally.

8 We have very serious concerns about the
9 Commission's recommendations to cut Medicare Part B
10 reimbursement to 340B hospitals. These recommendations
11 undermine Congressional intent for 340B and do not advance
12 the interest of Medicare. They would result in no savings
13 to the Medicare program and negligible savings to
14 beneficiaries, about \$6 per beneficiary per year, or 50
15 cents per month, optimistically. In fact, most of the \$70
16 million of estimated beneficiary savings would not even go
17 directly to beneficiaries, as MedPAC's own figures show
18 that 86 percent of beneficiaries have some form of
19 supplemental insurance.

20 These proposals could greatly harm essential
21 safety net hospitals and their patients. It is unclear why
22 the Commission would recommend an inequitable policy that

1 would cut Medicare reimbursement to a group of hospitals
2 selected on the basis of the fact that they care for the
3 neediest, while ignoring the larger trend of escalating
4 drug prices. Part B 340B spending represents less than \$4
5 billion, compared with more than \$100 billion in Medicare
6 Part D spending.

7 Since its first meeting on this topic in November
8 2014, the Commission has expressed uncertainty about the
9 scope of its jurisdiction over a Public Health Service
10 program. We heard more of that, perhaps, today. Yet, the
11 Commission has not assessed the impact of sweeping changes
12 proposed for 340B today by the agency that does have
13 jurisdiction, HRSA.

14 Thank you, and we ask you to revisit your
15 recommendations.

16 DR. CROSSON: Thank you.

17 MS. HALKIAS: My name is Becky Halkias. I work
18 with Temple University Hospital, which is located in North
19 Philadelphia.

20 I've read the transcripts from your November and
21 December meetings and I want to commend the Commissioners,
22 and it was also exemplified today, of your concern about

1 patient access to care. And, what I urge you to consider
2 is the impact of the decision on individual hospitals like
3 Temple, who uses the money that it gets from the 340B
4 hospitals to serve the patients that it serves and the
5 impact that the S-10 decision will have on Temple
6 University Hospital.

7 It has about an 80, 85 percent public pay,
8 Medicaid-Medicare caseload, and it has no ability to cost
9 shift. It doesn't use the funds to expand, you know, the
10 things that you mentioned, to expand its mission, to expand
11 what it offers, to buy equipment, to underwrite its
12 administrative census. It has no baseline. It loses so
13 much money that if we didn't have the UPL and supplemental
14 payments from Medicaid, we wouldn't be able to make it. We
15 lose money on our Medicare patients. We will lose money on
16 that, and we have a very small uncompensated care fund.
17 And, there are other small groups of similarly situated
18 hospitals around the country.

19 Congressman Gradison, you were there when the DSH
20 program was created, and while some of the hospitals'
21 uncompensated care funds -- uncompensated care programs may
22 be reduced, the need for our disproportionate share funds

1 is not because our payments have dual -- we have double the
2 amount of dual eligibles. They have multiple chronic
3 diseases and comorbidities. And they also have need for
4 behavioral health and substance abuse. Those are the
5 reasons we lose money on our Medicare basis.

6 Please look into the needs of this small group of
7 hospitals and how they are hurt by the S-10. That's our
8 question to you.

9 Thank you.

10 DR. CROSSON: Thank you.

11 DR. DOWLING: Good afternoon. My name is Robert
12 Dowling. I'm a physician and Vice President of Policy at
13 ION Solutions, a physician services organization that
14 represents over half the community oncologists and about a
15 third of the community urologists in the United States.

16 I've been following MedPAC's deliberations on
17 Part B reimbursement and I'd urge the Commission to
18 consider the following as you deliberate further,
19 particularly on ASP methodology.

20 First, MedPAC recommendations regarding ASP
21 should be based on actual reimbursement. ASP includes
22 manufacturer prompt pay discounts not passed on to

1 providers, and the combination of prompt pay discount
2 inclusion in sequestration means that the actual reimbursed
3 rate is about ASP plus two percent. Many of the ideas
4 under discussion by MedPAC without correction of these
5 errors will result in virtually all drugs at most times
6 being paid at less than the acquisition cost.

7 Second, MedPAC has acknowledged that there is
8 little data available as to whether the current ASP
9 methodology is encouraging physicians to use higher-priced
10 pharmaceuticals over lower-cost alternatives. Our own
11 analysis suggests that the driving force in product
12 selection is clinical effectiveness and not -- and that the
13 current ASP methodology inhibits rather than encourages the
14 use of higher-priced drugs.

15 Third, ASP has resulted in lower Medicare Part B
16 spending. Part B spending was rising at an average of 25
17 percent per year under AWP. The rise has been just over
18 four percent per year under ASP.

19 Fourth, Medicare should consider the undeniable
20 shift from private practice-based medical oncology care to
21 employed hospital health care systems. Flawed policy will
22 further exacerbate this shift in care to more costly and

1 less accessible sites of delivery.

2 So, we urge you to make recommendations regarding
3 Part B payments that are based on the full spectrum of drug
4 reimbursement and purchase data, and only when such data
5 unequivocally support the need for policy change and the
6 benefits outweigh the risks should the Commission recommend
7 revision.

8 Thank you very much.

9 DR. CROSSON: Thank you.

10 MS. TESTONI: Good morning. My name is Maureen
11 Testoni. I am General Counsel with 340B Health. We
12 represent about 1,100 340B hospitals.

13 And, I just wanted to say -- to share our
14 concerns with this recommendation. Our hospitals provide
15 more uncompensated care than non-340B hospitals. We do see
16 this as a fundamental change of the 340B program because it
17 is using your criteria, which is different from the 340B's
18 program criteria, to distribute the savings. In some ways,
19 it's an expansion of the program, because there are
20 hospitals that do not qualify for the 340B program now that
21 would qualify under the criteria, the new criteria that
22 you're establishing, and we don't believe that there's been

1 enough of a review of the impact on the 340B hospitals and
2 we're hoping that you will reconsider this vote.

3 Thank you.

4 DR. CROSSON: Thank you.

5 MR. HUNTER: I'll just lean down.

6 [Laughter.]

7 DR. MILLER: [Off microphone.] Maybe pull the
8 microphone out.

9 MR. HUNTER: Well, that'll work, too, Mark.
10 Thank you. Perfect.

11 Chairman Crosson, Commissioners, Executive
12 Director Miller, good afternoon. My name is Justin Hunter.
13 I'm Senior Vice President of Public Policy, Legislation,
14 and Regulations for HealthSouth. We operate 121
15 freestanding inpatient rehabilitation hospitals in 29
16 states and Puerto Rico. In 2014, we treated just under
17 135,000 patients, over 85 percent of whom were Medicare
18 beneficiaries.

19 The Commission was recently furnished a detailed
20 report and analyses that was prepared by Dobson DaVanzo on
21 behalf of the Federation of American Hospitals on matters
22 pertaining to inpatient rehabilitation hospitals and issues

1 that you all are considering later today. The report
2 underscores a point with which we have long agreed, and
3 that is that under prospective payment, including the IRF-
4 PPS, costs matter a lot.

5 The Dobson analyses affirmed that high-margin
6 IRFs are not attaining all of their success through payment
7 exclusively. The analyses found that in 2013, high-margin
8 IRFs received payments that were 12 percent lower than low-
9 margin IRFs. The analyses also found that costs per
10 discharge were 55 percent lower for high-margin IRFs than
11 for low-margin IRFs.

12 The Commission will likely vote to approve some
13 type of recommendation dealing with the IRF-PPS outlier
14 payment policy later today. The Dobson analyses addressed
15 the effects of such a potential move, and the results show
16 that low-margin IRFs would, depending upon the extent of
17 such an increase, receive well in excess of 20 percent of
18 their total payments from Medicare in the form of outlier
19 payments.

20 We at HealthSouth have carefully monitored on a
21 regular basis the distributive effects of IRF-PPS outlier
22 payments for years, and it is comprised of IRFs that are

1 submitting higher charges annually and higher cost-to-
2 charge ratios on a recurring basis.

3 DR. CROSSON: Please sum up.

4 MR. HUNTER: Yes, sir, Mr. Chairman.

5 We suggest, respectfully, that before the outlier
6 pool may be expanded, that its current structure be
7 carefully examined, precisely understood, and reformed.

8 We appreciate the Commission's consideration of
9 our views and concerns in this area and welcome the
10 opportunity to help inform you make sound policy
11 recommendations for the IRF-PPS, for the citizens who are
12 treated by it, its health care providers, and most
13 importantly, the taxpaying public.

14 Thank you.

15 DR. CROSSON: Thank you.

16 MR. THOMAS: Jay, I just have one comment. I
17 think it's -- I think it would be important in the chapter
18 related to the hospital update and the 340B to make sure we
19 capture some of the comments, especially from the Essential
20 Hospitals letter. I mean, I think there are some key
21 components in there, I mean, assuming we confirm that
22 information, that should be included as far as the impacts

1 on individual hospitals, the fact that we have dual
2 eligibles and the impact that that could have.

3 I think the comments from the representative from
4 Temple, I think there are many hospitals that are probably
5 in that situation, that we ought to make sure we capture
6 that in the chapter and just be clear that that's a concern
7 as we look at this 340B modification.

8 And, I'm not sure if we're going to make broader
9 comments about 340B. If we do, I think it's important for
10 us to comment on the relative size of the program given the
11 total expenditures in the drug area and that these funds
12 are critical to help subsidize hospitals that do take care
13 of lots of dual eligible Medicare patients as well as those
14 that are just fully uncompensated.

15 So, I would just make that as a -- or ask that as
16 an add as we put this -- put the chapter together.

17 DR. CROSSON: Thank you, Warner. I will discuss
18 this with Jon and Mark.

19 Seeing no other comments, we are adjourned until
20 1:15, which is approximately one hour from now.

21 [Whereupon, at 12:07 p.m., the meeting was
22 recessed, to reconvene at 1:15 p.m. this same day.]

1 than use the Commission time to have a duplicative
2 discussion, it has been the practice of MedPAC in the last
3 year or two when we find ourselves in that situation, to do
4 this expedited discussion and voting process, the staff
5 will come, present a very brief discussion of the issue and
6 the recommendation. We'll pause for a second to see if
7 there are any Commissioners who have developed new issues
8 between now and December. Following that, we will proceed
9 to the vote, and then after the vote, we will move on to
10 the next of the seven areas.

11 And with that, Ariel and Kate, you are up first,
12 but don't feel in a rush.

13 [Laughter.]

14 MS. BLONAIRZ: Medicare covers the services
15 delivered by physicians, advanced-practice nurses,
16 physician assistants, therapists, and other providers in
17 all settings. In 2014, spending on these services was \$69.2
18 billion, or 16 percent of total fee-for-service. Over a
19 billion services were covered, delivered by nearly 900,000
20 practitioners.

21 This slide summarizes our payment adequacy
22 findings, just a reminder that we talked in depth last

1 month about all of our indicators of payment adequacy,
2 which will be published in our March report.

3 This year, we generally see no difference from
4 prior years in Medicare beneficiaries' ability to access
5 care. It's largely comparable to or better than access for
6 the privately insured. For example, 88 percent of
7 beneficiaries are mostly or somewhat satisfied with their
8 care, as compared with 80 percent for those with private
9 insurance.

10 The supply of providers has grown consistent with
11 beneficiary growth. Volume of services grew slightly, 0.4
12 percent overall, and there were small declines in volume
13 growth for imaging and tests, minus 1.1 percent and minus
14 .6 percent, respectively, but these modest declines do not
15 raise concerns about access.

16 Finally, differences in compensation by specialty
17 continue to implicate mispricing of certain procedural
18 services versus cognitive services.

19 So the draft recommendation reads "The Congress
20 should increase payment rates for physician and other
21 health professional services by the amount specified in
22 current law for calendar year 2017."

1 There is no projected effect of the
2 recommendation on program spending, and the recommendation
3 is unlikely to affect beneficiaries' access to care or
4 providers' willingness and ability to furnish care.

5 So I'll conclude and can take any questions.

6 DR. CROSSON: Are there any Commissioner
7 questions or comments?

8 Alice.

9 DR. COOMBS: I have one comment about the reading
10 material, but I could take it up later, if you want.

11 DR. CROSSON: Okay. I think that would be fine.

12 DR. COOMBS: Okay.

13 DR. CROSSON: Thank you.

14 Okay. Seeing no other comments, we will proceed
15 with the vote. As before, I'll ask for votes in favor,
16 votes against, and abstentions. All Commissioners in favor
17 of the recommendation, please raise your hand.

18 [Show of hands.]

19 DR. CROSSON: All opposed?

20 [No response.]

21 DR. CROSSON: Abstentions?

22 [No response.]

1 DR. CROSSON: Thank you very much, Ariel and
2 Kate.

3 [Pause.]

4 DR. ZABINSKI: All right. Ambulatory Surgical
5 Centers.

6 At the December 2015 meeting, we presented update
7 information on ambulatory surgical centers and provided a
8 draft recommendation. The draft chapter that you have has
9 been updated and includes responses to questions asked by
10 the Commissioners at the December meeting.

11 For Kathy, we have added discussion that in the
12 future, it may be reasonable to consider a negative update
13 for ASCs to motivate the collection of cost data.

14 For Bill Gradison, we have added discussion of
15 CMS's rationale for allowing ASCs to suppress data on five
16 quality measures that will be made publicly available in
17 April 2016. CMS's reasoning is that some ASCs experienced
18 difficulties in implementing the changes to their billing
19 processes that are necessary for these data to be
20 collected. We also mentioned that suppression of these
21 data is applicable only to the data that would be made
22 publicly available in April 2016. So, without further

1 action by CMS, ASCs will not be allowed to suppress data on
2 these five measures that are made publicly available after
3 April 2016.

4 So facts about ASCs in 2014 are that Medicare
5 payments to ASCs were over \$3.8 billion. The number of
6 ASCs was 5,446, and 3.4 million beneficiaries were treated
7 in ASCs.

8 Beneficiaries' access to ASC services has been
9 stable. In 2014, volume per beneficiary decreased .8
10 percent, but this may have been due in part because of an
11 increase in the complexity of services provided. Also, the
12 number of ASCs increased by 1.9 percent.

13 In addition, Medicare payments per beneficiary
14 increased in 2014 by 3.1 percent. Growth in the number of
15 ASCs also suggests that access to capital has been
16 adequate, and moreover, in two transactions in 2014, the
17 companies that own and operate ASCs were able to borrow
18 over \$1 billion to complete those transactions.

19 As in previous years, our analysis is limited for
20 two reasons. First, even though CMS has begun collecting
21 data on quality measures in October of 2012, there is not
22 yet sufficient information to assess ASC quality. Second,

1 we cannot assess margins or other cost-based measures
2 because ASCs don't submit cost data, even though the
3 Commission has recommended on several occasions that these
4 data be submitted.

5 So for the Commission's consideration, we have
6 this draft recommendation for your consideration, that the
7 Congress should eliminate the update to the payment rates
8 for ambulatory surgical centers for calendar year 2015.
9 The Congress should also require ASCs to submit cost data.

10 In terms of implications, under current law, ASCs
11 are projected to receive an update in 2017 of 1.6 percent,
12 which reflects a CPI-U of 2.2 percent minus a multi-factor
13 productivity adjustment of .6 percent. Therefore, relative
14 to the statutory update, this draft recommendation would
15 provide small savings of less than \$50 million in first
16 year and less than \$1 billion over 5 years.

17 Because the number of ASCs has grown and volume
18 of services has been stable, we don't anticipate this draft
19 recommendation diminishing beneficiaries' access to ASC
20 care or providers' willingness or ability to furnish those
21 services

22 And finally, ASCs would incur some administrative

1 costs to submit the cost data.

2 And that concludes the presentation.

3 DR. CROSSON: Okay. Just for the record, that
4 was Dan Zabinski accompanied by Zach Gaumer. Thank you for
5 that.

6 Are there any Commissioner questions or comments?

7 [No response.]

8 DR. CROSSON: Seeing none, we'll proceed to the
9 voting on the draft recommendation. All in favor, please
10 raise your hand.

11 [Show of hands.]

12 DR. CROSSON: All opposed?

13 [No response.]

14 DR. CROSSON: Abstentions?

15 [No response.]

16 DR. CROSSON: Thank you very much.

17 Now we have Andy Johnson back and Nancy Ray, who
18 are going to talk to us about the update for outpatient
19 dialysis services.

20 MS. RAY: So I will summarize the information on
21 the adequacy of Medicare's payments for outpatient dialysis
22 services that we discussed at the December 2015 meeting.

1 Regarding the questions you asked us during the
2 December meeting, we have tried to address them in the
3 draft chapter, as indicated in the cover memo. For
4 example, Jack, we have added information about enrollment
5 in the ESRD SNPs in the chapter.

6 First, some key facts. Outpatient dialysis
7 services are used to treat most patients with end-stage
8 renal disease. In 2014, about 383,000 beneficiaries were
9 treated at roughly 6,300 dialysis facilities. Medicare
10 spending on outpatient dialysis services was \$11.2 billion.

11 Moving to our findings on payment adequacy,
12 access to care indicators are favorable. Between 2013 and
13 2014, growth in treatment stations, a measure of dialysis
14 capacity, kept pace with the growth in the number of
15 dialysis beneficiaries. For-profit and freestanding
16 facilities account for the increasing capacity.

17 Quality is improving for some measures. For
18 example, home dialysis, use of home dialysis is modestly
19 increasing. We also see declines in hospital admissions
20 and mortality.

21 The dialysis industry appears to have good access
22 to capital. For example, during the last several years,

1 the two largest chains either acquired or purchased
2 majority stakes in health care-related companies.

3 Moving to our analysis of Medicare payments and
4 providers' costs, in 2014 the Medicare margin is 2.1
5 percent, and the rate of marginal profit is nearly 18
6 percent. The 2016 Medicare margin is projected at 0.8
7 percent.

8 This brings us to our draft recommendation, and
9 it reads, "The Congress should increase the outpatient
10 dialysis base payment rate by the update specified in
11 current law for calendar year 2017.

12 The draft recommendation has no projected effect
13 on spending relative to the statutory update.

14 Based on CMS's latest forecast of changes in the
15 ESRD market basket costs for calendar year 2017, the update
16 to the 2017 payment rate would be 0.55 percent. This
17 recommendation is expected to have a minimal effect on
18 reasonably efficient providers' willingness and ability to
19 care for Medicare beneficiaries. We do not anticipate any
20 negative effects on beneficiary access to care.

21 Now I will turn the session back to Jay.

22 DR. CROSSON: Thank you.

1 Any Commissioner questions or comments?

2 [No response.]

3 DR. CROSSON: Seeing none, we will proceed to the
4 vote. All in favor of the draft recommendation, please
5 raise your hand.

6 [Show of hands.]

7 DR. CROSSON: All opposed?

8 [No response.]

9 DR. CROSSON: Abstentions?

10 [No response.]

11 DR. CROSSON: Thank you very much, Nancy and
12 Andy.

13 Now Carol Carter will take us through the
14 recommendation for skilled nursing facilities.

15 DR. CARTER: Before I get started, I wanted to
16 give you a little snapshot of the industry, then the size
17 and the spending on this sector that are on this slide.

18 Last month, we went over the details of the
19 indicators for the adequacy of payments for SNFs, and the
20 details are in the paper.

21 In summary, access to SNF services is adequate,
22 even though service use declined slightly, consistent with

1 trends in inpatient hospital use.

2 Quality performance was mixed. The average
3 facility rates of discharge back to the community and
4 potentially avoidable readmissions during the SNF stay both
5 improved, but the readmission rate during the 30 days after
6 the discharge got slightly worse, and the functional
7 measures remained basically unchanged.

8 Capital is generally available and expected to
9 continue during 2016. With the Medicare margins listed on
10 the slide, it is no surprise that Medicare continues to be
11 a payer of choice in this sector.

12 Last month, we also discussed the rationale for
13 revising and rebasing the SNF PPS. I want to review the
14 rationales for each. The well-known shortcomings of the
15 payment system need to be corrected. The payment system
16 favors rehabilitation care, over-treating medically complex
17 cases, and payments for non-therapy ancillary services,
18 such as drugs, are poorly targeted.

19 A PPS based on patient characteristics, such as
20 the one we recommended, would decrease payments to SNFs
21 that furnished a lot of intensive therapy that is unrelated
22 to a patient's care needs and would increase payments to

1 SNFs that treat a high share of medically complex patients.
2 Based on a facility's mix of cases and their therapy
3 practices, payments would shift from freestanding SNFs to
4 hospital-based SNFs and from for-profit to non-profit SNFs,
5 basically from the highest margin providers to lower margin
6 providers.

7 The rationale for rebasing the SNF PPS is that
8 Medicare margins have been above 10 percent for 15 years
9 and are expected to remain so in 2016. However, the
10 margins vary widely. The 25th and 75th percentiles of the
11 margins illustrate the wide variation. Cost growth in this
12 sector indicates a lack of fiscal pressure.

13 Given the large variation in Medicare margins,
14 taking small steps to rebase payments, is a way to protect
15 low-margin SNFs while the PPS is redesigned.

16 This leads us to the draft recommendation, and it
17 reads, "The Congress should eliminate the market-basket
18 update for 2017 and 2018 and direct the Secretary to revise
19 the prospective payment system for skilled nursing
20 facilities. In 2019, the Secretary should report to the
21 Congress on the effects of the reformed PPS and make any
22 additional adjustments to payments needed to more closely

1 align payments and costs.

2 In terms of implications relative to current law,
3 program spending would decrease from between \$750 million
4 to \$2 billion over one year and between 5- and \$10 billion
5 over 5 years.

6 For beneficiaries, access for medically complex
7 patients will increase.

8 For providers, the recommendation will reduce the
9 disparities in Medicare margins across providers. The
10 impact on individual providers will vary based on their mix
11 of cases and current therapy practices.

12 And with that, I'll turn the discussion back to
13 Jay.

14 DR. CROSSON: Thank you, Carol.

15 Are there any Commissioner questions or comments?

16 [No response.]

17 DR. CROSSON: Seeing none, we'll proceed to the
18 vote. All Commissioners in favor of the draft
19 recommendations, please raise your hand.

20 [Show of hands.]

21 DR. CROSSON: All opposed?

22 [No response.]

1 DR. CROSSON: Abstentions?

2 [No response.]

3 DR. CROSSON: Thank you very much, Carol.

4 [Pause.]

5 DR. CROSSON: And Evan Christman is going to take
6 us through home health services.

7 MR. CHRISTMAN: Good afternoon. Today's slides
8 will summarize the full presentation that we had at the
9 December meeting. There is more detail in the paper
10 provided to you. I would note that the paper includes
11 several revisions.

12 First, Mary, we clarified the discussion of the
13 financial impact of hospital-based home health agencies on
14 their parent institution, and also in the quality section,
15 we added cross-sector measures, we add a discussion of the
16 need for cross-sector measures in home health.

17 Warner, you asked many questions about
18 hospitalization and home health, and we provided more
19 details on the value-based purchasing program that is
20 beginning soon. And we also added information about the
21 common reasons for hospitalization and the relationship
22 between agency size and hospitalization rates.

1 As a reminder, Medicare spent \$17.7 billion on
2 home health services in 2014. There were over 12,000
3 agencies, and the program provided about 6.6 million
4 episodes to 3.4 million beneficiaries.

5 Turning back to our framework, here are the
6 indicators. Beneficiaries had good access to care in most
7 areas. Ninety-nine percent live in an area served by home
8 health, and 82 percent live in an area with five or more
9 agencies operational. The number of agencies is near the
10 all-time high hit in 2013, again, with over 12,400
11 agencies.

12 The number of episodes has declined slightly in
13 recent years, but this comes after several years of rapid
14 growth. Even with this decline in the last few years, the
15 number of episodes in 2014 is 60 percent greater than the
16 level in 2002.

17 Quality measures have not changed significantly
18 in 2014, with functional measures mostly showing small
19 gains while the rate of hospitalization is unchanged.

20 Access to capital is adequate. We continue to
21 see interest in the sector by outside investors with some
22 institutional post-acute firms buying home health agency

1 chains to expand their presence in the sector.

2 The margins for 2014 are projected to equal 10.8
3 percent, with marginal profit estimated to equal 13.3
4 percent, and the estimated margins for 2016 are 8.8
5 percent. I would note that these are average margins, and
6 our review of the quality and financial performance for
7 relatively efficient providers suggests that better-
8 performing agencies can achieve adequate outcomes with
9 profit margins that are significantly higher than other
10 agencies. And I would also note that margins for home
11 health agencies in Medicare have averaged 16 percent a year
12 since 2001.

13 Overall, our indicators are positive, indicating
14 that payments are more than adequate. Because of the
15 positive indicators and the consistently high margins, the
16 Chairman's recommendation is to pursue a rebasing that
17 would better align payments with costs.

18 Now, in addition, we have noted a problem with
19 the incentives with the home health PPS: that it uses the
20 number of therapy visits provided in an episode to set
21 payment. Under the current system, payment increases as
22 the number of visits rises. The Commission and others have

1 noted that this incentive distorts decisions about care,
2 and the higher rate of volume growth for these episodes may
3 reflect financial incentives and not patient needs.

4 As a result, our recommendation will include a
5 clause calling for the end of therapy visits as a payment
6 factor. It would make the system fully prospective by
7 basing payment solely on patient characteristics.
8 Implementing this particular change would be budget
9 neutral. It would move money generally from firms that are
10 more profitable to ones that are less profitable. In
11 practice, this means higher payments for nonprofits and
12 hospital-based agencies and lower payments for freestanding
13 and for-profit agencies.

14 Since our indicators were positive, the Chairman
15 has proposed that we recommend no update for 2017 and
16 further rebasing. The recommendation also includes the
17 clause I noted. It reads: The Congress should direct the
18 Secretary to eliminate the payment update for 2017 and
19 implement a two-year rebasing of the payment system
20 beginning in 2018. The Congress should direct the
21 Secretary to revise the PPS to eliminate the use of therapy
22 visits as a factor in payment determinations concurrent

1 with rebasing.

2 This change would have the impact of lowering
3 spending relative to current law by \$250 to \$750 million in
4 2017 and \$5 to \$10 billion over five years. The impact to
5 beneficiaries should be limited, and it should not affect
6 provider willingness to serve beneficiaries. And, again,
7 eliminating therapy as a payment factor would be budget
8 neutral in aggregate but redistributive among providers, as
9 I mentioned previously.

10 This completes my presentation, and I look
11 forward to your questions.

12 DR. CROSSON: Thank you.

13 Any Commissioner, questions or comments?

14 [No response.]

15 DR. CROSSON: Seeing none, we will proceed to the
16 vote. All in favor of the draft recommendation, please
17 raise your hand.

18 [Show of hands.]

19 DR. CROSSON: All opposed?

20 [No response.]

21 DR. CROSSON: Abstentions?

22 [No response.]

1 DR. CROSSON: Evan, thank you very much.

2 Now we have Kim Neuman, who's going to talk to us
3 about hospice services.

4 MS. NEUMAN: I'm going to summarize the
5 indicators of hospice payment adequacy that we discussed in
6 December and that are described in detail in your mailing
7 materials. Included in those materials are responses to
8 your questions from the December meeting.

9 For example, for Bill Gradison, we added
10 information on hospice use for the under age 65 population
11 and the share of hospice days paid by Medicare.

12 So first a couple facts about hospice in 2014.

13 In 2014, more than 1.3 million Medicare
14 beneficiaries used hospice, and over 4,000 hospice
15 providers furnished care to those beneficiaries, and
16 Medicare paid those providers about \$15 billion.

17 Looking at our indicators of payment adequacy,
18 first, indicators of access to care are favorable. The
19 supply of hospice providers continues to grow, increasing
20 more than 4 percent in 2014. For-profit providers account
21 almost entirely for the growth.

22 Hospice use also increased. About 47.8 percent

1 of Medicare decedents used hospice in 2014, up from 47.3
2 percent in 2013. Average length of stay held steady in
3 2014.

4 Different from most other sectors, we do not have
5 quality data to examine for hospice providers currently.

6 In terms of access to capital, the continued
7 growth in the number of providers suggests capital is
8 accessible.

9 This brings us to margins. As you'll recall, our
10 margin estimates assume cap overpayments are fully returned
11 to the government and exclude nonreimbursable bereavement
12 and volunteer costs.

13 For 2013, we estimate an aggregate Medicare
14 margin of 8.6 percent and a rate of marginal profit of
15 about 12 percent. For 2016, we project an aggregate
16 Medicare margin of 7.7 percent. This projection includes
17 the effect of the sequester.

18 So this brings us to the draft recommendation.
19 It reads: The Congress should eliminate the update to the
20 hospice payment rates for fiscal year 2017.

21 The implications of this recommendation are a
22 decrease in spending relative to the statutory update of

1 between \$250 million and \$750 million over one year, and
2 between \$1 and \$5 billion over five years.

3 In terms of beneficiaries and providers, we do
4 not expect an adverse impact on beneficiaries, nor do we
5 expect any effect on providers' willingness or ability to
6 care for Medicare beneficiaries.

7 So that concludes my presentation, and I turn it
8 back to Jay.

9 DR. CROSSON: Thank you, Kim.

10 MR. ARMSTRONG: Just a quick question. On Slide
11 2, to make sure I get this, so this says that of all
12 Medicare beneficiaries who passed away in 2014, 47.8
13 percent were in the hospice program. Is that correct?

14 MS. NEUMAN: Yes.

15 MR. ARMSTRONG: And that number, is it going up?
16 And do we have a sense for like where we think we would
17 want that to get to?

18 MS. NEUMAN: So that number has been going up.
19 In your paper, there's a chart that shows the trend -- it's
20 toward the beginning. In 2000, that figure was about 23
21 percent, and now we're up to nearly 48 percent. So it has
22 been a pretty big climb.

1 In terms of where that number might go, it's hard
2 to say. We do know that there is variation across states
3 in hospice use rates, and we have some states that are in
4 the 60 range. So, you know, it's difficult to predict.
5 But, you know, we see it that level at least in some
6 places.

7 DR. MILLER: And, also, I think we've done some
8 analysis broken down by categories of beneficiaries, and it
9 appears to be going up pretty uniformly across categories,
10 like SES, that type of thing.

11 MS. NEUMAN: It's been going up across almost all
12 categories that we've looked at. That chart in the report
13 kind of shows those growth rates.

14 You know, we've seen a few categories where there
15 has been more rapid growth, so the over-85 population is
16 notable, for example, for quite rapid growth. But it has
17 been growing across all groups.

18 MR. ARMSTRONG: Just reflecting briefly on
19 somewhere in our travels, we're talking about hospice
20 benefit being covered within MA plan benefits. And I know
21 there are a lot of good reasons to want to see that go up,
22 but -- and I'm not concerned that this payment decision

1 will have any impact on the future growth rate, but it's
2 just something for us just to keep in mind as we make this
3 decision.

4 MS. UCCELLO: I had a similar question several
5 years ago, and I remember I asked it somewhat differently,
6 and I think I asked you to look at it by a cause of death
7 kind of situation to see kind of where we could cap off on
8 this, because certain causes of death would not lend
9 themselves to this. So is there kind of a natural plateau
10 that we would be reaching?

11 MS. NEUMAN: I think that is true. There's
12 certain deaths that are going to be unexpected that you
13 would not anticipate hospice use and sort of how to
14 quantify how much of that is difficult.

15 DR. CROSSON: And, parenthetically, I think
16 another issue that we have discussed -- and I think there's
17 a lack of clarity as well -- is as to when and how long the
18 -- when entering in the course of a terminal illness and
19 how long the ideal involvement in hospice is as well.

20 MS. BUTO: And I don't expect us to have this
21 data necessarily, but do we have any data in those areas
22 where there is a rapid growth in hospice or greater

1 penetration, I guess, of hospice of whether there is an
2 association with hospitalizations of those disease
3 categories going down? Is there any impact -- when it was
4 initially implemented, there was a notion that there would
5 be a reduction in some of the more intensive costs related
6 to end of life, and I'm wondering if anyone has done an
7 assessment of that relationship. Do you know?

8 MS. NEUMAN: So are you asking about sort of
9 hospice's impact on certain kinds of services? Or are you
10 asking about its impact on overall costs?

11 MS. BUTO: I was thinking of inpatient hospital
12 in particular. I would think that would be the easiest to
13 quantify whether, say, deaths related to, you know, Stage V
14 cancer in certain categories, if we are seeing a growth in
15 the use of hospice for those patients, whether you'd see a
16 decline in inpatient admissions related to that. But I'm
17 guessing if anyone has done that, it was done by a research
18 institution. It wouldn't be necessarily our job. That
19 association or relationship is helpful in thinking about
20 your question, which is where we want to go with hospice.
21 Is it a cost-effective alternative or is it just another
22 add-on service to what's already going on?

1 DR. MILLER: So I think what we're going to say,
2 Kim, is, funny you should ask, right? We did actually do
3 some work on this. I'm trying to look at Kim and Jim, who
4 are mostly not making eye contact right now, which is
5 pretty much how it goes. We did some outside work with a
6 contractor because this question -- I mean, this is a
7 perennial question, and there are very strong statements,
8 and there are studies out there that, depending on the
9 methodology, say one thing and a different methodology say
10 different things.

11 So we took a pretty hard look at this. I'm not
12 in a swamp here, right? We're trying to find a place on
13 the schedule to bring it back into play, so I'm actually
14 glad that you asked it because it's an incredibly relevant
15 question, and we think we've -- Kim has worked with some
16 outside folks to do some really good work, and we're going
17 to try and bring that back, and then one quick bonus, at no
18 extra charge.

19 The other thing is, remember, in the MA world, MA
20 actually uses hospice at -- I think I have this right -- a
21 slightly higher rate than fee-for-service sector. I wasn't
22 going to tag on, but as long as I'm in, I'm going to --

1 [off microphone] so we'll have something for you.

2 MR. THOMAS: Just a clarifying question, or a
3 question on the slide that shows the potential impact. It
4 seems like the spread, you know, given the size of the
5 dollars, is pretty large. Because I think we're talking
6 about \$15 billion in total spend, is that right? Over, you
7 know -- thinking about getting up to a \$5 billion impact
8 over five years, it's a pretty large impact. I know that
9 probably the total costs are escalating, but do you have
10 any comment on that?

11 MS. NEUMAN: So we use standard categories to
12 report the impacts, and so the impact for hospice falls in
13 this category of \$1 to \$5 billion. You would not expect it
14 to be \$5 billion. You would expect it to be closer to the
15 lower end of that range. But we all report using the same
16 categories, and so that's why you see that.

17 DR. MILLER: And the long history on that,
18 Warner, which you would have no reason to know -- and for
19 any other Commissioner who hasn't refreshed their memory on
20 this recently -- we're required by law, when we make
21 recommendations, to basically demonstrate that -- I can't
22 even remember the language, but report an awareness of the

1 fiscal impact of what we're doing so that there isn't just
2 sort of this notion of, hey, do this, do that, and no sense
3 of, you know, the budgetary impact.

4 At the same time, we have to be very conscious of
5 the fact that there's two houses in Washington who do
6 official estimates -- the Office of the Actuary and the
7 Congressional Budget Office -- and this is not an
8 estimation operation. So what we do is we do these broad
9 estimates, get CBO to bless them, and then put up these
10 categories so that we're not doing estimates like CBO, but
11 we have done our job with respect to Congress that we are
12 aware of these budgetary impacts. And if somebody wants a
13 point estimate on that proposal, they ask CBO for the exact
14 number, and her answer is exactly right. For this set of
15 spending, you're much more likely at the low ends of those
16 buckets. And it's just a way to institutionally get our
17 job done and not cross lanes with another institution.

18 DR. CROSSON: Other questions or comments?

19 [No response.]

20 DR. CROSSON: Seeing none, we'll proceed with the
21 vote. All Commissioners in favor of the draft
22 recommendation, please raise your hand.

1 [Show of hands.]

2 DR. CROSSON: All opposed?

3 [No response.]

4 DR. CROSSON: Abstentions?

5 [No response.]

6 DR. CROSSON: Thank you, Kim.

7 [Pause.]

8 DR. CROSSON: And, finally, Stephanie Cameron is
9 going to present us the recommendation for long-term care
10 hospital services.

11 MS. CAMERON: Good afternoon. Last month, we
12 presented the findings from our payment adequacy analysis
13 for LTCHs. Before we begin the summary of last month's
14 presentation, Alice, you had asked how moving the patient-
15 specific criteria from a three-day ICU stay to an eight-day
16 ICU stay would alter the type of cases seen in LTCHs.
17 You'll remember that in 2014, about two-thirds of all LTCH
18 cases were classified into 25 MS-DRGs and that adding the
19 three-day ICU criteria increased the concentration of cases
20 within the top 25 MS-DRGs to just under 80 percent.

21 In response to your inquiry, we found that an
22 eight-day ICU criteria would result in about 85 percent of

1 cases classified within 25 MS-DRGs. We further found that
2 40 percent of these cases were classified into vent-related
3 groups, while two percent were classified into wound-
4 related groups.

5 Now, moving to our review of last month's
6 presentation and a summary of some background information
7 that was included in your mailing materials. You'll recall
8 that to qualify as an LTCH under Medicare, a facility must
9 meet Medicare's conditions of participation for acute care
10 hospitals and have an average Medicare length of stay of
11 greater than 25 days. Medicare pays LTCHs on a per
12 discharge basis with an upwards adjustment for cases with
13 extraordinarily high costs and a downward payment
14 adjustment for cases with extremely short lengths of stay.
15 The average Medicare payment in 2014 to LTCHs was over
16 \$40,000.

17 As we discussed in December, beginning this year,
18 an LTCH discharge must meet several criteria to qualify to
19 receive the full LTCH payment rate. First, the case must
20 not have a principal diagnosis relating to a psychiatric
21 diagnosis or to rehabilitation.

22 Second, the LTCH admission must be immediately

1 preceded by an acute care hospital stay.

2 Third, the discharge either needs to have three
3 or more days in the referring hospital's ICU or receive an
4 LTCH principal diagnosis that includes prolonged mechanical
5 ventilation.

6 Discharges that don't meet these criteria will
7 receive a site-neutral payment equal to the lesser of an
8 IPPS comparable rate or 100 percent of costs. The
9 implementation of this policy results in a high degree of
10 uncertainty regarding the changes in admission patterns and
11 per case cost.

12 As you'll recall, the criteria to qualify for the
13 full LTCH standard payment rate are consistent with the
14 direction of the Commission's 2014 and 2015 recommendation
15 for chronically critically ill beneficiaries.

16 Moving to a summary of our payment adequacy
17 analysis, we first look at access to LTCH services.
18 Remember that many beneficiaries live in areas without
19 LTCHs and receive similar services in other settings with
20 few apparent differences in quality or outcomes. Remember,
21 too, that the Congress imposed a moratorium on building new
22 or expanding current LTCHs from 2008 through 2012 and again

1 beginning on April 1, 2014, through September 30, 2017. We
2 found little change in the payment per case between 2013
3 and 2014, and while we found a 2.6 percent decrease in the
4 number of LTCH cases per capita, this is consistent with
5 volume reductions in other inpatient settings.

6 Next, we consider changes in quality. We lack
7 patient assessment data in this area and there are no
8 available quality measures to analyze, so we rely on
9 aggregate mortality and readmission rates. Since 2010,
10 these measures have been stable or improving.

11 When we considered access to capital, we found
12 that the moratorium has reduced opportunities for expansion
13 and, thus, the need for capital.

14 As we discussed last month, the reduction in cost
15 growth between 2013 and 2014 resulted in a 2014 aggregate
16 Medicare margin for all cases of 4.9 percent, while the
17 marginal profit, which assesses whether providers have a
18 financial incentive to expand the number of Medicare
19 beneficiaries they serve, was 20 percent.

20 Because of the implementation of the new payment
21 policy I previously discussed, we also calculated a pro
22 forma margin that includes only cases that would have

1 qualified to receive the full LTCH standard payment rate.
2 Using the most recently available claims data combined with
3 the revenue center specific cost-to-charge ratios for each
4 LTCH, we calculated this margin to be 7.4 percent in 2017.
5 Looking ahead, we project that the LTCH margin will decline
6 in 2016. Updates to payments were reduced by PPACA-
7 mandated adjustments in 2015 and 2016 and by a budget
8 neutrality adjustment in 2015.

9 We expect cost growth to be higher than current
10 law payments for the qualifying cases. Using the projected
11 growth in the LTCH market basket and taking into account
12 the uncertainties that I had previously mentioned, we
13 project that the LTCH Medicare margin for qualifying cases
14 will be between 3.3 percent and 5.9 percent in 2016.

15 Since this margin projection range reflects only
16 cases that would qualify to receive the full standard
17 payment amount, the total aggregate Medicare margin could
18 differ from these estimates to the extent that providers
19 continue to provide care to beneficiaries who do not
20 qualify to receive the full LTCH standard payment rate.

21 We make our recommendation to the Secretary
22 because there is no legislated update to the LTCH PPS. The

1 draft recommendation reads, "The Secretary should eliminate
2 the update to the payment rates for long-term care
3 hospitals for fiscal year 2017."

4 CMS has historically used the market basket as a
5 starting point for establishing updates to LTCH payments.
6 Thus, eliminating the update for 2016 will reduce spending
7 relative to the expected regulatory update by between \$50
8 and \$250 million in 2017 and by less than \$1 billion over
9 five years. We anticipate that LTCHs can continue to
10 provide Medicare beneficiaries with access to safe and
11 effective care and accommodate changes in cost with no
12 update to the payment rates for cases in LTCHs in fiscal
13 year 2017.

14 With that, I turn it over to you.

15 DR. CROSSON: Thank you, Stephanie.

16 Any Commissioner questions or comments?

17 [No response.]

18 DR. CROSSON: Seeing none, we'll proceed to the
19 vote. All Commissioners in favor of the draft
20 recommendation, please raise your hand.

21 [Show of hands.]

22 DR. CROSSON: All opposed.

1 [No response.]

2 DR. CROSSON: Abstentions.

3 [No response.]

4 DR. CROSSON: Thank you very much, Stephanie.

5 That concludes the expedited voting process for
6 this afternoon.

7 Now, we will move to the regular order, if that's
8 the right term, and we have two additional areas to discuss
9 this afternoon. We're going to start with the last of our
10 payment update recommendations, as well as some other
11 issues related to inpatient rehabilitation facilities, and
12 Dana Kelley is going to take us through this set of
13 questions and issues.

14 MS. KELLEY: Okay. Good afternoon. Last month,
15 the Commission discussed the findings from two analyses of
16 inpatient rehab facilities, our update analysis, and our
17 analysis of IRF case mix and coding patterns. Today, we'll
18 review those findings and then consider three draft
19 recommendations.

20 This slide summarizes the findings from our
21 update analysis. Overall, our indicators of payment
22 adequacy are positive. We looked first at access to IRF

1 services. Between 2013 and 2014, the supply of IRFs
2 remained fairly steady and the number of IRF discharges was
3 stable. The average IRF occupancy rate was about 64
4 percent, indicating that capacity was more than adequate to
5 handle current demand for services.

6 Next, we considered changes to quality -- or
7 changes in quality. We looked at risk-adjusted measures of
8 patient improvement in motor function and cognition as well
9 as discharge to the community and to SNFs and readmission
10 to the acute care hospital. These measures have been
11 stable.

12 We then considered access to capital. Hospital-
13 based IRFs have good access to capital through their parent
14 institutions. Large chains also have very good access to
15 capital. We were not able to determine the ability of
16 other freestanding facilities to raise capital.

17 Finally, the aggregate 2014 margin was 12.5
18 percent, up from 11.6 percent in 2013. Marginal profit in
19 2014 was 30.4 percent. Our projected margin for 2016 is
20 13.9 percent. You'll note that the projected margin is
21 higher than the 2014 margin. This is because we expect
22 that payment increases will continue to exceed cost growth.

1 Overall, we think, in aggregate, margins are sufficient to
2 cover the costs of care.

3 This brings us to our first draft recommendation.
4 It reads, "The Congress should eliminate the update to the
5 payment rate for inpatient rehabilitation facilities for
6 fiscal year 2017."

7 Eliminating the update for 2017 will reduce
8 spending relative to the expected statutory update. We
9 don't anticipate that this recommendation would have any
10 adverse impact on providers' willingness and ability to
11 care for patients or on beneficiaries' access to care.

12 Last month, we discussed some concerns we have
13 about the IRF PPS. As you have seen, the aggregate margin
14 is high and projected to increase. This situation often
15 prompts discussion of the need for rebasing. However,
16 profitability in this industry is highly concentrated. In
17 2014, hospital-based IRFs had an aggregate margin of one
18 percent, while freestanding IRFs had an aggregate margin of
19 25.3 percent. Freestanding IRFs have lower costs, on
20 average, than hospital-based IRFs do. That may be because
21 freestanding IRFs are more efficient, but we worry that
22 patient selection and coding may be a factor.

1 Our analysis showed that high-margin IRFs have a
2 different mix of cases than other IRFs do. As you'll
3 recall, in our analysis, we sorted IRFs into five equal-
4 sized groups or quintiles based on their margins. The IRFs
5 in quintile five have the highest margins, while those in
6 quintile one have the lowest margins. There are both
7 hospital-based and freestanding IRFs in every quintile,
8 although quintile one is predominately hospital-based.

9 As you can see, the shares of cases with stroke
10 and neurological disorders varied across the margin
11 quintiles. Looking at the red bars, IRFs with the highest
12 margins have a smaller share of stroke cases. Perhaps more
13 striking, they have a much larger share of cases with
14 neurological disorders, shown here in green.

15 We also found differences across the margin
16 quintiles in the types of stroke and neurological disorder
17 cases that were admitted. IRFs with the highest margins
18 take many more stroke cases with no paralysis. They also
19 take many more neurological cases with neuromuscular
20 disorders, such as ALS and muscular dystrophy.

21 We also noted some interesting patterns of coding
22 in IRFs. When we looked at IRF patients' preceding acute

1 care hospital claims, we found that patients in high-margin
2 IRFs appeared to be less severely ill during their
3 preceding hospital stay compared with patients in low-
4 margin IRFs. High-margin IRFs cared for patients who had a
5 lower average hospital case mix index. Their patients were
6 less likely to have been in an ICU or a CCU, and patients
7 who had been in an ICU had shorter stays there, on average,
8 than patients in low-margin IRFs. Patients in high-margin
9 IRFs were also less likely to have been high-cost outliers
10 during their preceding hospital stay.

11 But once patients were admitted to and assessed
12 by IRFs, the patient profile changed, with patients in
13 high-margin IRFs appearing to be more impaired, on average.
14 Patients in high-margin IRFs had lower motor and cognition
15 scores, indicating greater impairment. These lower scores
16 generally increase payment. We saw this pattern across all
17 the impairment group categories that we examined. In fact,
18 we found that at any level of patient severity as measured
19 in the acute care hospital, patients in high-margin IRFs
20 were coded with greater impairment.

21 You saw a slide similar to this last month. It
22 illustrates the kinds of differences in coding that we are

1 seeing. Here, we're looking at average motor function
2 scores at IRF admission for patients with two types of
3 stroke, stroke with paralysis and stroke without paralysis.
4 For ease of reading, I've removed the middle quintiles to
5 show motor scores only for the lowest-margin quintile and
6 the highest-margin quintile.

7 We would expect stroke patients without paralysis
8 to have better motor function scores than patients with
9 paralysis, and if we look down the columns, that's exactly
10 what we see here. If you look in the middle column, for
11 the lowest-margin IRFs, you can see that patients with
12 paralysis have, on average, a lower motor function score,
13 29.2, than patients without paralysis, 35.3. The lower
14 motor score of 29.2 indicates a lower level of motor
15 function and generally increases payment. We see the same
16 in the right-hand column for the highest-margin IRFs.
17 Stroke patients with paralysis have a lower motor score,
18 24.6, than patients without paralysis. In part because of
19 this lower level of motor function across all IRFs, stroke
20 patients with paralysis have IRF lengths of stays that are
21 two days longer, on average, than stroke patients without
22 paralysis.

1 But, we also see something unexpected in this
2 chart. In the highest-margin IRFs, the average motor score
3 for stroke patients without paralysis is 29.0. This is
4 almost exactly the same as the average motor score for
5 patients with paralysis in the lowest-margin IRFs. All
6 else equal, the payment for these two cases with a motor
7 score of 29 would be the same.

8 Kate, last month, you asked about differences in
9 quality of care across the margin groups. This slide shows
10 the average risk-adjusted readmission rates and rates of
11 discharge to the community and to SNF. For ease of
12 reading, again, just the highest- and lowest-margin
13 quintiles are shown here. Generally, the differences
14 across the margin groups are small. Compared with the
15 highest-margin IRFs, IRFs with the lowest margins do a bit
16 better, on average, on potentially avoidable readmissions
17 and on discharge to the community, but a bit worse on rate
18 of discharge to SNFs.

19 Our findings suggest that coding practices may be
20 contributing to greater profitability in some IRFs. Some
21 IRFs may be overstating the extent to which patients are
22 functionally and cognitively impaired, resulting in

1 payments that are higher than warranted.

2 To protect beneficiaries and taxpayers, Medicare
3 must ensure that IRFs' coding accurately reflects patients'
4 resource needs. Review of medical records merged with IRF
5 patient assessment data would help CMS assess coding
6 accuracy. Because such review are resource intensive,
7 medical record review should focus on providers that have
8 an atypical mix of cases or anomalous patterns of coding.

9 This brings us to our second draft
10 recommendation, which reads, "The Secretary should conduct
11 focused medical record review of inpatient rehabilitation
12 facilities that have unusual patterns of case mix and
13 coding."

14 Implementing this recommendation would reduce
15 Medicare's spending on IRF services if unjustified coding
16 activities were discovered. CMS would incur some
17 administrative expenses to conduct these activities. We do
18 not expect this recommendation to have adverse effects on
19 Medicare beneficiaries with respect to access to care or
20 out-of-pocket spending, or on providers' willingness and
21 ability to care for Medicare beneficiaries.

22 Our finding that some IRFs may systematically be

1 selecting certain types of cases suggests that the IRF case
2 mix groups may not be adequately capturing differences in
3 patient acuity and costs across cases and providers. Some
4 providers may be selecting certain types of patients
5 because their conditions are more amenable to upcoding or
6 because some conditions are more profitable to treat than
7 others.

8 Research is needed to assess variation in costs
9 within the IRF case mix groups and differences in relative
10 profitability across case mix groups. Identifying and
11 reducing variation within case mix groups and properly
12 calibrating payments with costs for each group is necessary
13 to avoid overpayments and to reduce incentives for
14 providers to admit certain types of cases and avoid others.

15 Ultimately, payment system reforms and rebasing
16 of IRF payments may be necessary to help protect the long-
17 run sustainability of the Medicare program.

18 In the near term, CMS could redistribute payments
19 within the IRF PPS by expanding the outlier pool. This
20 would better align IRF payments and costs by increasing
21 payments for the most costly cases. To maintain budget
22 neutrality, the expanded outlier pool would be funded by

1 reducing the base payment amount for all IRF cases.

2 In the interest of time, I won't go into details
3 about how the IRF outlier policy works, but the specifics
4 are outlined in your paper, summarized on the slide here,
5 and I'm happy to take questions about it.

6 Increasing the outlier pool from its current
7 level of three percent of total payments would shift
8 payments across case types. We estimate that total
9 payments would increase for cases with brain and spinal
10 cord injury and for cases with stroke. Total payments
11 would decrease for cases with neurological disorders and
12 for orthopedic cases, such as hip fracture and major joint
13 replacement.

14 Increasing the outlier pool would also shift
15 payments across providers. We estimate that total payments
16 would increase for hospital-based IRFs, nonprofit IRFs, and
17 low-margin IRFs. Rural IRFs would also see a slight
18 increase in payment. Total payments would decrease for
19 freestanding IRFs, for-profit IRFs, and high-margin IRFs.

20 We note that this recommendation would be a
21 short-term fix and that it could potentially have a
22 downside. By expanding the outlier pool, Medicare may

1 increase payments for providers who are less efficient as
2 well as for providers who care for patients whose acuity is
3 not well captured by the case mix system. While this
4 outcome is not desirable, our concern about the accuracy of
5 Medicare's payments may warrant this approach in the near
6 term. Over the longer term, as I noted, CMS must take
7 steps to ensure the accuracy of its payments.

8 This brings us to our final draft recommendation.
9 It reads, "The Secretary should expand the inpatient
10 rehabilitation facility outlier pool to redistribute
11 payments more equitably across cases and providers."

12 This recommendation would be implemented in a
13 budget neutral manner and should not have an overall impact
14 on spending. We do not expect this recommendation would
15 have adverse effects on Medicare beneficiaries with respect
16 to access to care or out-of-pocket spending. We do expect
17 this recommendation will reduce payments for some providers
18 and increase payments for others. It may also improve
19 equity among providers by diminishing the effects of
20 inappropriate coding.

21 That concludes my presentation. I've listed the
22 draft recommendations for your consideration here, and I'm

1 happy to take any questions.

2 DR. CROSSON: Thank you very much, Dana.

3 We'll start off with clarifying questions, and
4 we'll take all the -- the entire presentation and all the
5 recommendations for the purpose of clarifying questions.
6 Herb.

7 MR. KUHN: So, Dana, on this last issue on the
8 outlier pool, two questions on that. One, has the outlier
9 pool been stable at three percent for the last several
10 years, or does it move like the inpatient hospital, where
11 it could be three percent one year and they project maybe
12 five percent the next year or some variation?

13 MS. KELLEY: There's been some movement over the
14 last few years. CMS has over the last four years reduced
15 the fixed loss about each year to maintain a three percent
16 pool.

17 MR. KUHN: Okay. And, in your presentation, you
18 mentioned how it was maybe the coding was causing some of
19 these issues and, thus, triggering this recommendation.
20 But, could it also be, not so much coding, but could we see
21 some major changes by some chagemasters, by some of the
22 IRFs?

1 MS. KELLEY: We could, and that's something we
2 will look into more in the future, I think. The other
3 thing that could be going on is that, overall, for the
4 entire system, over time, the distribution of costs could
5 be narrowing. The tail end could be coming in somewhat, so
6 that for overall, the financial risk in caring for IRF
7 patients may be declining. That might not be true for
8 certain providers within the system.

9 MR. KUHN: But, then, if it were part of it, say
10 not the whole thing, but part of the issue were some
11 changes in charges, if we expanded the outlier pool,
12 wouldn't that be an incentive for more people to raise
13 their charges to capture more outlier payments?

14 DR. MILLER: Yeah. I mean, I thought -- first of
15 all, I want to just repeat what Dana said. Whether
16 somebody's an outlier is a function of two things. They
17 could be an inefficient operation and have high costs and
18 find themselves in the outlier pool more often, and that's
19 why this policy is kind of a rough justice thing.

20 The other is that they could have sicker
21 patients, but because of the coding practices, when they
22 should be getting payments from the outlier pool, they're

1 not, and so the outlier pool would be some rough justice.

2 Now, the charging thing, you guys' conversation
3 is throwing me a little bit, but what we're talking about
4 in the end are cost-to-charge ratios, because this is
5 reduced to cost for the purposes of determining whether you
6 exceed a threshold. So, you can engage in that kind of
7 behavior, but it doesn't -- it's going to -- if not
8 immediately, it is going to balance itself out in the math
9 of the calculation of the cost that ends up exceeding the
10 threshold.

11 MR. KUHN: Yeah, I hear what you're saying. I
12 guess what I'm trying to reflect on, I guess it was back in
13 the 1990s where we saw --

14 DR. MILLER: I thought you were going to say that
15 --

16 [Laughter.]

17 MR. KUHN: Yeah, as we saw some activity by a
18 particular consultant or consultants that got a bunch of
19 hospitals to improve --

20 DR. MILLER: That was -- there was a difference -
21 -

22 MR. KUHN: And that's what I'm curious.

1 DR. MILLER: Okay.

2 MR. KUHN: Is there a distinction there?

3 DR. MILLER: And I was wondering if that was in
4 your head, and here -- the difference here, and I'm making
5 line of sight on two of you behind him, right --

6 [Laughter.]

7 MR. KUHN: Sorry, guys.

8 DR. MILLER: The difference there was is there
9 was some averaging that they were using, right? It wasn't
10 so much that their own charges, and I'm not sure I can --

11 MR. LISK: [Off microphone.] It was the state.

12 DR. MILLER: -- it was a state -- right. There
13 was another piece of this that wasn't -- like, if you were
14 just in your own hospitals and you jacked your charges up,
15 the system would kind of correct behind you. But there was
16 a state average that came into play in the 1990s that they
17 were gaming that had to be cleaned out, and that was on the
18 hospital side, although I'm not sure I could explain the
19 exact calculation.

20 MR. KUHN: Well, that's helpful, just to know
21 that there's a distinction. And then, also, what was it,
22 six, seven years ago, we also had kind of a charge

1 phenomena in the home health space. Is this anything
2 similar to that, and is there any kind of relationship to
3 that?

4 DR. MILLER: If you give me some latitude, let me
5 --

6 MR. KUHN: Okay.

7 DR. MILLER: -- pin Evan down on that. I'm not
8 sure I could answer that.

9 MR. KUHN: And then, I guess, the -- and, so,
10 this is something to think through. This has been helpful
11 to kind of understand that distinction.

12 I guess the final thing, when Justin Hunter got
13 up during the first -- during this morning and made his
14 comments preparatory to this conversation, he had mentioned
15 that some providers, at least based on their analysis, were
16 getting more than 20 percent of their payments from
17 outliers. It seems kind of excessive. Is that a concern,
18 or I'm just curious, your thoughts on that.

19 MS. KELLEY: I think that given some of the
20 patterns we're seeing in the data, our concerns were more
21 on the side of people caring for more costly cases,
22 selection going on in certain facilities, and that that was

1 outweighing our concern about the distribution of outlier
2 payments currently.

3 DR. MILLER: [Off microphone.] And that is what
4 I would have said, too, and by and large, I think you're
5 right, and we've looked at other circumstances over history
6 where something seems to get distorted and a small set of
7 providers are extracting a lot of outlier payments, like
8 the phenomenon that you were talking about, and that's not
9 a good outcome, either.

10 I think -- you know, I really want to make the
11 point here, this is kind of a balancing type of
12 recommendation. There's bigger issues, we think, in the
13 system. We just can't quite put our hands on them yet, on
14 the coding side and on the kind of distribution -- or on
15 the coding side and what cases are being selected into
16 which providers.

17 DR. CROSSON: Alice.

18 DR. COOMBS: Thank you, Dana. I really like the
19 Slide 8. It's very persuasive and compelling.

20 One of the things I had to ask is, you know, the
21 industry has really contracted and I'm wondering if
22 something else is at work with the coding with certain

1 providers in this area in terms of IT, like the purchasing
2 of a new system is much more aggressive at coding than some
3 of the other systems, and I don't want to give names in
4 public, but some of them have decision software that
5 actually helps the provider so that they can actually tease
6 out codes that maybe it's a little bit more aggressive.
7 And I'm wondering if there's something else at work here.

8 But, I think Slide 8 tells us what the real deal
9 is. I think you did a fabulous job with the chapter.

10 But, I'm wondering, because this industry is so
11 constricted that a provider has such a large market share,
12 that provider may have something purchased during a time
13 frame that when you start comparing them with others, that
14 that may be a key reason why the coding is off somewhat.

15 MS. KELLEY: That certainly could be going on. I
16 think we do see a concentration of high margins in a
17 relatively small number of facilities, so that could be
18 some sharing of information that way.

19 What's interesting is when Justin Hunter was
20 speaking earlier, referring to a paper that they had
21 commissioned, you know, one of the things the paper
22 discussed -- and we got it yesterday, so we haven't had

1 time to fully assess it -- but one of the issues discussed
2 in the paper was that they believe that some of these
3 facilities, some of the higher-margin facilities are just
4 much more accurate in their coding, that they have better
5 training for their assessors and that their assessment is
6 just -- is done more accurately.

7 And, without judging whether or not that's an
8 accurate statement, if that were true, I think we would see
9 that same kind of accurate, more complete coding that can
10 result in higher payments, or higher case mix, I think we'd
11 see that at both admission and discharge. I'm not sure --
12 we've done most of our analysis on admission coding, but my
13 preliminary look at discharge coding suggests that it
14 doesn't quite look that way on the discharge side. So,
15 that's something we're also going to be looking into more
16 in the future.

17 DR. COOMBS: And one other thing -- and Herb kind
18 of alluded to it -- is that if you do -- I'm looking at the
19 recommendations. You do one versus the other. I mean, how
20 sure are we that all of the recommendations will go as a
21 family of recommendations that will be recognized? Because
22 if you do one without the other, if you're very aggressive

1 at pursuing the recommendation around coding or you don't
2 do the coding and you do the outlier, then it could have a
3 very skewed effect in terms of what happens with the
4 budget.

5 MS. KELLEY: Well, I think regardless of what the
6 Secretary does, I think this is an issue we continue to --
7 we intend to continue exploring, so hopefully, if we
8 continue to look into this and try and figure out what's
9 going on here, that will help move things along if the
10 Secretary were not inclined to take one of our
11 recommendations.

12 DR. MILLER: And I'm fine with everything you
13 said.

14 I'm not sure I see the vast distortion. I mean,
15 this is always an issue, and actually, we've had this
16 conversation in other settings, like will the Secretary
17 take it up, take up all of it. I'm not sure I see a vast
18 distortion if one thing occur but not the other. Ideally,
19 she would do both.

20 I think the coding oversight would give insight
21 into is it just accuracy or is there patient selection and
22 certain bias or certain decision tools that help things to

1 happen, which would also then point people like us and CMS
2 back to the payment system about how to develop the coding
3 and the categories to try to avoid that. It also could end
4 up with just some straight editing and things that happen
5 when the claims are submitted.

6 But I think any one of these in isolation would
7 probably be a step forward, although we do think both of
8 these need to happen. But I don't think if one happened
9 and not the other, there's some untoward outcome, but maybe
10 you --

11 DR. COOMBS: Well, I disagree because I think
12 that if you don't do the coding and you just did the
13 outlier piece, that could actually more disadvantage the
14 poor coder, if you will, or the person that doesn't code to
15 the extent that a more robust system might, so that could
16 actually handicap them further because they don't have
17 access to maybe the decision tools, and maybe the other
18 system is -- maybe there is selection going on.

19 DR. MILLER: I'll leave this here.

20 [Speaking off microphone]

21 Evan, there was a question from Herb.

22 MR. KUHN: Evan, we were looking at the outlier

1 recommendation here, talking about the outlier issues that
2 occurred on the IPPS issue back in the '90s, and I thought
3 there was an outlier issue with home health about seven or
4 eight years ago that CMS had to move into correct. I was
5 just curious about the background there and is there any
6 learnings from that, that could help influence or help give
7 us direction of what we're doing here.

8 MR. CHRISTMAN: Right, Herb. That's exactly
9 right.

10 Between 2005 and 2008, last year roughly, the
11 number of outlier cases shot up significantly, and it was
12 tracked to really an explosion in outlier cases in certain
13 parts of the country like Miami. And I believe that home
14 health outlier is a little different than the rest of the
15 PPSs in that they don't use cost ratios and things like
16 that. They compute the cost to the episode using some
17 standardized cost factors, and the supposition was that
18 agencies were making money on outlier cases by either just
19 flat out not providing visits and therefore not actually
20 incurring the costs or being able to provide visits for
21 less than the amount that was assumed in the standardized
22 cost factor CMS was using when it was computing outliers.

1 So they did two or three things. One, they put
2 in an agency-level cap that said that no more than 10
3 percent of your payments in a year may come from outlier
4 add-ons.

5 The second thing they did is they lowered -- they
6 just shrunk the size of the pool. They cut the pool in
7 half to 2.5 percent of payments, and I think those were
8 sort of the main things that come to mind.

9 My understanding of the IRF payment system is
10 relatively shallow, but as I recall, it has the standard
11 cost-to-charge ratios and things like that. So, depending
12 on where the gaming is going on, I'm not sure that the home
13 health situation is directly analogous. I think there was
14 a strong supposition in home health, but a good piece of it
15 was fraud, and they just wanted to cut it out, and so they
16 kind of put in this cap.

17 DR. CROSSON: Clarifying questions. Jack?

18 DR. HOADLEY: Yeah. I mean, these are very
19 compelling data, and I really do appreciate this analysis.
20 I was just wondering. Has there been any attention from
21 CMS to date on these? Has there been any attention from
22 the Inspector General or GAO on these kinds of questions?

1 MS. KELLEY: I think that CMS is aware of these
2 same sorts of anomalies and has been interested in it for a
3 bit of time. I don't know -- I'm not aware of any IG
4 attention here.

5 There was some -- well, I'll stop there, I think.

6 DR. MILLER: And we always brief -- in addition
7 to the Hill staff, we brief CMS on what we're thinking
8 often to make sure we're not doing something
9 administratively stupid and that type of thing.

10 When we ran them through this, they were aware of
11 why we were saying these things, and they did not react
12 negatively to these things. They don't always have
13 latitude on the phones, like, yes, we agree with you
14 because of who the membership is on the phone, but it was
15 decidedly not a surprise to them.

16 DR. CROSSON: Clarifying questions. David?

17 DR. NERENZ: Yes. Thanks, Dana. That's really
18 good.

19 Slide 5, please, if we could put that up,
20 obviously an interesting slide, a pretty clear association.
21 My question is really about the footnote. We talked about
22 this a bit the last time. You've got to be able to read

1 it. It's the definition of -- or what's included in the
2 neurological disorders. It's an interesting mix, and it's
3 obviously a set of conditions that can be devastating.
4 They're progressive in nature. Usually, the trajectory is
5 for less mobility and function over time.

6 So I'm curious. What actually gets done
7 clinically or professionally in an IRF setting for these
8 conditions, recognizing that it's kind of a unique part of
9 the trajectory here. An acute hospitalization has
10 occurred. That's one of the requirements, and now the IRF
11 is picking things up after that.

12 MS. KELLEY: It was a requirement. Just to
13 clarify, it was a requirement for this analysis that we
14 did, but not for an IRF stay.

15 DR. NERENZ: Okay. I'll keep going, but I
16 appreciate --

17 MS. KELLEY: Okay. I just wanted to clarify
18 that.

19 DR. NERENZ: But I'm still going to end up, I
20 think, in the same place.

21 I'm curious, then. What do we know about the
22 nature of those hospitalizations? So, for example, was it

1 a fall and now we're talking about a period of rehab to
2 restore to the prior level of function following a fall?
3 Is it a medical condition? I'm just curious, just because
4 it seems to matter. What's going on in the IRF setting for
5 these folks?

6 MS. KELLEY: So the first thing to know is that
7 for cases that were admitted to IRFs from the acute care
8 hospital and then admitted to an IRF for a neurological
9 disorder, there is a wide range of DRGs that they come from
10 in the hospital.

11 When I looked at the top 25, it captured perhaps
12 10 percent of the cases, so it's a wide variation in
13 reasons for their admission to the acute care hospital.

14 Many of the top DRGs are medical in nature --
15 pneumonia, cardiac events, things like that. So,
16 typically, it appears that the neurological disorder is
17 sort of a comorbidity along with some other acute event
18 that prompted the hospitalization, although that's not
19 always true. Some of the preceding diagnoses in the
20 hospital were for degenerative nervous condition. So
21 that's the first thing.

22 I spoke with some practitioners who both treat

1 patients in IRFs and place patients in IRFs about the kinds
2 of care that patients with neurological disorders would
3 receive, and what I understand is that after an inpatient
4 stay -- and I believe Alice may have talked a little bit
5 about this for us last month also. So, if she wants to
6 jump in here, that would be great. But after an inpatient
7 stay, it might be appropriate or necessary to help patients
8 regain their premorbid function, and that that would be a
9 reason why someone might need an inpatient stay in post-
10 acute care.

11 Some patients may also have medical needs that
12 can't be tended to at home and that may be more severe than
13 can sometimes be taken care of in a typical SNF, but they
14 also cautioned that patients with neurological disorders,
15 particularly patients with neuromuscular disorders,
16 sometimes might not be able to tolerate intensive therapy
17 up to three hours a day, as is required for IRFs.

18 So this was a patient population that there was -
19 - there seemed to be some hesitance to totally endorse
20 their presence in an IRF, but also no one seemed to want to
21 say it was never appropriate as well, so it seems that
22 there was room there for appropriate stays.

1 DR. COOMBS: So I will just say that the thing to
2 keep in mind is that the spectrum of MS, remission in and
3 out, and also for ALS, so you could very well have
4 selection involved in neuromuscular disorders in the high
5 margins having disease as less involved. So you can have
6 the diagnosis, and it's a whole spectrum, so you can
7 actually have a less sick MS patient.

8 And it's true. They might come in with
9 pneumonia, and their primary diagnosis may be one piece of
10 their clinical picture, but the neurologic pieces may be
11 metastable or maybe there's some facilitation that needs to
12 happen because they've been bedridden and immobilized and
13 deconditioned by whatever the primary illness is.

14 DR. NERENZ: That's fine. Obviously, there's an
15 association here between doing a lot of this work in this
16 set of patients and margin, and I'm just trying to
17 understand the dynamics.

18 DR. CROSSON: Clarifying questions. Kathy.

19 MS. BUTO: Yeah. And this is a related question,
20 just out of ignorance, but this strikes me as an area with
21 a wide latitude in terms of whether the individual would
22 really benefit from rehab therapy. The question is, does

1 CMS or contractors do any medical review, or are we just --
2 you know, is the program paying for the stay, regardless?

3 MS. KELLEY: There is the normal sort of review
4 that goes on to the max for IRFs, and we hear from some
5 IRFs that they feel that attention is more than is
6 warranted. But we often hear that from providers. So I
7 think it's probably the sort of regular level of medical
8 review that goes on in the PPSs.

9 MR. KUHN: Dana, would you also say that the 60
10 percent rule also was a pretty good enforcement mechanism
11 in that environment as well?

12 MS. KELLEY: So the 60 percent rule was very
13 effective in shifting certain types of cases out of IRFs
14 and did have quite an effect on the number of cases in IRFs
15 nationwide.

16 Interestingly, it caused a shift towards, as you
17 would expect -- both a number of cases came down, but at
18 the same time, cases shifted into the -- many of the cases
19 conditions that qualify or count towards the 60 percent
20 rule. One of those conditions is neurological disorders,
21 and this shift to neurological disorders happened when the
22 60 percent rule began to be more enforced.

1 DR. CROSSON: Other clarifying questions?

2 [No response.]

3 DR. CROSSON: Okay. What I'd like to do, as we
4 go into the discussion period, is get a sense of the
5 Commission here because we have three recommendations, but
6 as has been pointed out by Alice and I think others, they
7 are kind of related. So I'm thinking about having a
8 discussion period that takes all of them into account,
9 unless anybody feels strongly differently that we should go
10 one at a time.

11 [No response.]

12 DR. CROSSON: Not seeing that, we're open to a
13 discussion of all three recommendations, although at the
14 end of the discussion period, we will vote them
15 individually.

16 Herb.

17 MR. KUHN: So the only other thing I would just
18 like to comment on is draft recommendation No. 2 dealing
19 with the focus medical record review, and maybe it's
20 something we can -- when we review our final review of the
21 chapter, is maybe provide a little bit more narrative or
22 clarity of what we mean by focus medical review.

1 What I don't want people to walk away from this
2 and think, "Oh, gosh. There goes MedPAC saying it's
3 open season on IRFs by the RACs," and I don't think that's
4 what we mean whatsoever. It really is a focused review in
5 the process, and whether this is best performed by the
6 Medicare administrative contractors, whether the QINs, the
7 quality improvement networks, formerly known as the QIOs,
8 or some other entity, but I'd like us just to give a little
9 bit more direction of what we think about this, where it
10 best lies, to give a little bit more direction there so we
11 don't create an impression or give a sense that this is our
12 recommendation, to send the RACs in there and have at them.

13 DR. CHRISTIANSON: [Speaking off microphone.]

14 MR. KUHN: I don't think it belongs in the
15 recommendation. I think rather it could be in the
16 narrative of the chapter.

17 DR. CROSSON: So having said that, do we have an
18 opinion on this, Mark?

19 DR. MILLER: We don't have, unless Dana is going
20 to offer one as a surprise. Dana?

21 MS. KELLEY: [Shakes head from side to side.]

22 [Laughter.]

1 DR. MILLER: I don't think at all at the staff
2 level, we were thinking of a specific entity that did this,
3 and I think what we were thinking is if you -- whether it's
4 a MAC or whoever the case may be, if you see a provider
5 that tends to be very imbalanced in the types of patients
6 it takes and this notion of, well, look at the code coming
7 out of the hospital, look at the codes coming in at
8 admission, you would begin to do medical record review
9 there at that particular provider. I don't think we're
10 thinking this is an industry-wide things, and we hadn't
11 contemplated MAC, RAC, the new name, which I had forgotten.
12 And I think what we would say is this is something the
13 Secretary can decide, but it is a focused, not an industry-
14 wide type of thing that we're up to here.

15 DR. CROSSON: Right. So it seems to me --
16 correct me if I'm wrong here -- that the term "focused"
17 itself has two meanings here. One is focused by provider;
18 the other is focused on issue, right? And I think we
19 intend both by that?

20 DR. MILLER: Yeah. I mean, yes.

21 [Speaking off microphone.]

22 DR. MILLER: I'm trying to do this with making

1 sure Dana and I follow each other.

2 What we're saying is we see some patterns here
3 that raise questions in our mind, and the only thing -- and
4 so focused in the sense if somebody asked us, "So what are
5 you guys talking about when you say what are you looking
6 for?" these are the examples of what we're looking for. If
7 there's something else out there that CMS feels like it is
8 a way to get at the same issue, I mean, the issue we're
9 trying to get at is patient selection and inappropriate
10 coding.

11 So, yes, to your question, but I also wouldn't
12 say to the Secretary, "This is the only way you could do
13 this." I think we'd be more open to "Use your authorities
14 that you have to identify. Here's some examples of what we
15 see, and identify providers who have engaged in these types
16 of patterns or the behaviors that are driving these types
17 of pattern."

18 DR. CROSSON: Kate, and then, Cori, do I see your
19 hand? Yeah. Kate.

20 DR. BAICKER: So I found the extra information on
21 quality really valuable. It helps eliminate a story that,
22 "Oh, really, it's just much higher quality services that

1 are being provided in some settings versus others." The
2 fact that those measures looked very similar, I thought was
3 very supportive of the direction that the recommendations
4 were going.

5 And I support the recommendations. I have a hint
6 of a worry about the outlier payment component in that we
7 don't want to eliminate the incentive to keep an eye on
8 expenditures and really completely indemnifying against
9 outlier -- against expensive plans would remove the
10 incentive to manage as aggressively, but that's just one
11 thing to consider. And I'm persuaded by your arguments
12 that there are other countervailing advantages that make it
13 worthwhile.

14 So, with that one hesitation, I think that the
15 package move us in a great direction.

16 DR. CROSSON: So, Mark, when you talk about this
17 as a rough justice approach, I think I inferred from that
18 or perhaps we discussed the fact that this outlier approach
19 would be time limited; is that right?

20 DR. MILLER: I mean, the way I would think about
21 it -- and Dana should get in on this, but I also think you
22 almost said this toward the end of your presentation. You

1 know, what we'd all really like to do here is find -- you
2 know, have a payment system that makes it difficult to code
3 inappropriately and select patients and pace accurately
4 when the person presents at the door, with these
5 conditions, it's right. And one of the things that's
6 happening here is actually what happened in home health and
7 SNF several years back. We found this disparate financial
8 performance. We did a ton of work behind the scenes
9 looking at the payment systems and actually came forward
10 with kind of payment mechanisms literally that CMS could
11 take and implement that we thought would more accurately
12 pay for a given patient and also cut out some of the
13 practice of more therapy, more money, that type of thing.
14 Here we're not there yet, and the payment system has
15 certain characteristics that make it harder to get at that,
16 and which Dana can, you know, probably break down over.

17 So these two things are sort of ways to say we
18 need to get line of sight on this coding thing because we
19 think something's up here. The outlier thing is a rough
20 justice thing. If you had a revised payment system, then
21 maybe you go back to a 3 percent pool. But what we're
22 talking about here is basically an outlier pool that's

1 between 3 and 5 percent. That's the Secretary's authority,
2 really. Five percent is not an uncommon pool even in, you
3 know, regular PPS systems, and it would have the effect of
4 moving some dollars while CMS/MedPAC does this more heavy-
5 duty thinking.

6 So if we got a new payment system and the
7 Secretary said, you know, I'm going back to a 3 percent
8 pool, she's completely within her authority to do that.

9 MS. UCCELLO: I think Mark and Kate said better
10 what I want to say, but I'm going to try, anyway.

11 I think the point has been made that at this
12 point, across-the-board adjustments aren't really
13 appropriate. So what we've proposed I think is an
14 appropriate step to move us in the direction of making sure
15 that payments are accurate, adequate, and fair across
16 providers. And what I am most concerned about, not only in
17 IRFs but across other PAC systems, is patient selection,
18 and we want to ultimately have a payment system that pays
19 appropriately for the different types of patients so that
20 patients with high complex needs are able to find a place
21 to get help.

22 DR. CROSSON: Well said.

1 DR. HOADLEY: My thoughts are really very much
2 along the line of the last several comments, and I don't
3 think anything more needs to be said. I think this is a
4 well -- I mean, it's a very compelling set of data that
5 says there's something amiss, and I think we've figured
6 out, you know, the best steps we can to try to see that
7 addressed in the short with, like you said, some thoughts
8 about where the longer-term fix might -- the kind of
9 direction it might go in. We just don't have the
10 specifics.

11 DR. NAYLOR: So I also support the
12 recommendations. Terrific work, really. The only comment
13 was on the second -- and it really doesn't have so much to
14 do with the recommendation itself but in the rationale --
15 that have unusual patterns of -- I had to read that a
16 couple of times to -- and reading the rationale, of course,
17 I understand. And I'm just wondering if there's a value.
18 Obviously, we're not saying what should be done, but given
19 all of the work that led to this, whether or not we might
20 be a little bit more explicit in the rationale, that those
21 unusual patterns would include a focus on patients with
22 major extremity, joint -- all the kinds of work that led to

1 this. So I just thought you could be -- it might be
2 helpful to be more explicit in giving a sense of what those
3 patterns might be.

4 DR. CROSSON: Mary, are you suggesting a change
5 to the language or --

6 DR. NAYLOR: No. A change to the rationale on
7 page 52 to support it.

8 DR. CROSSON: Okay.

9 DR. HALL: Just a comment. There's a lot of
10 literature on IRFs, and most of it is very confusing. From
11 a provider standpoint, it's also quite confusing how even
12 their own patients get to IRF or don't get to IRF. And
13 this is a wonderful document, and I think the public needs
14 to know about t his. It's a tremendous piece of work.

15 DR. CROSSON: Thank you. Other comments?

16 [No response.]

17 DR. CROSSON: Seeing none, then I think we will
18 proceed to vote, and we can put up Slide 17, I think, which
19 has it all. So we'll take -- I'm sorry?

20 MS. KELLEY: One at a time [off microphone]?

21 DR. CROSSON: We're going to do them one at a
22 time, yeah. Sorry. So we'll vote on Recommendation 1,

1 Congress should eliminate the update to the payment rate
2 for fiscal year 2017. All in favor, please raise your
3 hand.

4 [Show of hands.]

5 DR. CROSSON: Opposed?

6 [No response.]

7 DR. CROSSON: Abstentions?

8 [No response.]

9 DR. CROSSON: The second recommendation: The
10 Secretary should conduct a focused medical record review of
11 IRFs that have unusual patterns of case mix and coding.

12 All Commissioners in favor, please raise your
13 hand.

14 [Show of hands.]

15 DR. CROSSON: Opposed?

16 [No response.]

17 DR. CROSSON: Abstentions?

18 [No response.]

19 DR. CROSSON: And, finally, the Secretary should
20 expand the outlier pool to redistribute payments more
21 equitably across cases and providers.

22 All Commissioners in favor?

1 [Show of hands.]

2 DR. CROSSON: Opposed?

3 [No response.]

4 DR. CROSSON: Abstentions?

5 [No response.]

6 DR. CROSSON: Thank you very much, Dana.

7 Excellent.

8 We'll wait a bit for the audience to rearrange
9 itself.

10 [Pause.]

11 DR. CROSSON: Okay. As I think we have mentioned
12 before, the Commission has a compelling interest in the
13 cost of pharmaceuticals, not just the Commission, probably
14 the entire country, and we have, as many of you are aware,
15 we have in the last several years begun to try to address
16 this both with respect to Part D and Part B Medicare costs.
17 We are going to spend time in the spring, in March and
18 April, looking in depth at some potential approaches here.

19 It is a little bit different for MedPAC and for
20 the Medicare program with respect to drug costs because, as
21 I think we mentioned earlier in the day, in the case of
22 drugs, Medicare is not the direct purchaser, as opposed to

1 the other provider areas that we have just finished doing
2 updates for. Medicare pays providers in Part B and pays
3 plans in Part D, and, therefore, our approaches, I think,
4 as we move into the spring, are going to be probably
5 different and more nuanced than some of the approaches that
6 we have just finished using with respect to those areas
7 where Medicare pays directly.

8 So, to start us off and prepare us for the
9 spring, Rachel and Shinobu are here to take us back a
10 little bit and then forward with respect to Part D.

11 DR. SCHMIDT: Good afternoon. Each year, we
12 bring you an update on the status of Part D, Medicare's
13 outpatient drug benefit.

14 In Part D, private plans deliver drug benefits to
15 enrollees, and in return, Medicare pays plan sponsors
16 monthly capitated amounts and other more open-ended
17 subsidies. Part D uses a competitive structure to provide
18 strong incentives for plan sponsors to offer attractive
19 drug benefits, yet manage drug spending and keep enrollee
20 premiums low.

21 In this presentation, we'll describe general
22 trends and tell you about the growing effects of high-cost

1 enrollees on program spending. We'll look at trends and
2 prices and how plan sponsors are trying to manage benefit
3 spending. We'll look at average out-of-pocket spending and
4 finish up by previewing what's ahead for the spring.

5 In 2015, out of 56 million Medicare
6 beneficiaries, about 39 million, or 70 percent, were
7 enrolled in Part D plans. Another four percent got drug
8 benefits through former employers that were the primary
9 insurer for their retirees in return for Medicare
10 subsidies. This is called the retiree drug subsidy. About
11 14 percent received drug coverage at least as generous as
12 Part D through other sources, such as TRICARE, FEHBP, and
13 VA. Approximately 12 percent had no drug coverage or
14 coverage less generous than Part D.

15 Part D program spending totaled \$78 billion in
16 2014, mostly for payments to private plans, but with about
17 \$2 billion of that for the retiree drug subsidy. And,
18 Medicare Part D makes up nearly 13 percent of total
19 Medicare outlays.

20 As has been true for a number of years, surveys
21 continue to show high enrollee satisfaction with the
22 program.

1 In 2016, Part D's defined standard benefit has a
2 deductible of \$360, and then the enrollee pays 25 percent
3 of covered benefits and the plan pays 75 percent. After
4 the enrollee reaches about \$3,300 in total spending, there
5 is a coverage gap in which enrollees get some plan coverage
6 plus a 50 percent discount on brand name drugs from
7 manufacturers. But, generally, enrollees pay quite a bit
8 more than the 25 percent cost share they had earlier. The
9 coverage gap will phase out by 2020. For an enrollee with
10 spending of about \$7,500 or more above that threshold, they
11 pay five percent, the plan pays 15 percent, and Medicare
12 picks up 80 percent through reinsurance. This is the
13 defined standard benefit, but in practice, nearly all Part
14 D plans use different benefit designs, typically with
15 fixed-dollar copayments. For about 12 million low-income
16 beneficiaries, Medicare pays for nearly all of their
17 premiums and cost sharing through the low-income subsidy.

18 Here are some key trends we've observed since the
19 start of Part D. Enrollment grew from 24 million in 2007
20 to 39 million in 2015. That's about six percent per year.
21 Enrollment among beneficiaries who do not receive the low-
22 income subsidy has grown faster than growth among those

1 with the low-income subsidy. Since 2010, some of that
2 growth has been associated with employers that quit taking
3 the retiree drug subsidy and instead set up employer group
4 Part D plans for their retirees. Today, 30 percent of Part
5 D enrollees receive the low-income subsidy, which is down
6 from 39 percent in 2007.

7 There's a lot of variation in Part D premiums,
8 but on average, they've grown at about three percent per
9 year and they've been especially flat at \$30 per month
10 between 2009 and 2015.

11 We saw that Medicare pays 80 percent of benefit
12 costs above Part D's out-of-pocket threshold through
13 reinsurance, so at the same time that average enrollee
14 premiums have been flat, there's been much faster growth in
15 spending on Medicare's reinsurance payments to plans,
16 especially since 2010.

17 Here are a few highlights about the plans
18 enrollees chose in 2015 and what's available for 2016. In
19 2015, 61 percent of enrollees were in stand-alone
20 prescription drug plans, which is down from 2007 levels.
21 For 2016, PDP offerings are down by 12 percent, but
22 beneficiaries will still have a broad choice of plans.

1 In 2015, 39 percent of Part D enrollees were in
2 Medicare Advantage drug plans, which is up from 2007. For
3 2016, the total number of MA-PD offerings increased by
4 about five percent.

5 Thirty percent of all enrollees received the low-
6 income subsidy in 2015, compared with 39 percent in 2007.
7 Twenty-eight percent of LIS enrollees are in Medicare
8 Advantage drug plans, which is much higher than at the
9 start of Part D, but still, most LIS enrollees are in
10 stand-alone drug plans. For 2016, there are fewer PDPs
11 with premiums below regional benchmarks, which means LIS
12 enrollees would not have to pay a premium to enroll in
13 those plans. Still, in most regions of the country, the
14 number of qualifying PDPs ranges from three to ten.

15 This slide shows the Medicare Trustees' estimates
16 of major components of Part D program spending. The key
17 take-away is that Medicare's reinsurance payments to plans,
18 which are shown in red, have grown much faster than the
19 rest, and as of 2014, reinsurance makes up the largest
20 piece of Part D spending. The direct subsidy payment, in
21 dark gray at the bottom, is the monthly capitated payment
22 to plans. That's become a smaller portion of program

1 spending. At the top is Medicare's spending for the low-
2 income subsidy, which is the second-largest component.

3 With growing spending on reinsurance, you might
4 wonder how many beneficiaries reached that threshold where
5 Medicare starts to pay for reinsurance, what we refer to as
6 high-cost enrollees. In 2013, which is the latest year for
7 which we have claims data, 2.9 million enrollees, or just
8 under eight percent, were high cost. About three-quarters
9 of those were beneficiaries with the low-income subsidy.
10 However, the number of high-cost enrollees without the LIS
11 increased faster than those with the LIS. One important
12 reason is a change in law that allows the 50 percent
13 manufacturers' discount on brand name drugs in the coverage
14 gap to count towards the out-of-pocket threshold.

15 The percent of spending accounted for by high-
16 cost enrollees has increased from 40 percent in 2011 to 47
17 percent in 2013. In other words, there's been a shift in
18 the distribution of drug spending. Generally, all Part D
19 enrollees are using more generics. For enrollees who only
20 fill a few prescriptions, as they've switched to generics,
21 their spending hasn't grown so much. Meanwhile, the eight
22 percent of beneficiaries with high costs are taking a lot

1 of both generics and brand name drugs, and their share of
2 overall spending has grown. For high-cost enrollees,
3 growth in the average price per prescription has been
4 driving overall spending growth, much more so than the
5 quantity of prescriptions that they filled.

6 Looking more broadly, growth in prices for brand
7 name drugs is starting to outstrip the moderating influence
8 of generics. These lines show price indexes for Part D but
9 do not reflect rebates and discounts. Overall, prices rose
10 47 percent between 2006 and the end of 2013. That's the
11 gray line in the middle. When generic substitution is
12 taken into account, prices only rose by two percent over
13 the same period. So, the use of generics has really kept
14 down overall Part D prices. Part D plans have been
15 effective at encouraging enrollees to use more generics,
16 and we've also had good timing in that many patents expired
17 over the past several years.

18 However, the moderating influence of generics has
19 started to lessen. You can see in the top line that
20 between 2006 and 2013, prices of single-source brand name
21 drugs grew by 114 percent. One-year growth between 2012
22 and 2013 was substantial. Meanwhile, the bottom line,

1 which reflects generic substitution, began turning upward
2 in 2013 at the highest rate we have seen since Part D
3 began. This uptick occurred even as the average generic
4 dispensing rate in Part D increased from 81 percent in 2012
5 to 84 percent in 2013. So, while generics have played a
6 very important role in constraining price growth, it
7 appears that brand price growth has started to overtake the
8 moderating influence of generics.

9 MS. SUZUKI: The steep price in brand prices we
10 have seen through 2013 is likely to continue, with even
11 more upward pressure on prices going forward. Industry
12 reports by the IMS Institute and PBMs confirm that 2012 was
13 a peak year for patent expirations, with a drop in patent
14 expiry since then. That means less opportunity to offset
15 price increases with new generics.

16 While generics helps to keep overall prices down,
17 we've all seen news reports about generic drugs with large
18 price increases. Warner and Jack, you've raised this issue
19 before. Last spring, we showed you how some generic drugs
20 had a one-year price increase that were on the order of
21 several hundred to several thousand percent. Such spikes
22 in prices can be due to things like lack of competition

1 with only one or two manufacturers in the market, shortage
2 of raw materials, or manufacturing delays due to quality
3 issues.

4 Another major source of upward pressure is the
5 drug pipeline that's increasingly focused on higher-priced
6 specialty products. According to a report by
7 PricewaterhouseCoopers, FDA approvals of specialty products
8 have surpassed that of traditional drugs, and an analysis
9 by the IMS Institute shows a strong growth in specialty
10 pipeline. According to that report, this trend is expected
11 to continue, as 42 percent of the late-stage pipeline are
12 specialty products.

13 Related to the pipeline issue is the
14 unprecedented launch prices of the new therapies. These
15 days, it is not uncommon to hear reports about high prices
16 of drugs to treat conditions such as cancer and cystic
17 fibrosis. We are also seeing high launch prices for
18 products that could be used by broader populations, such as
19 PCSK9 inhibitors to treat high cholesterol. Major insurers
20 and payers are concerned because of the \$14,000 a year
21 price tag, about double the value-based benchmark as
22 estimated by the Institute for Clinical and Economic

1 Review, or ICER.

2 Use of drugs with very high prices pose a
3 challenge for Part D because the use will likely grow and
4 put significant upward pressure on Medicare spending for
5 reinsurance and low-income subsidy. We're already seeing
6 an increase in the use of high-cost products. Between 2009
7 and 2013, the share of high-cost enrollees who filled at
8 least one prescription for a biologic product grew from
9 eight percent to 12 percent. Trustees have recently
10 reported that spending for the new hepatitis C therapies
11 have led to a large spike in Part D program spending in
12 2014. As more expensive therapies become available, larger
13 numbers of beneficiaries will reach the catastrophic phase
14 of the benefit, where Medicare pays for 80 percent of the
15 cost through individual reinsurance.

16 Plans use formularies to structure competition
17 among therapies and negotiate rebates with manufacturers
18 and to shift utilization towards lower-cost drugs. Some
19 plan sponsors have tightened their formularies while others
20 have kept them nearly the same. The use of utilization
21 management tools have grown over the years, which are
22 typically used to encourage the use of lower-cost therapies

1 or to prevent misuse or abuse. We're also seeing a greater
2 use of coinsurance rather than flat copayments,
3 particularly for non-preferred brand name drugs. In
4 effect, this puts more of the risk of price increases on
5 beneficiaries.

6 But plan sponsors are limited in the use of
7 certain management techniques because they have to meet
8 CMS's formulary requirements. For example, they have to
9 include at least two drugs per class and cover all or
10 substantially all drugs in six protected classes. While
11 plan sponsors are generally free to make mid-year formulary
12 changes that are positive, such as adding a new drug, they
13 must obtain CMS approval for negative changes, such as
14 adding a prior authorization. This may be particularly
15 problematic for a new high-cost drug launched mid-year.

16 These are the kinds of issues that will need to
17 be considered when we discuss policy options to share more
18 of the insurance risk with plan sponsors in March.

19 Plan strategies for managing enrollees' drug
20 spending have implications for program spending, because
21 Medicare subsidizes Part D spending, including payments for
22 cost sharing for the low-income subsidy enrollees. Plans

1 are using new tools to affect enrollee behavior. For
2 example, we're seeing the majority of plans use lower cost
3 sharing for preferred generics than for other generic
4 drugs. We're also seeing rapid increase in the use of
5 tiered pharmacy networks that typically offer lower cost
6 sharing at preferred pharmacies.

7 But since cost sharing amounts for LIS enrollees
8 are set in law, they don't face plans' benefit designs that
9 are intended to encourage the use of lower-cost drugs or
10 pharmacies. The difference between plans' cost sharing
11 requirements and the LIS copay amounts are paid by
12 Medicare's low-income subsidy. If LIS enrollees do not
13 choose a lower cost option, Medicare does not get the
14 savings that could have been achieved if the plans'
15 management tools had worked. And under certain
16 circumstances, not choosing the lower cost option could
17 result in higher costs for Medicare.

18 Growth in spending affects enrollees' out-of-
19 pocket spending, as well. The most obvious place is
20 through its effects on monthly premiums. As Rachel
21 mentioned earlier, the average monthly premium has remained
22 relatively stable, at about \$30, but there's a wide

1 variation across plans and the stability we've seen is
2 likely due to several factors.

3 One is because premiums are based on plan bids,
4 not actual spending, so spending for reinsurance has not
5 always been fully reflected.

6 Second, the influx of younger enrollees likely
7 has kept premiums low.

8 And, finally, more people are enrolling in MA-PDs
9 with lower premiums, which is partly due to their ability
10 to use the rebate dollars to reduce premiums.

11 Jon, last year, you expressed concerns when we
12 talked about rising prices that perhaps plans might shift
13 more of the costs to the enrollees. We did a new claims
14 analysis and found that between 2007 and 2013, on average,
15 beneficiary out-of-pocket for cost sharing has remained
16 stable or decreased, depending on the level of total annual
17 spending which affects the benefit base people reach.

18 The decrease seen for non-LIS enrollees appears
19 to reflect their behavioral response to plans' cost sharing
20 incentives, such as lower cost sharing for generics and
21 preferred drugs. Some of them are affected by the richer
22 benefit as a result of the phase-out of the coverage gap.

1 LIS enrollees have cost sharing protection, so their out-
2 of-pocket spending has been stable. However, the amounts
3 paid by Medicare's low-income cost sharing subsidy have
4 increased. Some of this increase is likely due to the
5 plans -- because the plans' management strategies that use
6 cost sharing differentials are not affected for this
7 population.

8 So, to summarize, Part D enrollees continue to
9 say that they're generally satisfied, they have many plan
10 options, and their premiums and cost sharing have been
11 stable. But the cost trends are increasingly of concern.
12 Costs for reinsurance is growing much faster than premiums,
13 and prices of single-source drugs continue to grow
14 aggressively and has begun to outstrip the price moderating
15 effect of increasing generic use. The trend in the drug
16 pipeline is shifting towards higher-cost biologics and
17 specialty drugs, putting more upward pressure on the
18 program costs, particularly the reinsurance, which is the
19 fastest growing and now the largest component of program
20 spending.

21 So, a key question for the future is whether plan
22 sponsors will be able to negotiate lower prices for these

1 newer therapies. In general, plan sponsors have less
2 bargaining leverage when there are no therapeutic
3 substitutes.

4 In March, we'll pick up our discussion from last
5 November about the policy approaches that may slow the
6 growth in program spending. We'll come back to you with a
7 combination of policy approaches discussed briefly in
8 November that attempts to balance the competing goals of
9 the program. First is providing stronger incentives for
10 plans to manage spending for high-cost enrollees while at
11 the same time providing them with more flexibility and
12 tools to manage costs. We may want to combine these with
13 policies to provide more out-of-pocket protection for
14 enrollees, and in light of the new strategies plans are
15 using to manage spending, we may also want to revisit the
16 LIS copay recommendation from 2012.

17 DR. CROSSON: We were talking.

18 [Laughter.]

19 DR. CROSSON: Sorry.

20 All right. Let's -- you were talking, too. We
21 weren't passing any notes, though.

22 Let's take clarifying questions.

1 DR. CHRISTIANSON: This is just a quick one on
2 Slide 9, just to make sure I understand it. What you've
3 displayed on the slide there I think are price data. The
4 title of the slide is "Growth in brand prices more than
5 offset effects of generic use." There's nothing in this
6 slide about use, so is there another slide to sort of
7 substantiate this in the chapter? I've forgotten.

8 DR. SCHMIDT: It's probably just a poor title.

9 DR. CHRISTIANSON: But have you done that
10 analysis to actually substantiate that claim that's in the
11 title of the slide? I've forgotten. You know, the chapter
12 is pretty complicated, and I've just forgotten whether
13 you've done that.

14 DR. SCHMIDT: I think the only -- no. I should
15 say no, right?

16 MS. SUZUKI: One thing we did say in the chapter
17 is that generic use has increased over time, but the
18 effects of generic on the overall drug prices, factoring in
19 the generic substitution, has diminished over time. So
20 we're comparing by, you know, 12-month period, what's the
21 effect of increasing generic use on moderating the price
22 increases? And in the most recent 12-month period, we've

1 seen less of an effect than in previous years.

2 DR. CHRISTIANSON: Okay, because this statement
3 came back at the end when you were stating what you found
4 out. So if you haven't done the analysis, you probably
5 should include it in the next version of the chapter.

6 DR. CROSSON: Clarifying -- let me just say we're
7 going to -- here's the kind of plan for the discussion.
8 We're going to have clarifying questions, and then we're
9 going to have kind of a two-part discussion, and we'll do
10 them simultaneously, I think is the easiest part. One
11 would be suggestions for the chapter, you know, increase
12 this, emphasize that more, this less, whatever. That won't
13 be the only opportunity. You'll have an opportunity in
14 writing later on as the chapter is finished. But also then
15 reflecting on the last slide and beyond, presaging our work
16 in the spring, are these the ideas we should be working on,
17 or are there other ideas? Or within the ones that you find
18 on the last slide, do you see one approach more important
19 than the other? So we're still on clarifying -- are you
20 clarifying my clarification?

21 DR. REDBERG: No. Actually, I was just looking
22 for the page -- I thought on page 40 it kind of addressed

1 Jon's question, just showing between December 2012 and
2 2013, Part D prices accounting for generic substitution
3 grew by 6.6 percent. So even though there were more
4 generic prescriptions from 81 to 84, because prices of
5 generics have gone up and overall drug prices have gone up,
6 that was how I read it, that we weren't going to see the
7 same kind of moderating effect of increasing use of
8 generics that we have in the past.

9 DR. SCHMIDT: Right. It was a combination of --
10 I think Shinobu actually just summarized things pretty
11 well. So we have seen the GDR go up, but we've seen the
12 sharp increase in brand-name prices, and the indexes that
13 were on that slide we just showed you are specifically
14 price indexes, not overall expenditures. Is that the
15 nature of your question?

16 DR. CROSSON: Okay. Not to confuse things by
17 clarifying further, but we're on clarifications.

18 MR. GRADISON: Of course, I realize that in the
19 past we've expressed concerns about the lack of incentives
20 for LIS covered people who use lower-cost pharmaceuticals.
21 But there's something here that really confuses me. You
22 indicated on Slide 6 that 30 percent of all Part D

1 enrollees received LIS, down from 39 percent. That's a
2 very dramatic change, it would seem to me, over that period
3 of time. But on Slide 15, that amounts paid by Medicare's
4 low-income cost-sharing subsidy have increases.

5 I can understand how that could happen, but could
6 you explain what actually does explain the one --

7 DR. SCHMIDT: Right. So --

8 MR. GRADISON: The two lines going in different
9 directions.

10 DR. SCHMIDT: So the percentage share being
11 smaller today than at the start of Part D I think is partly
12 the Baby Boomers entering Medicare in larger numbers.
13 They're younger. They tend to use fewer drugs. And we
14 also have this influx of employer group plans from people
15 who used to have their employer as the primary insurer
16 moving into these forms of Part D plans. So there's been a
17 big increase in enrollment generally, and the LIS
18 population has stayed relatively stable. It's grown a
19 little bit, but not nearly as much as the rest of things.
20 Meanwhile, the costs have been going up, so that's how you
21 explain the two.

22 MR. GRADISON: That's helpful. Thank you [off

1 microphone].

2 MR. THOMAS: On Slide 9, the chart, I just want
3 to make sure I understand. Is this chart just capturing
4 pricing changes, or does this capture volume changes as
5 well?

6 DR. SCHMIDT: So this is a chain-weighted price
7 index prepared for us by a contractor, so the weights of
8 the prices of particular drugs do change a bit over time as
9 utilization changes. By and large, it's designed to
10 reflect changes in prices. It's a little bit confusing, I
11 understand, but that's how it's built.

12 DR. MILLER: If you could only give [off
13 microphone] one answer, it would be it is measuring price.

14 MR. THOMAS: What if you could give more than one
15 answer?

16 [Laughter.]

17 DR. MILLER: If you gave more than one answer,
18 what you would say is that, remember, whenever you do
19 something like this, you might have, like, bread and meat.
20 And if, you know, one is 50 percent of what you buy and the
21 other is 50 percent, you'd be following those prices. But
22 if those proportions changed, then they would affect the

1 price because the proportion of what you're buying changes.
2 And what this tries to do is track that change in the mix
3 over time. It is a way of measuring price, but also
4 understanding that your underlying mix might be shifting
5 over time. That's the longer answer.

6 MR. THOMAS: Okay. So it strikes me that there's
7 probably three -- well, there's probably more than three,
8 but there's at least three drivers of cost, right? The
9 number of people going into the plans, right? The price.
10 And then the volume of the drugs kind of per person. Is
11 that right?

12 DR. SCHMIDT: [Nods yes.]

13

14 MR. THOMAS: So do we have clarity or is there
15 kind of an understanding of how those three are kind of
16 driving the total cost? I guess that's one.

17 MS. SUZUKI: This wouldn't reflect the number of
18 people going in. I would think of it more like -- Mark
19 explained it perfectly, but --

20 DR. MILLER: [off microphone] write that down.

21 [Laughter.]

22 DR. SCHMIDT: Actually --

1 MS. SUZUKI: It's a market basket concept.

2 DR. SCHMIDT: Yeah.

3 MS. SUZUKI: So we're trying to capture a
4 snapshot of market basket of goods, drugs purchased by Part
5 D enrollees in each of these periods. But because new
6 drugs come onto the market, we need to factor that in over
7 time. So that's what the chain-weighted does. It
8 gradually changes. But it tries to measure --

9 DR. SCHMIDT: There is something in the mailing
10 materials that I think gets to what you're asking, though,
11 on Table 11 on page 53 of the mailing materials. I think
12 Scott may have asked before what's driving trend, and so
13 here it's looking for all Part D enrollees. The average
14 price per prescription changed very little between 2007 and
15 2013, and that's largely reflecting generic use. And the
16 number of prescriptions per month went up a little bit, by
17 about 2 percent per year, for all Part D enrollees. But
18 then --

19 MR. THOMAS: Which page again?

20 DR. SCHMIDT: This is page 53, Table 11. But if
21 you look particularly at those that reached that out-of-
22 pocket threshold where reinsurance is starting to pay, then

1 that's where we have a separate point saying that actually
2 it looks like growth in the average price per prescription
3 seems to be driving things. So for the high-cost
4 enrollees, the average price per prescription grew by
5 almost 7 percent on average over the period, but the number
6 of prescriptions changed by about 1 percent.

7 MR. THOMAS: Okay. I guess as part of this
8 report is the -- just so I understand kind of what we want
9 to accomplish. So as our goal to really just kind of give
10 a status of this or to also as part of that have discussion
11 or recommendations on how to mitigate escalation in cost?

12 DR. MILLER: So what I think is happening here
13 is, you know, we're sort of required to do, you know, once
14 a year the update stuff, look at each of the sectors. In
15 MA, we had recommendations. In Part D, we're looking at
16 the sector. And in the March meeting, we're going to come
17 back to at least this array of issues and start looking at
18 how to mitigate some of the growth that we're seeing,
19 particularly in the reinsurance portion of the benefit,
20 which is where the rapid growth is.

21 So in March, we're going to return to this and
22 sort of talk more about policy and start to get consensus

1 here. This conversation is twofold, just the way Jay said
2 a second ago. Anything in the information chapter, is this
3 all straight questions, that type of thing. And then
4 looking ahead, do you have specific things you want us to
5 focus on? So March, we're going to start to really firm
6 that up, but that's what this slide is about -- the last
7 slide. I'm sorry.

8 DR. CROSSON: Okay. We're still on clarifying
9 questions.

10 MR. KUHN: Just one question about the use of
11 tiered pharmacies, and there was a discussion in the paper
12 about that and the fact that it was -- I think the
13 reference was that it was a little controversial because
14 not all beneficiaries had access to all the pharmacies that
15 are -- or might not have access to pharmacies.

16 So I guess my question was: What percent of
17 drugs now come through mail order and what percent are
18 coming through pharmacies in the Part D space?

19 MS. SUZUKI: We expect it to be low. We haven't
20 looked at that recently. It's information that's not
21 readily available on the claims.

22 DR. SCHMIDT: I think it's less than 10 percent,

1 is my guess [off microphone].

2 MS. SUZUKI: When we last looked at this, it's
3 been less than 10 percent.

4 DR. CROSSON: Okay. So, again, at the risk of
5 confusing things, we're going to have two issues on the
6 table at the same time because they're a little bit
7 interrelated. One is a first cut at suggestions for the
8 chapter, realizing that you'll have time later on, if you
9 want, to review it in its final phase. Jim, that would be
10 sometime when?

11 DR. MATHEWS: Depending on the caliber and depth
12 and breadth of your comments here today, ideally we'd like
13 to get the chapter out for external review early next week.

14 DR. CROSSON: Okay. So comments on the chapter
15 that you see now, after having read it, is one item.

16 The second item, going back to the last slide
17 again, and anticipating our discussions in March, and the
18 point here being what can be done with respect to Part D
19 drug costs. Are these the issues? Are there other issues,
20 other approaches that you have in mind, that you've thought
21 of that we should consider to prepare for March? And among
22 the ones that are listed, do you have a prioritization? Do

1 you see one or more as much more important than the other
2 for us to consider? I guess that's three items at the same
3 time. And if we get all bollixed up, I'll separate them
4 out.

5 MR. GRADISON: Maybe this is already covered, but
6 I wish I had a better understanding of the relationship
7 between B and D, specifically Part B and Part D. Sometimes
8 I understand that on discharge from a hospital, the
9 hospital will provide let's say the first week or month or
10 whatever of prescriptions. I guess that's Part B. But if
11 it isn't, if it is Part D, I think we were told earlier
12 today that there's some problems in terms of payment, and
13 maybe I misunder- -- I'd just like to understand that
14 better. I could be more specific, because we talked about
15 it earlier today, I believe. But I just want to make sure
16 we tie those things together, if only for my own
17 understanding, which is, as you can tell from my questions,
18 somewhat limited.

19 DR. CROSSON: Okay. So something to address in
20 March is that interrelationship, to the extent that there
21 is, between B and D.

22 MR. GRADISON: The payment aspect is a question,

1 too.

2 DR. CROSSON: Yeah.

3 MR. GRADISON: Yeah. If I get the prescription -
4 - if I'm handed the prescription on discharge, I know
5 that's D. If I'm handed the medications, I'm not quite as
6 clear how that works in terms of paying for it as a
7 beneficiary.

8 DR. CROSSON: I'm sorry. Do you mean incidental
9 medications when you're in the hospital?

10 MR. GRADISON: No. On discharge.

11 DR. CROSSON: Okay. I guess I'm missing the
12 point here. Could you say it again?

13 MR. GRADISON: Am I wrong that -- Bill nodded
14 yes. Aren't there circumstances on discharge where you're
15 provided with an initial supply of medications?

16 DR. HALL: Yeah.

17 MR. GRADISON: Okay. How's that paid for?

18 DR. HALL: I'm not sure.

19 MR. GRADISON: Well, I'm not either. That's why
20 I raised the question.

21 DR. SCHMIDT: I would have guessed part of the
22 Part A payment.

1 DR. MILLER: I'll tell you what, we can come back
2 and add to this. I think it's fairly plain answers, that
3 it's part of, you know, A, and then what happens in B, and
4 then you have a co-payment if you're in the outpatient
5 setting in B. But I think it's a relatively
6 straightforward two-sentence answer when we roll back in in
7 March, just to not do it on the fly -- for me not to do it
8 on the fly and screw it up.

9 MR. GRADISON: Thank you.

10 DR. CROSSON: Well, as best I can tell, there's
11 nobody at the table who's ready to do it on the fly.

12 DR. NERENZ: Since we're kind of unsure and we're
13 guessing, I'll just throw one more of those. It seemed to
14 me that in the draft HRSA guidance about 340B there was
15 some specific mention of so-called discharge medications.
16 And if that's a Part B thing and not a Part A thing, that
17 suggests to me that maybe Part B is what's going on. But I
18 don't know that for sure either. But for what it's worth.

19 DR. CROSSON: All right. Well, we'll nail that
20 down.

21 MS. BUTO: So just a sidebar. You'll recall
22 that, last year maybe, we talked about at least an

1 outpatient, how should the hospital deal with giving away
2 Part D drugs versus can they write them off versus blah,
3 blah, blah. Anyway, we can bring that up when we talk
4 about the relationship, but there are lots of questions
5 about those relationships, including what happens when a
6 Part D plan provides essentially what is a Part B drug,
7 which some plans do -- many plans do.

8 But my question really is about this chapter.
9 You asked, Jay, you know, what should the chapter have, and
10 is there anything we'd like to see. I would like to see
11 some acknowledgment of the work that was done by really
12 Rachel and Shinobu for the June report, which it's almost
13 like that's not even, you know, acknowledged here, so that
14 we acknowledge the extremely good work that was done on the
15 whole issue of risk corridors, risk -- all we have to do is
16 allude to it and say we're coming back to it in the June
17 report, something. But if you read this, it's as if we had
18 never done that work or talked about it, when, in fact,
19 it's in the June report.

20 So maybe there is a tradition here where we don't
21 cross over between the reports, but it just seems to me a
22 good thing to do because a lot went into that.

1 DR. MILLER: I don't know -- I'm not aware of any
2 tradition.

3 [Laughter.]

4 DR. MILLER: So we can refer back to it. Have
5 you guys got a problem with that? Okay.

6 DR. CROSSON: All right. But this in itself is
7 establishing a tradition.

8 DR. MILLER: I'm not buying into that.

9 [Laughter.]

10 DR. MILLER: I want to be clear.

11 MR. ARMSTRONG: So a couple of different things.

12 First, with respect to the chapter for the near
13 term, I just want to, much as Kathy was doing, compliment
14 the staff. It is, I think, a great advancement over where
15 we were like a year ago, and we are, I think, pushing hard
16 on laying out a good objective evaluation of the issues
17 that set us up then for some of the real policy questions.
18 I actually don't have any suggestion for improving on that.

19 Second, yeah, I guess Slide 17, just a couple of
20 comments here.

21 First, generally -- and I know no one will be
22 surprised by this -- looking at ways in which we can

1 provide plans with more flexibility to manage costs I think
2 is an area for us really to pay attention to. So I would
3 encourage us to do that. And I think the chapter in
4 several places offers information that would help support
5 the argument that that's a good idea.

6 And then the second point I would make would be
7 it seems, at least for me, one of the headlines from the
8 analysis was the rate at which the reinsurance costs for
9 the Medicare program are skyrocketing.

10 And so my question with respect to work ahead
11 around policy would be: Well, what is a policy approach to
12 dealing with that issue? And I'm not really sure. But I'd
13 be interested in spending our time pursuing what kind of
14 answers to that question we might put on the table.

15 DR. MILLER: And the only other thing I would say
16 about that, to those of you who are close to MA, if there
17 are certain flexibilities that you think are good ideas --
18 you know, we have email, too -- you can send it to us. And
19 you should know that we're then out talking to plans trying
20 to control the water and whatever that analogy was and
21 bring in those ideas. And we have something of a list,
22 but, you know, we're accumulating, so feel free if there's

1 somebody on your staff you want to forward something.

2

3 DR. CROSSON: Okay. So we will go around this
4 way. Sue?

5 MS. THOMPSON: Just quickly. I think to
6 understand, because we see a lot of "all drugs and
7 biologics" used in the same sentence, but I think there's
8 perhaps a piece to understand what's the impact of the
9 biologics on this discussion. I mean, obviously, but what
10 is that? Can we quantify that?

11 DR. CROSSON: Okay. So, Sue, are you suggesting
12 this for both the chapter and then potentially for a focus
13 later in the year, both?

14 MS. THOMPSON: [Nods head.]

15 DR. CROSSON: Thanks. Not that I was putting
16 words in your mouth.

17 Okay. So, over here. Alice?

18 DR. COOMBS: Just in consideration of one of the
19 issues with LIS copayment, I thought we did something in
20 2012, and maybe it would be great to have enough data on
21 what the LIS population looks like. I thought we did
22 something on some demographic information back then in that

1 chapter. Did we look at the demographics?

2 DR. CROSSON: I don't remember.

3 DR. MILLER: Yeah. I'm not sure I'm remembering
4 either.

5 DR. SCHMIDT: I know that there is demographic
6 information that Shinobu puts together each year for our
7 data book --

8 DR. COOMBS: Yes.

9 DR. SCHMIDT: -- that's pretty detailed about the
10 LIS population versus Part D as a whole.

11 DR. COOMBS: Okay. Because I can't think that
12 this could be any thicker in terms of a chapter, but maybe
13 just to go over that information for review.

14 DR. MILLER: I was kind of coming up cold too.
15 But that is right. We have yet another publication, a
16 chapter that's only charts and data tables, and it is in
17 there, right? Right.

18 DR. CROSSON: Kate.

19 DR. BAICKER: I think the list of things you've
20 developed for thinking about in March is great, and the
21 thinking about that are out-of-pocket and protection for
22 enrollees, you know I'm a big fan of insurance acting like

1 insurance for people. And it turns out that 5 percent of a
2 really big number is still a pretty darn big number. So I
3 think that's a wonderful thing to think about as well as
4 proper incentives, even for the LIS beneficiaries to think
5 about tradeoffs in their choice of prescription versus
6 generic that are appropriate for their income, but also
7 preserve some incentive to make high-value choices. So I
8 think all of that is great to think through.

9 I might add, depending on what the state of the
10 literature is, some discussion about what we know about the
11 relationship between drug spending and non-drug spending,
12 if we see any commensurate reductions in other kinds of
13 spending that offset increases in drug spending or not, how
14 that looks different for standalone Part D plans versus
15 integrated MA-PD plans that have internalized those
16 externalities or not across siloes, I would love to get a
17 more holistic picture of how changes in the -- just like
18 changes between brand names and generics affects our
19 perception, changes between medical and surgical and drug
20 and nondrug treatments should enter into our interpretation
21 of the trend.

22 So there may not be good available evidence on

1 that, and that might be the answer, but to the extent that
2 there is, I think that that would be really helpful in our
3 discussion going forward.

4 DR. CROSSON: My sense of that one -- I may be
5 wrong, but my sense of that one is doing a comprehensive
6 analysis would be difficult, given all the variables at
7 play. It might be, though, possible to look at individual
8 pharmaceuticals that are developed for the treatment of a
9 certain disease. Let's say cystic fibrosis as an example
10 and then use that example to see specifically what that
11 might do for the hospitalization rate for -- I'm making
12 this up, so it's probably not the right example because
13 it's an expensive drug, I know. But pick that type of
14 relatively narrow example and look at that where you can
15 track the drug, the price, the expected costs, which in the
16 case of cystic fibrosis, a lot of that hospitalization
17 cost. Maybe we could find a few examples like that. Does
18 that sound reasonable?

19 DR. BAICKER: Could I actually --

20 DR. CROSSON: Yeah, yeah.

21 DR. BAICKER: So I think examples are always
22 really helpful in illustrating a principle at work. I

1 think it's pretty hard through example like that to really
2 understand cause and effect. I was imagining more trolling
3 around to see if there have been some good studies with the
4 recently available new data that have at least plausible
5 causal pathways mapped out. Rather than doing your own
6 primary research, I'd just love to get your take on the
7 state-of-the-art about what is known about this from the
8 literature, and to the extent that the literature suggests,
9 hey, there's some offset, then an illustrative example of,
10 for example, we see this happening in these trend always
11 drives the point home. But given the timeline, I was not
12 envisioning -- although if you want to, feel free -- a
13 whole new primary empirical analysis.

14 DR. CROSSON: Well, the latter part of your
15 comment elicited large smiles at the other end of the table
16 here, so I think you're right. Thank you for that. You're
17 right on target.

18 DR. SCHMIDT: I think that's because Shinobu
19 spent about a year doing that a few years ago.

20 DR. CROSSON: Oh, okay.

21 DR. MILLER: That's the point I wanted to pick
22 up, and I want to take this kind of crazy Kathy Buto idea,

1 referring back to our own work.

2 [Laughter.]

3 DR. MILLER: I don't know what she's thinking,
4 but as long as she's raised it, I'd actually like to
5 incorporate Alice's request for the demographics. And
6 maybe we can say here's a few sentences of what we find,
7 more detail here, and refer to the data book; and to her
8 question, we did a ton of literature review, and then they
9 actually did some primary work themselves, and they
10 actually selected some conditions to look at. Again, by
11 reference, pull that in, and then if there's anything new,
12 just to add to it. So maybe this tradition thing that you
13 guys wanted to get going is starting to happen, but it is a
14 big chapter, and so tons more is going to get pretty
15 weighty. But that's how we'll go at those two things, if
16 you're okay with that.

17 DR. CROSSON: We could even find a song called
18 "Tradition," don't you think?

19 DR. MILLER: Well, you know, there's a melody
20 running through my head even as you --

21 DR. CROSSON: Right. Yes, I'm getting a little
22 loopy, I know.

1 Jack?

2 DR. HOADLEY: I have one specific comment on the
3 current chapter in terms of this issue of things. On page
4 37, there is actually a paragraph that talks about this
5 issue of the LIS, the previous 2012 recommendation, and
6 goes on and talks about the Congress might consider giving
7 the Secretary more flexibility.

8 And I wonder given what we're anticipating for
9 the June report if we shouldn't -- not make those comments
10 here and sort of save those comments for the discussion
11 along with the other accompanying things that we might
12 address in the June report because I think along with
13 reiterating that we have a previous recommendation, we
14 often do that, but to sort of take the step further that
15 this implies might not belong here.

16 And I think one of the things that's really
17 exciting about this chapter is that it really does set up
18 what we're talking about, looking at the next couple of
19 months for the June report, and I was at one point trying
20 to list all the pieces of evidence that we had in here that
21 sort of pointed to the issues around both the high-cost
22 enrollees and the high-cost drugs. And I just kind of gave

1 up because there were too many of them, but between the
2 price index stuff, the level of reinsurance, the table that
3 you looked to a minute ago, I mean, we just have multiple
4 pieces of evidence that sort of join on this point, that
5 three or four years ago, we could sort of say this program
6 is kind of sailing along at reasonably modest growth rates,
7 much lower than anticipated. It was sort of that things
8 were pretty on track, and the last couple of years -- and
9 we always had this concern that there were expensive drugs,
10 and that that patent cliff, the big move that generics was
11 going to run out and that there would be eventually new
12 products coming to market that were important innovations
13 for a wide number of people, there's always been some
14 important new drugs. But for a period of time there, they
15 were mostly for pretty limited numbers of people, and we're
16 now in a new situation here. And that's what you're able
17 to point to with various different displays here, and I
18 think that's really where this menu of things that we were
19 starting to talk about in the fall is well designed.

20 So that, for example, in a very simplistic way,
21 we can reduce that trend in reinsurance by reducing the
22 rate of reinsurance and, as we've talked about, shifting

1 more to the plans and less to the federal reinsurance.
2 That, of course, is only an artificial step. The reason we
3 would be doing that is we're trying to change the incentive
4 structure somewhat. It's a means to an end of getting
5 better management of those high-cost enrollees and/or high-
6 cost drugs, and so that's where this goes together.

7 The formulary sorts of issues we've talked about,
8 I think are ones that -- and that comes under this title of
9 providing plans more flexibility to manage cost, so
10 thinking about that first on the formulary side -- I mean,
11 I think there are steps, although I think here, we're going
12 to be challenged to sort of make sure to do helpful things
13 without doing equal number of harmful things. I mean,
14 there are ways you could increase flexibility for the plans
15 and have some negative effect on access to drugs. We've
16 talked about this before with appeals and exceptions and
17 prior authorizations and things and how to make sure those
18 are done in a way that works to make sure the beneficiaries
19 who need a drug, if you're going to have more prior
20 authorization to control use of an expensive drug.

21 And we've seen some of this in the hepatitis C
22 world, especially on the Medicaid side, where very tight

1 prior authorization rules have meant that use of the hep C
2 drug by the Medicaid population has been way lower than a
3 lot of people would like, so I think it's the right area to
4 look at, but I do think we have to be careful about how we
5 sort of structure some of those choices.

6 So I am interested in ways to think about plan
7 flexibility. We didn't talk about it here in the
8 presentation, or at least very much. The medication
9 therapy management, which has never felt like it works very
10 well -- and various chapters in the past have commented on
11 that -- that is something that in theory ought to be able
12 to help address at least the high-cost enrollee's part, not
13 necessarily the high-cost drug's part.

14 I think Sue raised the question of biologicals,
15 and with biogenerics or biosimilars, whichever term you
16 like to use, coming on the market already, figuring out how
17 those will be covered, a lot of those are on the Part B
18 side, but there are some that will show up on the Part D
19 side as well, and what tools will plans be able to use to
20 encourage people to shift to those again, again doing it in
21 a way that works well and doesn't lead to other kinds of
22 access problems.

1 Same thing with the pharmacy networks. I do
2 wonder, the access issues that have been pointed out, CMS
3 indicated that this year, they would review the preferred
4 pharmacy part of the networks more tightly, and they would
5 provide indications to beneficiaries if they were
6 considering one of the plans where access was an issue.

7 In my looks at the Plan Finder this year, having
8 identified one particular plan sponsor who appears -- who
9 is the preferred pharmacy part of the network is relatively
10 small and doesn't seem to be the one that provides good
11 access. I don't see any indicators on the Plan Finder that
12 sort of flags that, so I'd like to try to find out more
13 about what CMS -- whether CMS followed -- how they followed
14 up on what they said back on the call letter. And before
15 we do things like broaden the authority that I talked about
16 a minute ago for the Secretary to look at things like
17 encouraging LIS beneficiaries to use preferred pharmacies,
18 we've got to make sure those are accessible to that
19 population. And what's accessible on a broad area may not
20 turn out to be available in the particular communities
21 where many low-income folks live. So I think that's going
22 to require a closer look at access to make sure if we're

1 going to suddenly say -- or we're going to allow the
2 Secretary to say that somebody has to pay more to use a
3 pharmacy that's not -- that doesn't offer the preferred
4 cost sharing, that that's going to cost more to an LIS
5 beneficiary if it turns out that they really don't have one
6 that's easily accessible to them. It's been required, you
7 know, bus rides or whatever to get that, then we're just
8 increasing the cost to that LIS beneficiary. We're not --
9 or they're going to -- you know, they're either going to
10 pay the cost, or they're going to incur another kind of
11 cost to go get that. So that's where I think -- those are
12 the areas where I think we have to operate cautiously.

13 Obviously, I've said many times about the issue
14 of increasing out-of-pocket protection of enrollees, the
15 third item on your agenda, and I'm all for that. And I
16 spoke to the fourth one sort of under the other rubric.

17 I've always been -- I wasn't here when the 2012
18 recommendation was done. I've always had general support
19 for that concept that there should be ways to encourage
20 more generic use, but I think it has some issues around,
21 and I think we do need to travel carefully on that area.
22 So I'll stop with those.

1 DR. CROSSON: Thank you, Jack.

2 All right. Craig, and then we'll go down this
3 way and come back up this way. Sorry.

4 Mary, were you waiting?

5 DR. NAYLOR: Yeah. I was going to see --

6 DR. CROSSON: Now you raise your hand up?

7 DR. MILLER: She was waiting.

8 DR. CROSSON: Oh, you wanted to go after Jack?

9 MS. UCCELLO: I was letting him --

10 DR. CROSSON: You better. You better.

11 MS. UCCELLO: I'm going.

12 DR. MILLER: She's very scrappy.

13 DR. CROSSON: Right, right.

14 [Laughter.]

15 MS. UCCELLO: I was letting him go because we had
16 given him -- we had ceded him.

17 DR. CROSSON: I didn't know you wanted to go
18 after him.

19 MS. UCCELLO: I don't care when I go, but I'm
20 doing now.

21 [Laughter.]

22 MS. UCCELLO: I think the chapter is great the

1 way it is, especially if you just add the little references
2 to the stuff we talked about before. That would be great,
3 but I don't think you have to do any big major stuff.

4 In terms of what we do in the spring, clearly
5 from the findings that are in this chapter as well as
6 things we've done in the past, there is really a need to
7 focus on these high-cost enrollees. And I think the things
8 that are mentioned here in terms of tools to managed care,
9 to manage utilization, to steer people into lower cost
10 drugs all makes sense. But I think we really still need to
11 acknowledge that prices themselves are a really big deal,
12 and we can't lose sight of that.

13 And in the chapter, there's a little point. It's
14 citing a paper that looked at the costs of hep C and showed
15 that the projected offset, savings offset over 20 years in
16 terms of reduced liver events only offset about 75 percent
17 of the cost of the drug.

18 And I would argue even if those savings offset
19 100 percent of the cost of the drug, all of those savings
20 should not accrue to the drug companies. I think some of
21 that savings needs to be shared among the payers, including
22 Medicare, including the consumers.

1 Now, I acknowledge that there's not necessarily
2 much we can do on the Medicare side in terms of price, but
3 I think the things that we started back in the fall that
4 just talked about the process of drug development and
5 pricing, I think would be helpful. And this is not just a
6 Medicare issue. It's a broader issue than that, and we've
7 acknowledged that. But I think it's something we just
8 kind of need to keep our eyes on.

9 DR. CROSSON: Thank you.

10 MS. UCCELLO: Carry on.

11 [Laughter.]

12 DR. CROSSON: Okay.

13 DR. MILLER: Can I ask one thing? And I may have
14 lost a thread in there. So keep your eye on it, but you
15 can't -- but we're not sure we can do -- so, yeah, in
16 amend, where do you --

17 MS. UCCELLO: Well, I don't know. I think --

18 DR. MILLER: All right. And that's a perfectly
19 fine answer, but I was -- you know, I often --

20 MS. UCCELLO: I think -- I know that there were
21 limitations on what Medicare can do about drug pricing.

22 DR. MILLER: Okay.

1 MS. UCCELLO: But I don't think that that should
2 necessary limit the things that we look at.

3 DR. MILLER: Okay. And that is also helpful
4 because often I'm trying to interpret how to actually act
5 on what people are saying, and that last little bit helped.

6 DR. CROSSON: So, you know, I think that -- and
7 this is simplistic, but what we can do, hopefully, in the
8 end with respect to drug prices is just different from what
9 we can do with respect to all the other areas of payment
10 where we can say pay less, you know, pay a lot less.

11 At least at the moment, although we could
12 theoretically entertain some innovative notions, at the
13 moment we have to think about it as if we are trying to --
14 as I think about it, we're trying to restructure the
15 marketplace both in Part B and in Part D. So it's a
16 different set of tools, and I don't know -- although we've
17 just finished talking about a bunch of them, I don't know
18 that we have fully explored all the possibilities or kind
19 of considered which ones are more likely to be effective
20 than others. And that's a lot of the work that we have to
21 do, something like that.

22 Jack, do you want to comment on that?

1 DR. HOADLEY: Yeah. On that point in particular,
2 I mean, there are clearly some steps about really getting
3 into the root of crisis that are outside of Medicare. So
4 changing patent law, changing the Hatch-Waxman rules would
5 be pretty clearly not a Medicare policy.

6 There are other policies that are more direct,
7 and one that's certainly been circulating a lot is the idea
8 of a Part D rebate parallel to the Medicaid rebate. It's
9 usually been focused in terms of doing it for the LIS
10 population because the argument has been capture the
11 savings that would have been captured back when those
12 people recovered under Medicaid.

13 You could also apply that same kind of a rebate
14 to a broader population. There's nothing that says that
15 Congress could not choose to -- or we could not choose to
16 recommend that a rebate policy be established across the
17 board for all beneficiaries.

18 There are policies around secretarial
19 negotiation. I mean, there's a lot of arguments why simply
20 changing the current policy that says the Secretary may not
21 negotiate and just changing that policy alone probably
22 doesn't accomplish any real change in pricing, but there

1 are ways to create some tools for the Secretary to use.

2 One of them that has been mentioned is to create
3 some kind of an arbitration process for true single-source
4 drugs or some other kinds of things like that, that would
5 at least go after some of those drugs that could be done
6 within the Medicare scope. Those are clearly more
7 controversial items than any of the ones that we have been
8 talking about today, but if there was enough interest
9 around this table to sort of take those stronger
10 approaches, they I think fall clearly within our
11 jurisdiction, and we could take them on.

12 DR. CROSSON: And I think based on earlier
13 conversations, we have talked about at least commenting,
14 not necessarily folding into recommendations

15 DR. HOADLEY: Based on earlier conversations, we
16 have talked about at least commenting, not necessarily
17 folding into recommendation, but at least commenting on
18 some of those approaches.

19 DR. MILLER: You're right. That's at least what
20 you were saying, Cori.

21 MS. UCCELLO: Yes, and clearly, I should have
22 just gone before Jack.

1 [Laughter.]

2 DR. MILLER: It would have helped me immensely,
3 because I -- now I understand what he's saying.

4 DR. CROSSON: Okay. All right.
5 Craig.

6 DR. SAMITT: So, I also think the chapter's
7 perfect as is.

8 In terms of the March discussion, though, and
9 I've raised this before and I don't know if this is
10 feasible, but when we talk about policy approaches, I see
11 plans and I see beneficiaries. I don't see providers.
12 And, I've asked whether there is some consideration about
13 provider accountability here, as well. And, so, as we look
14 at ACOs and some of the other levers that we're looking at
15 to align with provider around value, why not aligning
16 providers around Part D costs, if not Part B costs, as
17 well, as a subcomponent. So, again, I don't know if
18 there's any feasibility as the ACO world develops, but I
19 would add it as a fifth category, because I'd love to hear
20 more about some options there, as well.

21 DR. CROSSON: Good point. Good point. Thank
22 you.

1 All right. Rita, and then I'm going to come
2 back. Rita and Warner, and then we'll come back this way.

3 DR. REDBERG: So, I want to also say it was a
4 great chapter and I don't have suggestions for change.

5 But, I would want to get back to some of the
6 things we have talked about before, such as that not all
7 drugs are created equal, and, you know, when we're talking
8 about drugs, and it's certainly striking when you look at
9 the numbers of drugs that Medicare beneficiaries are on
10 now, like four-and-a-half is the average per enrollee, you
11 know, and you think that there tends to be a synergistic
12 increase in the number of drug-drug interactions and harms
13 when you get up to that level of drugs, that some of them
14 are more effective and others. That is in, unfortunately,
15 no way related to price, because supply and demand doesn't
16 really work in the drug market.

17 And, so, if, you know -- so, some are just not
18 that effective, but some are actually, I think, harmful and
19 still being used, and I thought of it in particular because
20 in the protected drug classes, the three that are very
21 heavily -- influence the trends, antidepressants,
22 antipsychotics, and anticonvulsants, I think likely have

1 people that would be better off not on some of those drugs.

2 And I don't know if that can be -- you know, we
3 don't really look at sort of appropriate use or overuse of
4 drugs, but I think that spending on very expensive drugs
5 that are not helping our Medicare beneficiaries is
6 certainly an area where it would be a win-win to reduce it,
7 and I don't know if that fits into the MTMs, which
8 currently aren't that effective, but could be made perhaps
9 more effective.

10 The other thing I thought about when we're
11 talking about the hep C, and clearly, that big impact --
12 and it's a big problem, in general, for Medicare, but
13 certainly for the hep C drugs -- you know, a lot of the FDA
14 approvals are based on studies that don't involve Medicare-
15 age beneficiaries, so we really don't know if older people
16 are going to have benefit at all from these drugs.

17 You know, I think that for Medicare to really
18 behave responsibly, we need to demand to have data in
19 Medicare beneficiaries on which to base these decisions and
20 not think that Medicare beneficiaries are going to be the
21 same as 35 and 40-year-olds that are studied and a lot of
22 the healthy ones where comorbidities have been excluded,

1 which does not happen for our patients, and that's a big
2 problem and not one we can address on our own, but
3 certainly make it clear and work with other agencies that
4 have jurisdiction.

5 DR. CROSSON: Warner.

6 MR. THOMAS: So, I think there's a lot of good
7 information in the chapter. I guess what I would recommend
8 that we consider including is more information around the
9 fact that, you know, we appear to be somewhat hamstrung
10 that we, because we don't, essentially, pay for drugs
11 directly, that we are impacted on how we can impact the
12 pricing of those drugs, and that I think that should be a
13 component of the discussion in the chapter.

14 If you look at Table 6, you know, some of the
15 largest plans have premium increases of 21 percent, 17
16 percent, 25 percent. I mean, those are pretty large
17 increases that are directly to the beneficiary. And, you
18 know, obviously some of what drives that is utilization,
19 but probably a large component of that is pricing, as well,
20 and, you know, the single-source component.

21 So, I just think that -- I understand we're going
22 to take up drug pricing in a broader way in March or April,

1 but I think to -- I'm just not sure there's enough emphasis
2 in this chapter around the concern of pricing in general as
3 it relates to this program and the impact that it's having
4 on the beneficiary as far as the premium cost.

5 Now, obviously, they still like the program.
6 It's very attractive to them. It's helpful. But, the
7 premiums are going up pretty substantially. We spent a lot
8 of time this morning talking about beneficiaries and the
9 pricing of drugs and how we can benefit them, and I'm just
10 -- I'm not sure we're capturing the drug cost concern
11 enough in this chapter. So, I think if there were more
12 comments around that, I think it would be helpful, and
13 frankly, I think it's something we struggle with as an
14 industry and as a Commission, is how do we deal with the
15 whole drug pricing component and its impact on benefits and
16 programs like this.

17 DR. CROSSON: Right. So, I think we did
18 establish a new tradition a little while ago, which is that
19 this kind of status quo chapter could be expanded a little
20 bit along the lines that Warner is talking about, but also
21 along the lines of, at least in a summary way, you know,
22 what we think about this, these trends, and at least just

1 presaging some of the work that's going to come later. Is
2 that --

3 DR. MILLER: The other thing that would --
4 certainly, leaning into saying what we're going to be doing
5 later, no issue at all.

6 The other thing that I was thinking is whether in
7 the set-up for the chapter we sort of say, look, you know,
8 there was a decision made in legislation to approach
9 Medicare drugs this particular way -- you know, market-
10 based, plans bid, that type of thing -- that has this
11 particular feature. You're not directly purchasing and
12 pricing drugs, which means the tools that you have are a
13 certain type of tools. Or, maybe, this actually does work
14 more towards the end, and then you can lean into the --
15 what was the word you used? Presage?

16 DR. CROSSON: Presage.

17 DR. MILLER: Presage, okay, you know, what we're
18 -- I think that means what we're going to do.

19 [Laughter.]

20 DR. MILLER: Then you could lean into that part
21 of the comment, and maybe that gets at some of what Warner
22 is asking there.

1 MR. THOMAS: I think if it's a status report and
2 we have in our summary that cost trends are increasingly of
3 concern, okay, so how concerned are we about a 20-plus
4 percent increase in beneficiary cost sharing? I mean, to
5 me, that's pretty substantial if you compare it to some of
6 the cost increases we've talked a lot about this morning
7 that were nowhere near that amount. So, it's just -- it's
8 just a comment.

9 DR. CROSSON: Coming back around, did I see you,
10 Jon? Coming back around this way, and then up to Jon. So,
11 Bill and -- no? Mary, no?

12 DR. NAYLOR: Great chapter.

13 DR. CROSSON: Okay. Jon.

14 DR. CHRISTIANSON: Just in terms of things to
15 focus on, we've talked about this before, but I think this
16 question of whether having the Medicare program be the
17 reinsurer to the extent that it is in this program, it
18 seemed like a good idea at the beginning. We talked before
19 about whether we thought -- you know, there's also
20 implications of pulling back from that in terms of
21 implications for beneficiary premiums and cost sharing and
22 so forth. But, I think we need to take a good look at

1 that, because conceptually to me, it no longer makes sense
2 to have as much of the reinsurance fall to the government
3 as currently exists in this program.

4 DR. CROSSON: Jack.

5 DR. HOADLEY: I was thinking, with the comments
6 that Cori made and also some of Warner's comments, I mean,
7 the first bullet on this agenda is stronger incentives for
8 plans to control spending of high-cost enrollees. When I
9 started my comments, I also sort of made a reference to
10 high-cost drugs, and maybe what we really need is that that
11 is a bullet, too, that it's stronger methods to address the
12 high-cost drugs. We've already established, I think, in
13 the good work that Shinobu and Rachel have done, that a lot
14 of the high-cost enrollees are there not because they're
15 using high-cost drugs but because they're using many lower-
16 cost drugs. There are some people, and you're seeing a
17 growth in the number of people who are using high-cost
18 drugs. So, really, they are two separate kinds of pieces
19 of the issue.

20 I mean, I also wanted to reinforce something Rita
21 said in terms of this, and I think you've done this before
22 and I just can't remember if it's something you do in the

1 data book, but, you know, sort of the share of enrollees,
2 not just -- you talked about the average of four drugs per
3 person, but the share of enrollees who are using, say, ten
4 or more drugs, and I don't remember what kind of number
5 that is, but it's not tiny, as I recall.

6 And I even heard an anecdote recently of somebody
7 whose parent was taking ten drugs. They contacted the
8 plan, hoping to get a comprehensive medication review, and
9 were told they weren't eligible for their MPM program,
10 which is -- could possibly just have been error, but
11 nonetheless, that's what they got told. So, there's not
12 only somebody who has four, which seems like a lot, but the
13 ones who are ten.

14 But, that's a very separate and different focus
15 than the high-cost drugs and what are the tools, whether
16 it's anticipating the biologicals and the biogenerics,
17 biosimilars, but also just the sort of single-sourced high-
18 priced drugs, and we really should make sure we're
19 addressing each of those sort of as separable issues. And
20 maybe when we sort of have a repeat of this slide coming up
21 in the next meeting or something like it, that would be my
22 suggestion to break out.

1 MS. BUTO: Just to continue on Jack's point, and
2 that would be across B and D, because, obviously, there are
3 more tools potentially available for Part B, and D is, I
4 think, another kettle of fish.

5 DR. CROSSON: Okay. This is very good input.
6 Rachel and Shinobu, thank you much for the chapter. I hope
7 you have gotten some good ideas here, and we also have
8 gotten a good sense of priorities for the spring.

9 So, I think we're finished with our agenda for
10 the day and now we have an opportunity for public comments.
11 And if there are any individuals who wish to make a
12 comment, please come to the microphone so we can see how
13 many people we have.

14 I'll just make a couple of comments here, which
15 we make each time, and then I'll add one. We invite you to
16 make these comments. We listen carefully. This is a
17 useful tool to us. However, from the perspective of --
18 from your perspective, it's important to know this is not
19 the only or the best way to provide input. There are both
20 interactive communications mechanisms with the Commission
21 and -- I mean, with the staff, and then also through the
22 staff to the Commissioners, as well as in-person meetings

1 with Mark and his staff as you need that, before we get to
2 the end of issues and particularly before we get to voting.

3 The other comment I'd like to make is that it has
4 been the tradition here at the Commission for these public
5 comment periods to be focused on the issues of that morning
6 or afternoon and not, you know, the next day or in the
7 morning or the afternoon. So if you have a comment on the
8 issues we tackled this afternoon, we would invite you to
9 make those comments.

10 We'll ask you to keep your comments to two
11 minutes, and when this light comes back on, that's an
12 indication that the two minutes has expired.

13 Please give us your name and your affiliation, if
14 there is one, and proceed.

15 MR. KATHRINS: Thank you. My name is Richard
16 Kathrins. I'm the president and CEO of Bacharach Institute
17 for Rehabilitation, a nonprofit rehab hospital in New
18 Jersey. I also in a voluntary capacity serve as the vice
19 chair of the American Medical Rehab Providers Association,
20 AMRPA, the national trade association representing 500
21 rehab facilities and units.

22 AMRPA respects the work of the Commission and

1 appreciates the opportunity to provide public comment, both
2 written and oral. We're concerned that MedPAC's faulty
3 assumptions underlying their December analysis and today's
4 discussion could lead to recommendations that are poorly
5 targeted at the problems that they seek to address.

6 First, we are concerned that stratifying the IRF
7 sector based on Medicare profitability places scrutiny on
8 providers that have found ways to find efficient resource
9 utilization through economies of scale or other means, and
10 the analysis does not show profitability that is a static
11 factor over time and thus may draw influences that are
12 linked to permanent aspects of the sector and should not
13 serve as a Medicare policy.

14 Second, AMRPA is troubled by the presumption that
15 margins are due to improper coding and patient selection.
16 MedPAC presumes that more profitable IRFs are selecting
17 fewer patients with specific conditions, such as strokes
18 with paralysis rather than the inverse. They have
19 overlooked a multitude of other factors driving case mix
20 such as clinical expertise, regional availability, and
21 referral patterns.

22 In addition, we do not believe that the

1 hospital's DRG can draw apples-to-apples comparison between
2 functional, cognitive, and medical status of the patient as
3 they move from the acute-care hospital to the post-acute-
4 care level. There are no functional assessments done in
5 the hospital setting under the DRG program.

6 Some of our members are troubled by the
7 discussion describing the outlier payments as a program to
8 reallocate payments to low-margin providers. Outlier
9 payments are a critical component of the payment system
10 that allow IRFs to treat highly complex patients that are
11 not a policy tool to redistribute funds within the sector.

12 Thank you very much for your time.

13 DR. CROSSON: Thank you.

14 MR. BAIRD: Hello. My name is Andrew Baird. I
15 am the director of government affairs for Health South, and
16 in addition to the prior commenter's points, which were
17 cited by my colleague Justin Hunter earlier this afternoon
18 in a report that was submitted to the Commission, which I
19 encourage a review and assessment, I would like to make one
20 point about CMS' comments on the outlier issue in terms of
21 its use and its policy.

22 It is worth noting that CMS has always had under

1 existing law the authority to raise the outlier percentage
2 from its current 3 percent mark up to 5 percent, but yet it
3 has never adjusted its current 3 percent mark.

4 Indeed, in the FY2012 final for the IRF PPS --
5 that's our payment system -- CMS reiterated a previously
6 stated policy view about the size of the outlier pool,
7 saying, and I quote, "The outlier policy of 3 percent of
8 total estimated payments optimizes the extent to which we
9 can encourage facilities to continue to take patients that
10 are likely to have unusually high costs while still also
11 providing adequate payment for all other cases."

12 It is further noteworthy that every year since
13 that final rule in 2012, CMS has lowered the outlier
14 threshold percentage by reducing the fixed loss amount, as
15 was discussed briefly today, by nearly 19 percent over
16 those five years in order to maintain that 3 percent pool,
17 meaning that for each year the previous year's threshold
18 was too high and there were not enough cases to account for
19 that full 3 percent pool.

20 So just some facts from CMS. Thank you for your
21 time and consideration.

22 DR. CROSSON: Thank you.

1 Seeing no one else at the microphone, we are
2 adjourned for the day, and we will reconvene tomorrow at
3 8:30.

4 [Whereupon, at 4:08 p.m., the meeting was
5 recessed, to reconvene at 8:30 a.m. on Friday, January 15,
6 2016.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 15, 2016
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, FAAN, RN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
CORI UCCELLO, FSA, MAAA, MPP

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P R O C E E D I N G S

[8:30 a.m.]

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DR. CROSSON: Well, good morning, everybody.
Welcome back to MedPAC. Welcome to our observers as well.

We have two agenda items today. The first one is an update on our continuing work on the potential for a unified payment system in the area of post-acute care, and Carol Carter is going to take us through that work.

DR. CARTER: Good morning, everybody. Before I get started, I wanted to thank Doug Wissoker and Bowen Garrett, who are both here from the Urban Institute. Their work has been top-shelf, and they are really fantastic colleagues, so I wanted to thank them.

The IMPACT Act of 2014 requires the Commission to consider the design of a prospective payment system spanning the four post-acute-care settings -- home health, SNFs, IRFs, and LTCHs. Currently, Medicare pays for PAC services using separate payment systems for each setting. As a result, though many of the patients treated in different settings are similar, Medicare's payments can differ considerably. Further, the Commission has been critical of the home health and SNF payment systems because

1 they encourage providers to furnish therapy that is
2 unrelated to a patient's care needs. A unified payment
3 system would span the four settings and correct these
4 shortcomings, basing payments on patient characteristics
5 and not the site of care.

6 The first of the two mandated reports is due at
7 the end of June, and it must recommend features of a
8 unified payment system and, to the extent feasible,
9 estimate the impacts of moving to such a system. A second
10 report, due much later -- probably around June 2023 -- must
11 propose a prototype design.

12 This is the third session considering the design,
13 testing, and impacts of a PAC PPS. In September, we
14 outlined an approach to the mandate and reviewed
15 preliminary results using stays in CMS' post-acute-care
16 payment reform demonstration, or PAC-PRD. The results were
17 promising, and we concluded that a unified payment system
18 looked feasible.

19 In November, we confirmed our preliminary results
20 for an expanded set of patient groups, some of which you
21 suggested. We discussed companion policies that could be
22 implemented at the same time to dampen the volume

1 incentives that would remain in a prospective payment
2 system, such as a readmission policy, a value-based
3 purchasing program, and the use of a third-party benefit
4 manager. We also discussed waiving setting-specific
5 regulations under a unified PPS. We noted that in the long
6 term, Medicare needs to adopt payment reforms that
7 encourage an efficient, coordinated approach across
8 episodes of care.

9 Today we present our work modeling payments for
10 all 2013 post-acute stays under a unified payment system.
11 The results suggest the need for certain payment adjusters
12 and not so much for others. We provide rough estimates of
13 the impacts on payments. In March, we will explore the
14 need for an adjuster for low-volume, isolated providers and
15 look at a prototype outlier policy. We will also discuss
16 different ways to think about establishing the aggregate
17 level of payments. And, finally, in April we will finalize
18 the report.

19 This slide summarizes the broad approach we're
20 taking to meet the first mandated report. The elements of
21 the mandate are in red, the methodology for each is in
22 yellow, and the purpose of each step is in green. The

1 mandate has two requirements. It requires us to evaluate
2 and recommend features of a PPS using data from the PAC-PRD
3 data -- and that's the first row -- and then to estimate
4 the impacts -- and that's in the second row.

5 While the PAC-PRD data has unique strengths, the
6 sample is limited. Therefore, we wanted to estimate the
7 impacts using a larger sample of PAC stays. So we devised
8 a combined methodology to take advantage of the PAC-PRD
9 data while using a larger sample. There is an extensive
10 discussion of the methodology in the paper so I will give
11 only an overview here. Basically, we developed three
12 models, and each one has a specific purpose.

13 To evaluate and recommend features of a PAC PPS,
14 we first developed a "full model" to predict the costs of
15 stays using patient characteristics and the unique data in
16 the PAC-PRD. And that's the first column. The purpose of
17 this step is to establish the relative costs of stays and
18 test whether a unified payment system is feasible. To
19 estimate the impacts, we needed to build a model without
20 the specially collected information since that information
21 is not available for other stays.

22 So then we re-estimated the model using the same

1 PAC stays but using only predictors that are available in
2 administrative data, and we refer to that as the
3 "administrative model." By comparing the accuracy of
4 predicted costs using the full and the administrative
5 models for the same stays, we could evaluate if the
6 administrative model would establish accurate relative
7 costs of stays, and that's in the second column. If the
8 administrative model was accurate, we could use it to
9 estimate the impact of a PAC PPS using 2013 stays, and
10 that's the model in Column 3.

11 To give you a sense of the difference between the
12 full and administrative models, I've listed the types of
13 factors we've included in the models to predict the
14 relative cost of stays. Age and diagnoses are readily
15 available information and are included in all of the
16 models. The models differ in whether and how well they
17 include information on patient impairments, functional and
18 cognitive status, and routine costs. For example, some
19 impairments and cognitive status could be approximated
20 using diagnosis codes. Others, like functional status, had
21 no equivalent in administrative data, and so they were left
22 out of the administrative models. Both models using the

1 PAC-PRD stays include the same 6,400 stays, while the
2 administrative model using 2013 data includes 8.9 million
3 stays.

4 To evaluate the models, we looked at many
5 different patient groups listed on this slide. They are
6 defined in the paper, and we report on 13 clinical groups,
7 a variety of impairment and severity groups, community
8 admissions, and other groups including demographically
9 defined groups, such as the aged and disabled and dual-
10 eligible. We also identified stays that used a lot and
11 little/or no therapy to see how a PAC PPS would affect
12 them.

13 Our first set of analyses look at whether we can
14 use the administrative model, without the unique PAC-PRD
15 data, to accurately predict the relative costs of stays and
16 estimate the impacts of a PAC PPS.

17 Using the same PAC-PRD stays, we found that full
18 and administrative models were very similar in accurately
19 predicting the relative cost of stays. The administrative
20 models would establish accurate relative weights for almost
21 all of the patient groups we examined with minor
22 exceptions. Those exceptions, such as patients with high

1 and low functional status, underscore the importance of
2 collecting patient assessment information for accurately
3 predicting the relative costs for these groups.

4 The models also explained similar (and high)
5 shares of the variation in the costs of stays. The
6 accuracy of the administrative models confirmed our plan to
7 use them to roughly estimate the impacts of a unified PPS
8 using 2013 PAC stays. Our results also suggest that while
9 data on functional status do not substantially improve our
10 ability to predict the relative costs of stays in aggregate
11 or for most groups, the data were important for predicting
12 the relative costs of the functional status groups.

13 Now we turn to the results using the 2013 data
14 using the administrative model. We first examine how well
15 that model predicted the relative costs of stays using a
16 very large sample of stays.

17 We found that patient characteristics could
18 establish accurate relative costs of stays in aggregate and
19 across most of the patient groups. The details of the
20 results are in the paper. The results held for almost all
21 of the clinical groups we examined, the frailty groups, two
22 of the medically complex groups, community admissions, and

1 the demographic groups. For most rural groups, our results
2 suggest that there would be no need for a broad rural
3 adjustment, but the result for frontier providers suggested
4 there might be a possible need for an adjustment for them,
5 and I'll come back to that in a minute. For stays treated
6 in teaching IRFs, the model was pretty accurate in
7 establishing the relative costs, so it didn't look like a
8 separate teaching adjustment would be needed. It appears
9 that a robust risk adjustment method could accurately
10 predict the costs of these stays.

11 There were a handful of groups where the average
12 predicted costs deviated from the average actual costs, and
13 those fall into broad categories -- those where the results
14 were expected and illustrate the objectives of a unified
15 PPS, and those that suggest the need for a payment
16 adjustment or warrant further study. On this slide, we
17 identify the therapy and setting results that we expected
18 from a unified PPS. For these groups, providers' current
19 therapy practices, current PPS shortcomings, and the cost
20 structures of high-cost settings explain the results, and
21 the findings do not suggest a need for payment adjustments.
22 For example, stays with low therapy costs were likely to be

1 medically complex and their predicted costs were higher
2 than their actual costs. Conversely, stays with high
3 therapy costs were likely to include services that were
4 unrelated to the patients' care needs, and, therefore, the
5 predicted costs were lower than their actual costs. We
6 want a unified PPS to correct the existing PPS incentives
7 to furnish unnecessary therapy, not replicate them.

8 For stays treated in IRFs and LTCHs, many of the
9 types of stays treated in these high-cost settings are also
10 treated in lower-cost settings. Therefore, the predicted
11 costs for these settings will be lower than their actual
12 costs because of the averaging that's going on. The
13 objective of a PAC PPS is to establish a uniform payment
14 across settings, so this is also an expected finding. A
15 transition would give LTCHs and IRFs time to adjust their
16 costs to payments under a unified payment system.

17 Now let's look at the results that may warrant a
18 payment adjustment or further study. First, the results
19 for very short stays uniformly suggested the need for a
20 short-stay policy to prevent large overpayments that would
21 result from assuming a stay of average duration. And
22 although we did not specifically analyze outlier stays, a

1 stay-based payment system should also have a high-cost
2 outlier policy to protect providers from large losses and
3 help ensure beneficiary access to care. We plan to present
4 information about an illustrative outlier policy in March.

5 Two other groups may warrant further study. The
6 results for the frontier providers indicated that these
7 providers may lack of economies of scale due to their low
8 volume. We will present more information on this in March
9 also.

10 Another group was one that Alice suggested, and
11 those were extremely sick patients that were defined as
12 patients with severity illness level 4, on dialysis, with
13 severe wounds, and sufficiently sick that they were not
14 discharged home to home health care. Our results indicate
15 that developing a good risk adjustment will be critical to
16 ensuring access for these patients. Otherwise, providers
17 may avoid admitting these patients. An outlier policy
18 would augment payments when the costs of stays are
19 exceptionally high.

20 Now we turn to the estimates of the impacts.
21 Because our task is to examine the feasibility of a unified
22 payment system, we estimated aggregate payments under a

1 unified payment system at the same level of payments as
2 current law. Our estimates do not reflect policy changes
3 since 2013, such as the recently enacted LTCH policies.
4 Our estimates also do not assume any changes in provider
5 behavior. For example, between now and when a PAC PPS is
6 implemented, the patient mix in LTCHs is likely to change,
7 but we have not factored these into our estimates. The
8 estimated impacts should be considered as directional and
9 relative, rather than point estimates.

10 Our first analysis of impacts looks at how the
11 relative profitability of stays will change under a PAC PPS
12 by comparing the ratio of payments to costs, and I've
13 listed several groups that illustrate the results for
14 almost all of the groups. In the first column, you will
15 see the ratios under current payments, and they range from
16 1.03 to 1.28. The variation in the ratios reflects the mix
17 of settings where the stays are treated, the high level of
18 payments particularly in home health and SNFs, and the
19 biases of both of those payment systems that favor
20 rehabilitation care over treating medically complex
21 patients. For example, the ratio for orthopedic medical
22 groups -- and that would include patients like hip fracture

1 -- their ratio was 1.28.

2 In the second column are the ratios under a PAC
3 PPS. You can see that the range is narrowed considerably,
4 from a low of 1.15 to 1.2, suggesting that the relative
5 profitability of groups would become more uniform under a
6 PAC PPS. Providers, therefore, will not have strong
7 incentives to selectively admit some patients over others
8 or to favor rehabilitation care over treating medically
9 complex cases.

10 Two groups that deviate from this pattern were
11 the therapy groups I previously talked about and the
12 extremely sick group. Because extremely sick patients are
13 also treated in SNFs and IRFs, the average PAC payment
14 would be lowered by this mix of settings. Although the
15 average payment for this group would just about cover the
16 average costs of these stays, the ratio for that group is
17 lower compared to the average for the other groups. This
18 result reinforces the need to have an adequate risk
19 adjustment method. The other key takeaway from this slide
20 is the overall level of payments. We estimate that
21 aggregate payments were 18 percent higher than costs, and
22 next month we'll lay out different ways one might think

1 about establishing a level of payment.

2 A second impact analysis looks at the shifts in
3 payments under a unified payment system. Compared with
4 current policy, a unified PPS will shift payments across
5 stays, increasing payments for some groups and decreasing
6 them for others. Payments will increase for many of the
7 medically complex and patient impairment and severity
8 groups. Payments will decrease for clinical groups where
9 rehabilitation therapy is a key component of care and that
10 provision of therapy was not related to patient
11 characteristics.

12 A unified PPS will also shift payments from high-
13 cost settings to low-cost settings and from high-cost
14 providers to low-cost providers. Payments to SNFs,
15 hospital-based, and nonprofit facilities will increase
16 because a PAC PPS that bases payments on patient
17 characteristics would consider the medical complexity of
18 patients often treated there.

19 Payments are estimated to decrease for IRFs,
20 LTCHs, freestanding, and for-profit providers for two
21 reasons. First, payments will decrease for stays with
22 therapy services that are unrelated to patient

1 characteristics. And, second, many of the types of
2 patients treated in IRFs and LTCHs are also treated in
3 lower-cost settings. Within LTCHs, we also looked
4 separately at stays that meet the LTCH-qualifying criteria,
5 and the payment reductions for those stays would be smaller
6 than the reductions for LTCHs overall.

7 To summarize, a PAC PPS is estimated to shift
8 payments from rehabilitation care to medical care, and to
9 narrow the profitability by type of stay. This will
10 decrease the incentive to selectively admit certain types
11 of patients over others. A PAC PPS will raise payments to
12 providers that treat medically complex patients and lower
13 payments to providers whose costs and service mix are
14 unrelated to care needs and where lower-cost settings treat
15 the same types of patients.

16 These results are expected and reflect the
17 objectives of a unified payment system. A high-cost
18 outlier policy and a short-stay policy will help align
19 payments to providers' costs, and a transition period will
20 give providers time to adjust their costs.

21 The estimated impacts will create incentives for
22 many providers to change their practices and cost

1 structures, but the impacts on any given provider could
2 differ from these general trends and will depend on several
3 factors: first, the mix of the patients it treats; the
4 second is the current setting where the patient is treated,
5 that PPS and its design and its incentives; the provider's
6 current practice patterns such as whether it often provides
7 services that are unrelated to care needs; and the
8 provider's ability to match its costs to the payments it
9 will receive under a PAC PPS.

10 Our results lead us to the following conclusions:

11 Most importantly, a PAC PPS is feasible and will
12 break down the silos between settings. Payments will be
13 based on patient characteristics and not the setting and
14 would correct some of the shortcomings of the current PPSs.
15 A unified PPS will dampen incentives to selectively admit
16 some types of patients over others.

17 Our results have many implications for the design
18 of a unified payment system. Administrative data could
19 form the basis of a PAC PPS, but functional assessment data
20 are needed to calibrate payments for certain types of
21 patients. Payments for stays in home health agencies will
22 need to be aligned with the setting's lower costs.

1 In terms of payment adjustors, our results
2 suggest the need for a short-stay policy to prevent large
3 overpayments. A broad rural adjustment and an IRF teaching
4 adjustment didn't appear to be needed, but low-volume
5 isolated providers may need protection and we'll be coming
6 back to that in March.

7 In addition, a high-cost outlier policy will help
8 ensure beneficiary access to care and protect providers
9 from large losses. A transition period would give
10 providers time to adjust their costs and protect
11 beneficiary access.

12 In addition, the risk adjustment factors can be
13 refined over time if there is systematic under- or
14 overpayments that occur. And, as in any payment system,
15 the relative weight should be recalibrated regularly to
16 reflect changes in the relative costs of stays.

17 And, finally, policymakers need to consider the
18 level of payments.

19 And with that, I'd be glad to answer any of your
20 questions and look forward to your discussion.

21 DR. CROSSON: Well, thank you, Carol, for this
22 rather elegant modeling and analysis. I have to admit,

1 when we first started here, I was kind of scratching my
2 head as to how we were going to get through this rather
3 complicated situation and you've done it excellently.

4 So, let's take clarifying questions. Mary, and
5 then Kathy.

6 DR. NAYLOR: So, let me echo Jay's comment. I
7 think that this is really extraordinary, beautiful work,
8 elegantly presented.

9 So, can you talk a little bit about the patient
10 impairment categories and how they were constructed, page
11 14-15, because they seem somewhat overlapping, but I was
12 interested in knowing how they were constructed and
13 defined.

14 DR. CARTER: So, those groups do overlap. We
15 were mostly just trying different definitions to see how
16 different constellations of those qualifications differ, if
17 the model would treat them differently.

18 So, you're right, these groups do overlap. So,
19 one of the groups is severity of illness four, so we ran
20 everybody through a DRG grouper, even for the home health
21 community admits, and anybody that was assigned to level
22 four severity is in that group.

1 A different group looks at whether patients had
2 multiple, that is five or more, comorbidities, and, so,
3 obviously, some of those also are severity level four.

4 The third group was the one that Alice had
5 defined, and that's severity level four, they're on
6 dialysis, and they had severe wounds, and those all
7 overlap.

8 The impaired cognition group, in the PAC-PRD
9 data, those patients were assessed for their cognitive
10 impairment and so we used that data. When we moved to the
11 administrative model and we didn't have cognitive function,
12 we used ICD-9 codes for dementia and coma and Alzheimer's
13 and things like that. So, we were relying on diagnosis
14 codes. And, it's not a perfect overlap, but we were trying
15 to do the best we could with some proxies.

16 DR. NAYLOR: One other question around the
17 severely ill -- what is the language -- extremely sick.
18 Obviously, the highest cost group, as evident in your work.
19 What proportion -- and I know I just said and we just --

20 DR. CARTER: It's less than one percent.

21 DR. NAYLOR: It's less than one percent. Okay.

22 DR. CARTER: Yes.

1 DR. NAYLOR: Thank you.

2 DR. CHRISTIANSON: Kathy.

3 MS. BUTO: Carol, this work made me feel that we
4 could move almost immediately to a PAC PPS. It's probably
5 an exaggeration, but I was so impressed with the amount of
6 work and detail that you put into it.

7 But, I really had a couple of questions about
8 some of the exceptions or the adjustments -- short stay,
9 high cost, and then low volume isolated. Are those kinds
10 of patients or facilities -- I guess these are really
11 facilities with patients that --

12 DR. CARTER: But, they're really patient groups.

13 MS. BUTO: They're patient groups.

14 DR. CARTER: What we're reporting are patient
15 groups.

16 MS. BUTO: Okay. Are they uniformly evident
17 across provider types, or do you find that, for instance,
18 with IRFs, you have more of certain kinds of patients that
19 fall in one of these categories? Which ones are the short
20 stay? Are they evenly distributed, or are they in certain
21 facilities, that kind of thing?

22 DR. CARTER: Just to look at the need for an

1 adjustor, we did look at sort of using the current
2 definitions in law and also just the shortest tenth
3 percentile of the distribution by setting. And the reason
4 we did that is because the stay durations are pretty
5 different across the settings. So, we just wanted to look
6 at the low end of the tail in each of the settings to see
7 whether it would look like a short stay policy would be
8 required.

9 MS. BUTO: Okay. And, I guess the other question
10 was something you raised in just the set-up, which is how
11 important to proceeding to a unified PPS would be making
12 smoother the conditions of participation? In other words,
13 how much of a barrier or an impediment to a PAC PPS would
14 the current conditions and the differences be?

15 DR. CARTER: Well, I think something like the 60
16 percent rule comes straight to mind, where you can't be
17 paying uniform -- trying to move to being agnostic, if you
18 will, about where patients are treated and still require
19 IRFs to have 60 percent of its cases in specific groupings.
20 So, that one is obvious to me. Something like the LTCH
21 length of stay criteria -- if we're going to pay LTCHs kind
22 of regardless of the types of patients that are there, you

1 would expect -- they might want to take different types of
2 patients and they wouldn't need to stay 25 days. So, those
3 are two examples.

4 MS. BUTO: What about the three-day prior
5 hospitalization requirement for SNFs?

6 DR. CARTER: Well, that one's trickier, because
7 that one is sort of a speed bump, if you will, in some
8 ways, for converting long-stay patients to Part A
9 qualified. So, I think we'd need to think a little more
10 carefully about whether to proceed with them.

11 DR. MILLER: And this, I think, really has
12 implications for the second round, so I'm out of order and
13 Jay just got back to catch me at it.

14 So, I think one of the implications of Kathy's
15 question to think about as we go forward is this constant
16 tension, and I'm going to use your inlier, as I think you
17 asked about. I mean, in a sense, what you want is a
18 payment system where you look across the broad distribution
19 and you're doing a pretty good job of capturing everybody.
20 You have an outlier for those and an inlier, where you say
21 this is it for everybody. To the extent that you have the
22 need or the temptation to go in and do it by setting,

1 you're going back to rebuilding, and that's going to be a
2 constant tension throughout this, and this is why in some
3 ways transitions and how fast we're ready to move on this,
4 I think, come into play.

5 But, that's really a second round kind of
6 discussion, but your question, I think, goes right to it.

7 MR. ARMSTRONG: So, first, I do just want to say
8 I can't remember feeling so excited about something I
9 really understood so little about --

10 [Laughter.]

11 MR. ARMSTRONG: But the prospect of being able to
12 really make this work after the debates and the whining
13 we've done about silos and post-acute for seven years is
14 incredibly exciting to me, even for nine o'clock in the
15 morning on the East Coast.

16 [Laughter.]

17 MR. ARMSTRONG: And, Mark, just to your point,
18 this may be a second round or a next month kind of a
19 question, but so much of post-acute care, when managed
20 really well, within the context now of what hopefully will
21 be a prospective payment, actually moves between these
22 different settings, and you kind of want it to move between

1 these different settings. So, how would this kind of a
2 payment model accommodate that?

3 DR. CARTER: I think I heard your question
4 correctly, which is does it encourage or discourage
5 movement across the settings. So, this doesn't really do
6 much for that. This is just trying to get pricing uniform
7 across the settings, and that's why in November we did
8 spend some time talking about the preference for bundled
9 payments to try to really discourage, you know, patients
10 moving between settings unnecessarily, so that would put a
11 provider at risk for an episode of care and then we're sort
12 of agnostic about how they move or even stay in place and
13 transition between different levels. So, it doesn't really
14 get at what you're talking about.

15 MR. ARMSTRONG: So, on down the road, though,
16 there will be some, I'm sure, administrative issues we'll
17 have to raise, like who gets the payment and how does the -
18 -

19 DR. CARTER: Unbundled payments.

20 MR. ARMSTRONG: Yeah.

21 DR. CARTER: Yes, of course. And we did talk in
22 November, because of the continued incentive for volume, we

1 talked about the companion policies, like readmission
2 policies or, you know, Medicare spending per beneficiary.
3 So, we are holding -- yes, we're going to pay you on your
4 PPS rate, but we're looking at how much spending you're
5 generating downstream.

6 DR. MILLER: [Off microphone.] The only other
7 thing I would say is I don't think that this necessarily
8 gets in the way of that and, in some ways, is a step
9 towards it.

10 DR. CARTER: Oh, I think, definitely.

11 DR. MILLER: But we tried to bring out in
12 November that you guys -- we didn't use the term whining,
13 but the notion of when are we going to get to a bundle,
14 that kind of payment. I think this takes you a little ways
15 down the road on the uniformity, but it doesn't get you to
16 --

17 DR. CARTER: Yeah.

18 DR. MILLER: -- right, as she said.

19 DR. NERENZ: This is really excellent. Thank
20 you. It's hard enough to do this well in one defined
21 setting when you have some grasp of how the underlying
22 phenomenon are working. To do it across settings is really

1 hard and it's done very well. Thank you.

2 Clarifying question. Slide 13, please. In the
3 right-hand column, at a glance, it looks like this is set
4 up to illustrate an 18 percent positive margin. I
5 understand it's an illustration. I understand also things
6 are never that simple in practice. But, my question is,
7 the model presumably has two main components when used in
8 practice. It would have relative weights for the groups,
9 but also, then, a multiplying factor that would turn the
10 weights into dollars. Is that a fair assumption?

11 DR. CARTER: Yes.

12 DR. NERENZ: Okay. So, this 1.18 actually could
13 be adjusted up or down depending on that second factor --

14 DR. CARTER: Yes.

15 DR. NERENZ: -- and we could recommend about
16 that, Congress could act, CMS could decide. So, the 1.18
17 isn't kind of an inevitable set in stone forever --

18 DR. CARTER: That's just the level of payments.

19 DR. NERENZ: Thank you.

20 DR. CARTER: Yes. And, it's not a margin. I do
21 want to point that out. That's just ratio, yeah.

22 DR. MILLER: And you used the term

1 "illustration." I mean, this is set to be budget neutral
2 with the dollars that are --

3 DR. CARTER: Yeah. It's not an illustration.
4 This is fact. Yeah.

5 DR. MILLER: You threw that in, but I didn't know
6 whether you meant it the way you meant.

7 DR. NERENZ: Well, I guess I was just saying that
8 if this model were implemented in practice and we sat
9 around looking at it two years from now, five years from
10 now, it wouldn't have to always be 1.18. It could be --

11 DR. CARTER: Oh, and of course, it wouldn't be --

12 DR. NERENZ: Right.

13 DR. CARTER: -- because we, by the time this gets
14 implemented, will have had many years of sequestration --

15 DR. NERENZ: Okay. That --

16 DR. CARTER: -- and productivity -- anyway, so
17 that number has already changed.

18 DR. CROSSON: This is the good news? Is this the
19 good news?

20 [Laughter.]

21 DR. CROSSON: Clarifying questions, others.

22 Warner.

1 MR. THOMAS: Just on the same chart, on page 13.
2 So, for the four areas, do we know the aggregate, or what
3 are the aggregate dollars in these four buckets, roughly?
4 Do we know the total dollars?

5 DR. CARTER: Oh, \$60 billion.

6 DR. MILLER: [Off microphone.]

7 MR. THOMAS: Sixty, \$70 billion?

8 DR. MILLER: [Off microphone.]

9 MR. THOMAS: Yeah.

10 DR. CARTER: Yeah, oh yeah. It's 65, something
11 like that.

12 MR. THOMAS: Okay. And just so I can understand
13 the comments you just made about profitability, so, the
14 1.18, if I'm understanding this, so you're saying that's
15 just a -- that's a factor. How does that relate to
16 profitability? So, if we looked at the profitability on
17 the payment updates we do for each of these various areas,
18 is there any way to equate those --

19 DR. CARTER: Well, so, this is payments divided
20 by costs.

21 MR. THOMAS: Right.

22 DR. CARTER: When we calculate our margins, we

1 take payments minus costs and divide by payments. So,
2 basically, we're saying what's the margin as a ratio of the
3 spending. So, all of these numbers would be a little lower
4 once you divide through by payments.

5 DR. MILLER: [Off microphone.] For the four
6 sectors that we went through, they range from about seven
7 to 12, 13, somewhere in there?

8 DR. CARTER: In this year, maybe a little higher,
9 yeah.

10 MR. THOMAS: And, has there been any thought, or
11 will there be work either done now or in the future about,
12 you know, to the extent that there's the ability to
13 consolidate some of these services, it's more than likely
14 that you'll be able to run these facilities at a
15 potentially higher occupancy, you'll be able to run them in
16 larger types of organizations. So, you would think on a
17 unit basis you'd be able to have a better cost structure.
18 Is there any thought about that?

19 DR. CARTER: I agree with that. I do think it's
20 one of the reasons why we saw for the frontier hospitals,
21 which are smaller, they don't have the same economies of
22 scale. But, we haven't thought about, so how would these

1 cost structures change and could we model that. We haven't
2 done that.

3 MR. THOMAS: Because, I know when we've looked at
4 payment updates in the past, that smaller -- usually,
5 smaller facilities have a lower profit margin, probably
6 because they have a higher cost structure, given the
7 overall fixed costs.

8 DR. CARTER: Right. I mean, the one thing that
9 the Commission has consistently looked at is it's not just
10 small, but you should be isolated, because we do have this
11 pattern of providers being very close to each other --

12 MR. THOMAS: Right.

13 DR. CARTER: -- and both being small and both
14 having poor financial performance. So, I think it's the
15 combination of being small and isolated that we would be
16 worried about.

17 MR. THOMAS: Thank you.

18 DR. CROSSON: Okay. Seeing no more questions,
19 we'll proceed to the next round. What I'd like to do, Mary
20 is going to lead off, but Mary, before that, I'd like Mark
21 to just remind us what we're doing here, the timing of
22 this, how we're going to use this information, et cetera.

1 DR. MILLER: Okay. So, one thing I think I would
2 say is there's sort of a three-part process to this, and
3 just to remind everybody -- I'm pretty sure Carol said all
4 this, but this is a mandated report requested by Congress.
5 It's due in June. We're doing this and we're doing it now
6 and we're doing it as rapidly as we are because we're under
7 a very clear legislated deadline.

8 But, there's sort of a three-part dance to this.
9 We do this report. Then the Secretary collects the new
10 functional status information and creates a system, you
11 know, her version of the system, or whoever is Secretary,
12 and then we come in behind that and do another report.

13 So, the way I'm thinking about this report is we
14 would put out something in June, and some of these
15 statements towards the end are some of the kinds of
16 statements, some are more conclusionary statements, but
17 imagine a report at the end that goes, look, you should
18 think about models -- and I may get some of this wrong,
19 Carol, but for non-therapy ancillaries and routine care,
20 and you have to think about how home health sits in the
21 middle of that, and you want to consider an inlier, an
22 outlier, adjustments of these types, low volume, that type

1 of thing.

2 And, so, in a sense, what we're saying to the
3 Secretary in the report in June is when you step out with
4 the real data and start to construct this, this is what our
5 research would suggest you should take into consideration
6 for the purposes of constructing the model, or constructing
7 the system, and that would be the nature of the report that
8 we would put together in June.

9 Is that what you were looking for?

10 DR. CROSSON: That was -- I think that was
11 elegant, elegant, too.

12 MS. BUTO: [Off microphone.] Can I ask one quick
13 question about that? The work that was done before, that
14 we talked about, I think, in September, or November, I'm
15 not sure when it was, where we looked at the differences in
16 costs between home health and all the institutional
17 providers and the need for the non-therapy adjustment,
18 whatever that's called, ancillary adjustment, is that going
19 to be in the June report, as well?

20 DR. MILLER: [Off microphone.] Think of each of
21 those in the material as all put into the -- oh, sorry --
22 all put into the June report, and so you'll have all the

1 analytics in there, and then at the end -- what I see at
2 the end, or at the beginning, whichever way you want to
3 think about Executive Summary, is a series of statements
4 that says, this is what we're seeing as the shape of this
5 thing. And even though the work that Carol has done with
6 Urban Institute folks, there is a model, but we wouldn't
7 view that as the model that ultimately gets implemented.
8 The Secretary will construct one, and then we'll -- with
9 more detailed data, and then we'll come behind that and
10 comment a second time.

11 Is that your question?

12 MS. BUTO: Yes, that was my question.

13 DR. MILLER: Carol, that was on --

14 DR. CARTER: Yeah, that's good.

15 DR. CROSSON: So I think what we're looking for
16 then here is do people generally -- because you can see the
17 direction this is going. Do people generally agree with
18 the conclusions from the model itself, the conclusions from
19 the model? Are there other things that we might want to
20 add, change emphasis, that sort of thing?

21 So, Mary, you can start off.

22 DR. NAYLOR: So I want to join Scott in saying

1 how excited I am again about this great work with you and
2 your Urban colleagues.

3 And to build on Mark's comment, this piece, this
4 section, this third section and the evolution of this work
5 highlighted for me some additional opportunities. I don't
6 know if you want them or not at this point, but more than
7 ever, the focus on a post-acute unified payment system has
8 caused me to look at the community population in home
9 health as a big outlier in this in framing the design and
10 wondered whether or not as you think about home health and
11 think about the recommendations for design that we really
12 consider just including post-acute, someone who has just
13 had a hospitalization, because that gives you common ground
14 among all of the people.

15 So it either is a sensitivity approach, which is
16 to say we're including and not including how with this
17 change, so I don't know if you want to consider that, but
18 it really --

19 DR. CARTER: Well, we did analyze them
20 separately.

21 DR. NAYLOR: Oh, you did.

22 DR. CARTER: We did, yes.

1 DR. NAYLOR: Okay.

2 DR. CARTER: But that's different than excluding
3 them from the model and rerunning everything.

4 DR. NAYLOR: Well, if we present alternatives,
5 one might be that we present an alternative -- or that
6 would present the design as it is with all in, but then say
7 a consideration going forward is to think about a very
8 different population than -- in terms of needs, in terms of
9 cost.

10 DR. CARTER: Right.

11 DR. NAYLOR: So it's just a thought. I mean, it
12 came out multiple times in your work here.

13 DR. CARTER: So you're not suggesting changing
14 the home health benefit, but just saying we might pay for
15 it differently.

16 DR. NAYLOR: Yeah.

17 DR. CARTER: Okay.

18 DR. NAYLOR: You might pay for this group
19 differently than this unified, and that way, everyone that
20 we're considering has in common that they have had an
21 immediate hospitalization prior to the post-acute services.

22 And here is where I totally agree. The

1 functional status data absolutely is critical in this
2 design, and I would suggest it be for all patients because
3 this is a core outcome of post-acute care, and so not just
4 subgroups.

5 I also really liked the attention that you paid
6 and the critical need for accurate prediction of what
7 routine care, especially nursing care, needs to be. This
8 is really now the highlight, centerpiece of caring for
9 medically complex people, and there's actually some work
10 that I'll send to you that's been done in helping to pull
11 this out.

12 On the issue of -- and so I'm really looking at
13 this more as a clinician. On the issue of cognitive
14 impairment, I would encourage the use of proxy, meaning the
15 diagnosis, but I would also really acknowledge the
16 limitations of that. Most people do not have a diagnosis
17 of dementia and yet they might have severe, moderate -- or
18 they might have moderate to severe impairment or mild
19 impairment or delirium, much of which is then recognized
20 and yet in this population is really important. So I think
21 it's a good beginning.

22 In the model itself, I think helping to

1 understand the categorization and the overlap of impairment
2 and severity just -- you have it all, but fleshing that out
3 more in the report, I think would be great.

4 And the last thing was the variation in stay
5 cost, 57 to 60 percent administrative full model, but then
6 you talked about differences in specific groups. I think
7 it would just be helpful to know which clinical groups are
8 the 22 percent versus 60 percent, but really just --

9 Oh, one last thing I want to say is, in all of
10 our efforts to make sure that we really focus on the
11 medically complex as a target population in the post-acute
12 benefit, I guess one area that we just will want to make
13 sure, that for people whose patients' characteristics and
14 needs really require the therapy, how to make sure we
15 adequately provide appropriate levels of rehabilitation
16 therapy, when that is aligned with their goal, so just some
17 conversation about that, but really terrific work. Thank
18 you.

19 DR. CROSSON: Okay. I have Kate, then Herb,
20 Kathy, Craig, and Warner. Who did I miss?

21 DR. BAICKER: So this is a really great analysis,
22 and I thought the way you outlined what the steps were and

1 the goal of each step was really helpful in helping walk us
2 through it, and the shrinking of the variance in those
3 ratios is pretty impressive. And that seems like exactly
4 what we want the model to be able to do, and it seems like
5 it's accomplishing that goal.

6 Some of the issues that you've brought to the
7 surface that I think would be great to signal as where
8 we're going in the long run once the better data are
9 available are some of the outlier payments and short-stay
10 adjustments and things like that are necessary now with the
11 data that we have and may be necessary in the long run, but
12 ideally, we minimize those exceptions.

13 As more data, richer data comes in with the more
14 granular information that you're expecting in the next
15 wave, one of the things that would be great to do with that
16 data is try not to have the kinds of payment cliffs that
17 we're always trying to avoid in other settings. From what
18 you've presented, it seems clear that they would be needed
19 in the interim period, but to signal with the richer data,
20 we hope to be able to accomplish a model that captures most
21 of that stuff would be great.

22 And then modeling things based on what people are

1 actually spending now seems again necessary with the data
2 on hand. In the long run, I would love to move towards a
3 model that produces the cost of efficient delivery for this
4 group of people, and that may mean very different payment
5 structures and cost structures than exist today because
6 what we see today is the product of the siloed funny
7 payment system that we have today. So, again, I don't
8 think there is a way to get around that in the short run,
9 and it's nothing one can fix in June. But one of the goals
10 of incorporating more information and richer data would be
11 to move towards a model where the payments are based on
12 what we think efficient delivery is for the patient with
13 those given conditions, not based on how the costs are
14 allocated today.

15 So those are just thoughts about some of the
16 verbiage that might be in the report signaling where we
17 think things should go.

18 As far as the analysis that has been done with
19 the data that's available, I think it's done a great job of
20 shrinking variation in payment to cost that was not helpful
21 for patients or the system.

22 DR. MILLER: You have made the efficient provider

1 or efficient point a number of times and the difficult that
2 we have working with the current data. That decidedly
3 feels like something at the conclusion of the -- right.
4 That's what you're saying.

5 DR. BAICKER: Yes.

6 DR. CROSSON: Herb.

7 MR. KUHN: I, too, want to join the others in my
8 compliments to both you and the folks at Urban. This was
9 really well put together, a great read, and I appreciate
10 what you've all done there.

11 Although when I read the first part of it, I had
12 to smile when it said that the Secretary's report is not
13 due until 2022, and I kept thinking, "I'll be on Medicare
14 when this thing is" -- when the next report comes in this
15 area, so maybe I'll be able to use this new payment system
16 when I get my knee replaced somewhere down the road.

17 DR. CROSSON: Could I just point out that that is
18 not the end of the world?

19 [Laughter.]

20 MR. KUHN: So a couple of observations here and a
21 couple thoughts on additional information. One, I like
22 where this is going, and I like the fact that truly,

1 hopefully, we'll be in a position where we'll base payment
2 based on the patient's characteristics and not about
3 therapy services that are needed. So I think that is
4 extraordinarily helpful.

5 Also, I like kind of where this is going
6 directionally because it seems like the money truly begins
7 to follow the patient where they need to be and now would
8 hopefully trigger payment based on the right place for the
9 right characteristics of that patient as we go forward, so
10 I like to follow the patient area out there.

11 The modeling on the PAC-PRD and the
12 administrative data, that crosswalk you did, I thought was
13 brilliant. I liked that very much, and particularly when
14 you look at the PAC-PRD that had low participation and
15 maybe was even self-selected of those that were in it, the
16 fact that you were able to model over to the administrative
17 data, the high correlation I thought was really terrific
18 because you showed here, and it's talked about in the
19 paper.

20 The functional status area, there is some
21 differentiation there, but I think that continued work can
22 be done in that area.

1 I did note in that area, though, in the paper,
2 you talked about on page 33 -- and I think also Mary raised
3 this as well about routine costs, and a lot of that will be
4 nursing. I guess I wrote a note in the margin on the paper
5 when I saw that about the differential rates that will be
6 out there, whether it's high nursing, low nursing, just the
7 complication of the difficulty of collecting that data. I
8 don't know if we need to chase that down in this report
9 now. That's something maybe for future years, but I do
10 wonder about how easy it is or how difficult it is to
11 collect that data since it's not available through the
12 administrative data. I might be overblowing that, but it's
13 just an observation I made on that as I was looking at it.

14 The other thing -- and picking it up a little
15 bit, which also has been said here -- is I keep thinking
16 about this, and as we move forward, how do we avoid the
17 perpetuation of the silo-based care? So we get a payment
18 out there, and there's this ongoing talk and some
19 innovation going on out there on what is known as these
20 continuing care hospitals and trying to get a unified
21 payment model, by normalizing the payments in a way that
22 get rid of the siloes, but really kind of an entity that

1 can cover all these different services for the patients,
2 and they can move the payment around.

3 So, as we kind of move these forward, a little
4 bit what Kate kind of picked up on, could there be some
5 conversation about maybe what these new innovations of
6 these continuing care hospitals or whatever they're being
7 referred to, how this model could maybe help incent those
8 kind of changes in new facilities or new ways of delivering
9 care as we go forward?

10 And then finally, one additional issue that
11 wasn't in the paper, but I was thinking about it -- and
12 maybe I'm totally off on this, but I was just trying to
13 think through -- the impact this might have on wage indexes
14 as we go forward. And the only reason I raise that, as I
15 recall somewhere in the wage index, that if you have higher
16 nursing costs than perhaps others, there is kind of a ratio
17 or a cap on nursing costs somewhere in there in the wage
18 index calculation. And maybe people can correct me if I'm
19 wrong, but as we change the model, as we may be move to
20 more nursing costs -- so maybe you've got 85 percent RNs to
21 LPNs or something like that -- there's a cap that's put in
22 place. I just don't want to see you in a -- and like I

1 said, I could be wrong here, but I don't want to be in a
2 position where you've got new payments coming through the
3 front door, but payments going out the back door, because
4 this triggers a change in -- or a wage index activity out
5 there. It would just be worth looking at to make sure
6 there is no impact there at all.

7 DR. MILLER: For myself, I'm not intuitively
8 immediately getting the issue, but we'll look at it.

9 MR. KUHN: Yeah, it would be worth looking at.

10 DR. CARTER: Yeah. I mean, the labor shares
11 obviously differ a little bit by setting, but I'm not aware
12 of what you're talking about, sort of the caps on the
13 nursing.

14 MR. KUHN: Yeah. And I'll go back and do some --
15 I just, you know, as I was reading --

16 DR. MILLER: We'll get on it.

17 MR. KUHN: Yeah. I was just looking at the
18 paper, and I was just thinking about that.

19 And then, finally, thanks for identifying the
20 outlier issue. I noticed that as I was reading, and I
21 think we'll bring that up at the next meeting. And I
22 appreciate you working on that too.

1 DR. CROSSON: Okay. Kathy?

2 MS. BUTO: So this work made me feel as if going
3 to separate revised PPS approaches for SNFs and IRFs and
4 even home health would be a distraction. In other words,
5 if the model can be developed, it would be better to move
6 directly and skip over those steps. I'm afraid that if
7 they agency gets caught up in revising those individual
8 siloed PPSs that this will never happen. That's one of my
9 fears. So let me just put that out there. I don't know
10 how that would -- I don't think that's to be reflected in
11 this report, and it may turn out that we run into a bump
12 that we're not aware of today. But it's just the thought I
13 had.

14 The other thought is related to what other people
15 have said, and that is -- and this, I think -- if we can
16 capture in the report would be good -- is some mention of
17 this issue, the conditions of participation or the
18 standards that these different entities are being held to
19 and maybe even a suggestion that some review needs to be
20 made of whether eventually we're talking about
21 institutional, non-institutional. And if the payment rates
22 then suggest some specialization like those that specialize

1 in really the high-cost cases, risk adjustment and other
2 things should be able to address that. But at the moment,
3 I don't see a great justification for continuing the
4 individual categories of institutional providers, if this
5 model can prove to be really robust.

6 But I just want to mention that I think the
7 individual PPS refinements could be a distraction and
8 actually slow the progress of moving to something like
9 this. Again, I don't know that we want to say that at this
10 point, but it's a concern I have about going forward.

11 DR. CARTER: So I just wanted to say one thing
12 about that, which is they could be a good stepping stone
13 because the patient characteristic-based PPSs that we have
14 recommended for SNF and home health are exactly like this,
15 and so if those providers can use the revised PPSs as
16 transition times to change their cost structures, be less
17 emphasized on rehabilitation care and more emphasis on
18 medically complex, that's exactly what this would do. So
19 it could set them up to change their behavior and practices
20 in ways early and ahead of what they would be expected to
21 do with the unified.

22 MS. BUTO: Right.

1 DR. CARTER: So that's the other version of --

2 MS. BUTO: I know where you're -- and I agree
3 with that. It's just that I don't think it would be early.
4 In other words, I think it would take a while to get to
5 that state, implement it, and it would actually end up --
6 even though that's a better state to be in, to move to
7 another PAC-PPS, I think it would delay getting there is
8 all. You might get there in a better place, but I think
9 it's really a balancing act of how much change can these
10 providers go through.

11 DR. CROSSON: Kathy, let me just ask you a
12 question, and maybe this is an answer I should know. Just
13 in terms of the terminology you were using about revising
14 the PPS and the complexity involved, just from your
15 experience at CMS, does that also include the terminology
16 we also use, "rebasing"? In other words, to what extent do
17 we use "rebasing" here as simply saying reduce the level of
18 payments, and would that involve as much complexity as
19 you're saying?

20 MS. BUTO: Well, reducing the level of payments
21 doesn't involve as much complexity, but I think in SNF PPS
22 in particular, I'm thinking the change from the weight

1 that's given to therapy services, rehab, and so on. The
2 changes that -- you know, having more of a focus on what
3 the patient needs is more than just rebasing or taking
4 money out of the system. It is going to mean actually
5 revising the way that PPS is implemented.

6 DR. CROSSON: Right. I understand that, but if
7 what you are proposing is actually a fundamental issue here
8 -- and it may well be -- it doesn't necessarily mean that
9 between now and 2022 or whatever, there could be no action
10 taken on some of these areas where we see a need for
11 reduction in payment.

12 MS. BUTO: Right. I mean, I think the way to
13 think about this is it generally takes about three years to
14 get a PPS system vetted, mounted, and then another several
15 years to actually get it under way in a way that the data
16 are reliable. Maybe that's sped up. I don't know, but it
17 takes a while. It would take probably 5 years just to do
18 that.

19 It's 2016. That brings us to 2021, even if it
20 were done today, which it's not going to be. So all I'm
21 saying is then to turn around and then in another couple of
22 years ask providers to undergo another set of changes, it's

1 a lot of change, and it depends on where we think we want
2 to go.

3 So I'm just saying it's something to think about.
4 We're not there yet. The model isn't ready, et cetera, but
5 I just wonder about that interim step and whether it might
6 delay ultimately getting --

7 DR. CROSSON: Craig.

8 DR. SAMITT: Carol, thank you. This is awesome.
9 I don't think I've ever seen Scott so excited before, so --
10 [Laughter.]

11 DR. SAMITT: I really appreciate it.

12 My question is about sort of unintended
13 consequences or reactions. So, on Slide 16, you talk about
14 the estimated impacts, but I am curious to see if you
15 thought through playing out the cards. So this goes into
16 place. How do the providers react? What actually happens,
17 and are there any potential things that we should take into
18 consideration that would make the model stronger or the
19 program stronger? Because we believe if we do X that Y
20 will happen, which could negatively affect quality or
21 access or beneficiaries or result in gaming and so on and
22 so forth. Have you modeled that out or thought that

1 through in terms of what the response would be by the
2 industry if this were put in place?

3 DR. CARTER: We haven't modeled it. We have
4 thought a little bit about how providers would change --
5 would be encouraged or have the incentive to change their
6 mix of patients.

7 So, for example, SNFs might take medically
8 complex, more medically complex cases. LTCHs might take a
9 broader range. IRFs might take a broader range. So I do
10 think that the mix of patients that you would see in
11 providers could be broader, but they would need to change
12 their cost structures because the costs in the different
13 settings are pretty different, and so that -- both of those
14 things are going to change. The costs need to change, and
15 the mix of patients need to change.

16 I mean, some things like in the SNFs, we know
17 that for-profit facilities tend to have longer stays, and
18 so they get more affected by a stay-based payment system
19 than non-profits. So having their lengths of stay start to
20 look like other providers is a change that we would expect.

21 DR. SAMITT: And those are the exact things that
22 I am thinking about.

1 But, for example, a couple that -- one that you
2 pointed out, that SNFs may take more medically complex
3 patients, I guess we would need some reassurances that they
4 would have the capacity to serve those patients --

5 DR. CARTER: Right.

6 DR. SAMITT: -- and that we wouldn't see an
7 erosion of outcomes or quality, and so I think we need to
8 take those things into consideration.

9 I also don't know when someone asked about the
10 inter-facility transfer or -- does this create any exposure
11 for under a single PPS to encourage sort of readmission or
12 transfer to another facility, and have we thought that
13 through, and how do we factor that into the consideration
14 of the model as well?

15 DR. MILLER: I guess what I was going to follow
16 up on, the beneficiary side and then the side that you're -
17 - you know, exposure side that you're talking about there.
18 We have some thinking, and it's hard to keep all of this in
19 your head because this is one of these things where we have
20 to do this by June, and so once a month, we're showing up
21 and you guys have to cast your mind back several months.

22 We talked a little -- one thing to keep in mind

1 about the new functional status data is it will both feed
2 into the payment system and how you adjust the payment, but
3 it will also be used for quality performance so you can
4 look at somebody's functional status on admission and
5 discharge and figure out how somebody is doing. And then
6 the second thing on the exposure thing, we did, I think --
7 it didn't just happen in my head, right? We did do some
8 discussion about looking at the aggregate population base
9 around this to see whether there is an inducement of
10 episodes -- or admissions and that type of thing. I
11 thought we did talk about that.

12 DR. CARTER: Well, we talked about companion
13 policies and readmission policies as one way of trying to
14 dampen kind of patients being prematurely discharged to
15 either another setting and then getting readmitted or being
16 readmitted to the hospital. You know, so we did have a
17 session trying to think a little bit about some of those
18 incentives, and Kathy had asked -- and we had included, I
19 think, in the November presentation a discussion of the
20 range of the quality measures because of how important it
21 is to monitor quality and outcomes as this is going on, and
22 the report will certainly have a section on that.

1 DR. SAMITT: Thank you.

2 MR. THOMAS: So I think this is information
3 that's very helpful. I think directionally it's excellent.

4 The couple of comments I would make as you
5 continue to look at this is, you know, we keep talking
6 about the SNF model and the rehab model, and I think we
7 have to kind of just think about it's the post-acute model,
8 and that, you know, kind of just like we're thinking about
9 in the acute-care hospital. You have different levels of
10 patients in an acute-care hospital. And I think if we
11 moved to a model that we just have one payment but we still
12 think of, well, we're going to have rehab, we're going to
13 have skilled nursing, I think it's going to -- it could be
14 a challenge to implement that versus can you have a
15 facility that gets a payment that obviously is risk-
16 adjusted based upon the type of care for that patient.

17 So that may be a nuance, and maybe I'm not
18 totally understanding, you know, what is presented. But
19 the regulatory issues that go along with being in each one
20 of those different areas is really limiting, and I would
21 really encourage in the future work to look at those
22 regulatory issues, because I think it's at the end of the

1 day we want the patient to be in the right setting where
2 they can be cared for appropriately, and it's my impression
3 or experience that sometimes the regulatory limitations or
4 -- just regulatory limitations or regulatory components
5 limit that or make that problematic.

6 So I'm not sitting here telling you I have the
7 answer at all, but I do know that that is a real challenge
8 for providers to figure out, you know, who qualifies for
9 which area and what's the duration of the stay and, you
10 know, versus if you think about we just need the person
11 when they're being discharged from an acute-care hospital
12 to get into the right setting where they can get the right,
13 appropriate level of care. And I think coming back to you,
14 to the extent we have more of these facilities that are a
15 little larger, they're going to be more capable. They're
16 going to be able to handle a more intense type of patient.
17 And I think that will ultimately have a better outcome
18 because we're going to have more clinicians there that are
19 kind of surrounding that patient and not have it bifurcate
20 into a bunch of different subspecialty areas that are kind
21 of just geared towards a specific type of patient.

22 DR. HALL: I'll just add my kudos to everyone

1 else's. I think this is very important work, and it proves
2 a couple of things. One is that sometimes when we complain
3 that systems are too complex to change, if we just try,
4 maybe we can work something out. I think you've
5 demonstrated that admirably.

6 The other is that we're talking a lot about
7 function, and if we did some kind of Google search of the
8 use of function in all of our reports, I would predict that
9 the term "function" wasn't used very much seven or eight
10 years ago, but now increasingly so, thanks to Mary and
11 others who have been goading us on in this direction. But
12 it really is the basis -- and when we talk about outcomes
13 and assessing quality of care, it's the one parameter that
14 puts it all together in a way that we now know is
15 reproducible and, most importantly, is very, very important
16 to the Medicare recipient and their family. So this is a
17 huge shift in our thinking, and it couldn't come too soon,
18 and I think it's wonderful.

19 A couple of people have mentioned as we went
20 around that while there are silos, sometimes those silos
21 serve a specific function in that there are specialized
22 needs that people have. For example, if I'm hospitalized

1 as a Medicare patient because I've had a respiratory
2 ailment, and I'm sent to a nursing home because I'll get
3 rehabilitated for a period of time, that's one entity. But
4 maybe the next-door neighbor who has the same thing, has
5 decubiti ulcers, has big sores, gaping sores that are
6 infected and need specialized care, maybe someone will need
7 some respiratory support periodically. Maybe someone needs
8 something as simple as IVs. Or maybe somebody says, "My
9 family would like to be close to me," or, "I'd like to stay
10 in a system where the same doctors will take care of me."
11 And that's a problem, as two or three people have pointed
12 out. But maybe it's an opportunity to let the providers
13 have an opportunity to suggest the changes, because for
14 every different health system, this conglomerate of
15 services that are not -- it's very easy to define what the
16 P&L is on each of these services. Why not let them come up
17 with innovative solutions? I don't think we have to
18 dictate -- one of our problems in long-term care is we
19 dictated things, and sometimes they're 45, 50 years old,
20 and they're not very good paradigms anymore.

21 So I think this is exciting not only for solving
22 or starting to solve a payment problem, but may really be

1 an enormous impetus to change how we measure health care
2 for Medicare recipients overall, and that's an incredible
3 advance. So I'm excited, too, Scott.

4 MS. THOMPSON: Carol, this is excellent. I join
5 everyone else, as enthusiastically as Scott. And on behalf
6 of those providers out in the frontier, thank you for
7 recognizing the unique situations and those low numbers.

8 I can't firmly state enough how difficult it is
9 in the frontier many times to find placement for these
10 folks. I mean, these services and these locations are very
11 small, and they often are running with waiting lists of
12 patients to get in. So, you know, again, thank you for
13 recognizing that piece.

14 But I can't also help but think about how
15 providers must be beginning to think about consolidating
16 these services under one entity and, you know, managing
17 cost structure, and in that I'm concerned with those
18 unintended consequences, that there may be some aspects we
19 need to think about, that there may be some elements of
20 these certain types of patients to care for that would
21 still be more desirable than those with long-term events,
22 tough long-term head injuries that will ultimately result

1 in a decrease of access for the patient. So I worry a
2 little bit about that, but I call that out. And I wonder -
3 - and I really hadn't thought about this until Warner
4 talked about it, and he brought that out several months
5 ago. When you run a hospital, if you're going to be a
6 licensed hospital, you have to have an emergency room.

7 Now, if we didn't have to have an emergency room,
8 P&L in hospitals would look a lot different in many cases.
9 And I would think if we're thinking ahead in terms of how
10 this is structured, that there would be some requirements
11 that all of those services be available and offered as we
12 consolidate and take these silos apart.

13 So my thoughts, but thank you. I think this is
14 extraordinary work. I'm really excited about it.

15 DR. CARTER: Could I just say, to kind of remind
16 you about in November, when we were talking about
17 conditions of participation, one idea -- and it's just an
18 idea -- is to have conditions, sort of a base level of
19 conditions that all providers would meet, and then have
20 separate conditions for patient groups. So if you wanted
21 to have ventilator care, you needed to meet those
22 requirements, you know, have the skill and the staffing and

1 the equipment. And if you wanted to take care of wound
2 care, you needed to have adequate staffing, trained
3 staffing.

4 So it would start to move conditions of
5 participation towards what are the types of patients I want
6 to treat and are capable of treating and gear our
7 conditions that way. Does that make sense to you?

8 MS. THOMPSON: Yep.

9 DR. CARTER: That's what I was hearing.

10 DR. MILLER: Can I ask one thing on yours? So I
11 followed the thread of all of your comments, I think, for
12 the most part, but then just right at the end, it sounded
13 like you said given, you know, the change and the need for
14 consolidation, you might need to have a full range of
15 services. And then what I was wondering, given your
16 opening comments on frontier, do you think if that was a
17 requirement -- and I'm not sure you were saying that, but
18 if it were a requirement, would they be able to do that in
19 the frontier?

20 MS. THOMPSON: They could and they would because
21 the cost structure would go down. Bigger numbers, bigger
22 denominator.

1 DR. CROSSON: The cost structure would go down as
2 a consequence of consolidation.

3 MS. THOMPSON: Correct.

4 MS. UCCELLO: So I just wanted to join the chorus
5 praising this fabulous work. But, also, I just wanted to
6 make sure that people didn't leave here with the impression
7 that we wanted to back off of any of the recommendations we
8 made yesterday in terms of revising the PPS for some of
9 these post-acute services and the rebasing.

10 I think, you know, 2025 is still an awfully long
11 time, and I think that people with complex needs, they need
12 places where they can go where their needs can be met. And
13 I think, if anything, I think we need to highlight the
14 urgency of doing the things that we recommended yesterday
15 as opposed to just letting them go by the wayside. And I
16 want to echo what Carol said about doing those kinds of
17 things sooner will help facilitate the movement toward this
18 more unified system.

19 DR. HOADLEY: You know, I was wondering, from
20 Kathy's comments earlier and your responses and Cori's
21 comments just now, I mean, the dates that we're obviously
22 triggering on are the ones that were put in the statute.

1 But is there a more structural reason why things have to
2 happen on this particular pace that was set up in the
3 statute in terms of 2022 and 2023? Is that just how much
4 time it's likely to take to take all these intermediate
5 steps? Or could this actually happen much earlier if there
6 was a compelling reason to do so?

7 DR. CARTER: Well, the functional status data
8 isn't being required to be collected until '18, and so you
9 could move sooner, but we've seen from our results that in
10 aggregate, the results look pretty good, but for the
11 functional status groups, they don't look so good. And so
12 that would be a reason to wait for those data.

13 That said, the administrative model without it,
14 you know, looked reasonable, and then the question is:
15 Well, how bad was it, I guess, for the functional groups to
16 delay implementation? And that's something we could talk
17 about.

18 DR. HOADLEY: So in thinking about transitions --
19 and I gather transitioning is not really part of what we
20 need to talk about in this particular report?

21 DR. CARTER: We could. We have said we think a
22 transition is decidedly important.

1 DR. HOADLEY: Right. So, I mean, talking about
2 transition in -- there's the obvious things you say about
3 transition in terms of just making things happen on a
4 gradual basis so there's not too much disruption. But I'm
5 thinking about from Kathy's comments, Cori's comments,
6 maybe talking about some bigger think version of transition
7 and whether it would make sense rather than update some of
8 the systems like SNF to do an administrative version of
9 this model as a transition much sooner or whether that's
10 not smart, but we could do an updated SNF. I mean, I
11 remember, you know, years ago the physician payment
12 transition. There were a whole lot of intermediate steps
13 that allowed the original adoption of the fee schedule to
14 operate, you know, to come in in a smooth way. And are
15 there particular considerations, is there anything we would
16 do different about rethinking, say, a SNF PPS in the
17 interim to smooth the transition towards where we're
18 thinking this would go? And even if we don't have concrete
19 steps but even just to think about it that way, whether the
20 preferences of sort of moving more forward on an
21 administrative consolidated PAC faster versus figuring out
22 a way to transition some of the existing systems, the same

1 as we've already thought about or a little bit differently
2 in order to get to this point as efficiently and as
3 smoothly as possible.

4 DR. CARTER: So the SNF PPS that we've
5 recommended is very similar to this, but the difference is
6 that it considers the MDS function data. And as we've
7 seen, functional status is important, and ability to
8 swallow, and there's some very specific things about post-
9 acute care that are captured in the assessment that are
10 folded into our redesign, that if you went to an
11 administrative model, you'd have proxies for some of them
12 but not all of them. So that would be the tradeoff.

13 DR. HOADLEY: So maybe even just articulating
14 some of those tradeoffs as part of the report discussion --

15 DR. CARTER: Okay.

16 DR. HOADLEY: -- would help, and then, you know,
17 we obviously don't stop when we submit this report in June.
18 We continue talking about SNFs, you know, either within the
19 silos or across, whether it's the bundling discussions or
20 just the routine update discussions, and then we could
21 follow up on those in whatever ways we see fit, you know,
22 over the next cycle.

1 DR. MILLER: And I think I see [off microphone]
2 how you're bringing this together, and I think Carol's
3 comment that in a sense conceptually, what we're saying in
4 the SNF and the home health redesign is conceptually what
5 we're doing here. And I think there's real truth to that.
6 And I think I see your point. I'm just saying this mostly
7 for my mental health, as you could say -- you know, you
8 could start transitioning earlier on this less complete
9 administrative model to moving in the right direction.
10 You'd probably have to have transitions and let's just say
11 bigger -- just for illustration, bigger outlier policies,
12 and then have those collapse as more detailed data comes in
13 and you build the system.

14 In this whole exchange of our recommendations on
15 SNF as separate from the big thing, I think the important
16 thing to take out of it is we're saying to the industry
17 it's changing, you know, and if there's real resistance to
18 going to the unified PPS, which there is, you know, it's
19 one way or the other, this is the direction Medicare seems
20 to be going, either by silo or across silos. And so I
21 think the timing continues to be a real issue, and the
22 burden on the agency a very important point. But the

1 signal of this is where it's going one way or the other I
2 think actually complements it.

3 MS. BUTO: Mark, can I just ask you a question?
4 Remind us how much of the change we're recommending for SNF
5 requires -- and maybe Carol -- can the agency go ahead and
6 do? Wasn't there a considerable amount --

7 DR. CARTER: They don't have the authority for an
8 outlier policy, but otherwise they do.

9 MS. BUTO: They can move ahead.

10 DR. CARTER: Yeah.

11 MS. BUTO: Okay. It's just that they haven't
12 moved ahead, and it's been a number of years, I think, that
13 we've recommended they move.

14 DR. MILLER: I don't want to speak for CMS, but
15 just for a moment, I think if they were here -- and, Carol,
16 keep track of this. I think what they would say is, you
17 know, we made changes in certain weights and we adjusted
18 things, and directionally they were, you know, what you
19 guys were saying. Carol then went back a year or so ago
20 and sort of said, well, but comprehensively, when you look
21 across that, how close are you getting to that? And we
22 still think there's a big --

1 DR. CARTER: It got worse.

2 DR. MILLER: It got worse.

3 DR. CARTER: Yeah.

4 DR. MILLER: So that would be a big gap. But I'm
5 trying to be a little more politic.

6 DR. CARTER: All right.

7 DR. MILLER: So, you know, I think they haven't
8 done what we've asked them to do. I think if they were
9 here they would say, yeah, but we tried to do some things.
10 And I think Carol would say, yeah, but you actually didn't
11 get there, and maybe even went backwards a little.

12 MS. BUTO: And my point was just that if we're
13 going to sort of more fully discuss this transition, so to
14 speak, as Jack was suggesting, I think it would be good to
15 point out where CMS could move ahead on certain important
16 elements right away and not have to wait for more authority
17 and so on and so forth, because, you know, nothing's
18 happening this year authority-wise.

19 DR. HOADLEY: Further talks is that notion of
20 sending the signals to the industry and figuring out a way
21 to make that start happening sooner.

22 DR. CROSSON: Okay. Excellent discussion.

1 Seeing no more comments, thank you again, Carol. And we'll
2 move on to our final presentation.

3 We're going to hold for a minute or two while I
4 think there's some more people coming in.

5 [Pause.]

6 DR. CROSSON: Okay. It's time for our last
7 presentation. We are going to pick up again and begin in
8 more depth our analysis of the payment models that were
9 brought forward in the MACRA legislation, specifically but
10 not totally focusing on alternative payment models. So
11 we've got David Glass and Kate Bloniarz. Did I mess that
12 up? Close enough? Close enough for a chairman. Okay.

13 [Laughter.]

14 DR. CROSSON: Kate, are you going to begin?

15 MS. BLONIARZ: Yes. So, as Jay mentioned, as we
16 discussed last in October, Medicare's payments to
17 physicians and other health professionals are now governed
18 by a set of provisions enacted in the Medicare Access and
19 CHIP Reauthorization Act, or MACRA. So we just continued
20 discussing today the set of provisions pertaining to
21 alternative payment models, or APMs.

22 I will recap the relevant provisions, including a

1 timeline, and will discuss potential incentives under the
2 APM provisions and the merit-based incentive payment
3 system, or MIPS.

4 David will then present draft principles for your
5 discussion and some key implementation issues.

6 On this slide, we wanted to put down the key
7 definitions from the statute. I won't read it aloud, but
8 it is on the screen.

9 The first is the definition of alternative
10 payment model, which we refer to "model" in this
11 presentation.

12 Second is eligible alternative payment entity,
13 which we refer to as "entity."

14 And finally, qualifying APM participants, which
15 we refer to as participants.

16 Here is an example of how this work. Let's posit
17 that Pioneer ACOs meet the eligible APM criteria. The
18 Pioneer ACO demonstration would be the model. A specific
19 ACO, like Partners, would be the entity. And the clinicians
20 who are part of the ACO, like Atrius in Boston, would be
21 the entity, and the clinicians who are part of the ACO
22 could be the participants. When David talks about draft

1 principles, it will generally be in reference to the APM
2 entity, but the principles also implicate the payment
3 models themselves because the model sets the rules under
4 which the entity operates.

5 The APM provisions are as follows. Clinicians
6 who are qualifying participants in an eligible APM entity
7 will receive a 5 percent incentive payment for each year
8 that they qualify between 2019 and 2024. They will also
9 receive a higher update from 2026 on.

10 To qualify, clinicians must have a specified
11 share of fee-for-service revenue, or beneficiaries, in an
12 eligible alternative payment model entity to qualify for
13 the incentive payment and higher update. The thresholds
14 are set in statute and start at 25 percent in 2019, rising
15 to 75 percent by 2023.

16 In general, clinicians will be participating in
17 APMs or subject to MIPS.

18 The MIPS is a system to assess performance for
19 clinicians who are not receiving the APM payment. The MIPS
20 will be an individual- or group-level payment adjustment
21 for clinicians based on their performance in four areas:
22 quality, resource use, clinical practice improvement

1 activities, and meaningful use of electronic health
2 records.

3 The MIPS starts in 2019 and is permanent. CMS
4 may use the current quality measurement systems in MIPS,
5 like those that form the basis of the current value
6 modifier.

7 The basic MIPS adjustments are budget neutral,
8 and the maximum downward adjustment is set in statute, at 4
9 percent in 2019 rising to 9 percent by 2022. The maximum
10 upward adjustment could be scaled up beyond these limits.
11 There's also \$500 million a year for exceptional
12 performance for five years in addition to the basic budget-
13 neutral adjustments.

14 I'll turn to the first of two items you asked
15 about last time, an illustrative timeline. CMS has not
16 issued rulemaking yet, but conceptually, certain things
17 need to happen to meet the statutory deadlines.

18 In 2016, we expect a proposed and final rule on
19 both APMs and MIPS.

20 During 2017, APMs will need to be defined, and
21 APM entities will likely need to be certified or approved.

22 Then 2018 could be the measurement period for

1 assessing whether clinicians are qualifying participants.

2 Then the APM incentive payment will be paid in 2019.

3 When CMS has implemented other value-based
4 purchasing programs for clinicians, they generally start
5 two years ahead of the implementation year. The first year
6 CMS sets regulatory requirements, the second year the
7 clinicians report the appropriate information to Medicare,
8 and the third year the payment adjustment would apply.

9 You had also asked us to consider the relative
10 incentives that a clinician would face, from joining an APM
11 entity versus staying in fee-for-service and being subject
12 to the MIPS. At this point, what we can give you is quite
13 speculative. We had to make some heroic assumptions
14 because none of the policies have been set.

15 For example, with respect to the APM provisions,
16 we don't know how CMS will define being at risk, for what
17 spending, and we don't know how many clinicians will
18 participate in these models.

19 On the MIPS side, we don't know what measures
20 would be in MIPS, much less the distribution of clinician
21 performance on these unknown measures. So we made policy
22 assumptions regarding the APM provisions as well as

1 assumptions about the potential range of performance.

2 And finally, we have some illustrative figures
3 for average clinician revenue and spending per beneficiary.

4 Starting with APMs, the qualifying participant
5 would receive the 5 percent incentive payment
6 automatically, which totals 3,750 in the first line. The
7 shared savings or losses experienced by the entity, on the
8 next line, could be much higher, from 36,000 to minus
9 \$36,000 in this example.

10 But remember that this is only if the APM entity
11 performs 5 percent above or below expected performance, and
12 is responsible for total A and B spending. Actual
13 experience to date in the ACO program is lower than this.
14 For example, it was around 1 to 2 percent.

15 Moving to MIPS, our illustrative example for MIPS
16 also uses a 5 percent range of performance, and when
17 applied to the professional services revenue, the range is
18 3,750 to minus 3,750. There's also additional funding for
19 exceptional performance, as I mentioned before, 500 million
20 per year from 2019 to 2024. So, in total, the illustrative
21 range is from \$7,500 to minus 3,750 in our example.

22 I want to also point out that the basic MIPS

1 adjustments are scaled to be budget neutral, so the
2 potential upside could be higher than what we've shown
3 here. But how likely is it that clinicians subject to the
4 MIPS would see large bonuses? And I'm going to say it
5 doesn't seem particularly likely.

6 We can't estimate what the MIPS performance
7 results will be, but the experience with other individual
8 or group-level assessment of clinician performance
9 generally finds that most clinicians cannot be easily
10 differentiated from average.

11 For example, the value modifier results for 2015,
12 which in Medicare applies to large groups of 100 clinicians
13 or more, found that 80 percent could not be differentiated
14 from average, and they received no adjustment. That's the
15 green bar on the right side. Ten percent of the groups
16 were assessed to be of high performance. That's the
17 turquoise bar at the very top. But none scored high enough
18 to receive the maximum adjustment, and 10 percent of the
19 groups were low performance, receiving a penalty. That's
20 the purple bar.

21 So to summarize all the moving parts, the only
22 certainty is the 5 percent incentive payment that

1 qualifying participants would receive. The potential
2 shared savings and losses for the APM entity could be
3 significant, but on the other hand, actual ACO performance
4 has been in the range of 1 to 2 percent.

5 With respect to the MIPS, there is theoretically
6 the opportunity for increases or decreases, but CMS's
7 experience to date with the value modifier has had most
8 groups getting no adjustment.

9 The risk and reward through the APM provisions is
10 greater than MIPS, but this is dependent on two key
11 definitions. First is the level of risk; and second, what
12 spending the APM entity is responsible for.

13 Finally, as MIPS has not yet been defined, it's
14 difficult to assess the potential risk or reward.

15 So I am going to turn it to David, who will take
16 you through some draft principles.

17 MR. GLASS: Thank you, Kate.

18 Here are the principles we drew out from your
19 discussions in October. We will discuss these in the next
20 two slides. For simplicity, we will use the term "entity"
21 as short and for an eligible alternative payment entity
22 made up of qualifying participants.

1 The first three principles follow for making
2 bonuses contingent on performance.

3 The first, you discussed at some length in
4 October. The basic principle, what you seem to be
5 gravitating toward, is that incentive payment should only
6 be paid to participants based on performance; that is, the
7 clinician's incentive should depend on the success of the
8 entity in which they participate. This principle follows
9 from wanting to protect the Medicare Trust Fund and
10 taxpayers and encourage meaningful delivery system reform.
11 The basic argument is that to protect the trust fund, we
12 want to make sure Medicare gets something for the incentive
13 payment rather than just paying for clinicians being an
14 entity. In addition, if we want the delivery system to
15 change, there has to be sufficient incentive to make the
16 effort to do so. Making bonuses contingent on performance
17 is one way of doing that.

18 The second principle, that the entity have a
19 sufficient number of beneficiaries to detect changes in
20 spending and quality follows if the entity is at risk. For
21 the entity to take on risk, it will have to be confident
22 that its performance results are reliable. It will not

1 want to take on risk for random fluctuations. The number
2 of beneficiaries in the entity will need to be sufficient
3 for results to be statistically reliable.

4 The Commission has also stated the desire to move
5 towards quality outcome measures that are meaningful to the
6 beneficiaries, such as rates of potentially preventable
7 hospital admissions and readmissions. These also require a
8 sufficient population to be measured reliably.

9 The third principle, that an entity be at risk
10 for total Part A and Part B spending follows if the goal is
11 to encourage care coordination and delivery system reform.
12 If the entity were at risk for just its own billing, the
13 results would be counterproductive for two reasons. First,
14 the entity would have no reason to reduce spending outside
15 the entity; for example, there would be no incentive to
16 reduce hospital readmissions. Second, the 5 percent
17 incentive is an add-on to fee-for-service billing. So if
18 its own billing goes up, but the entity's revenue and
19 incentive payments both go up, this could be a particular
20 problem if the risk were lower than 5 percent.

21 Now, by implication, if the entity is at risk for
22 Part A and B spending, the design of the model itself will

1 have to require that. Some models, such as medical homes,
2 may not contemplate that now but could be redesigned to do
3 so in the future.

4 These three principles related to administration,
5 and again, these are phrased in terms of the APM entity,
6 but the alternative payment models themselves must permit
7 the actions.

8 The first is that the entity have the ability to
9 the shared savings with beneficiaries. To engage
10 beneficiaries and give them some reason to further the
11 goals of care coordination and use the entity's providers,
12 for example, the entity should have some latitude to share
13 in any savings with the beneficiary. This might take the
14 form of reduced cost sharing for using the entity's
15 clinicians. The Commission has supported this principle
16 for ACOs.

17 The second principle is that the entity be given
18 relief from regulations designed to deter unnecessary
19 volume and spending. If entities are at risk for total
20 spending, they will already have an incentive not to ramp
21 up volume unnecessarily. For example, regulations
22 requiring a three-day inpatient stay before a SNF stay

1 could be a way of allowing a more innovative use of SNFs.
2 This principle follows only if the entity is at a two-sided
3 risk for performance.

4 And the last principle is that there be a single
5 entity to assume risk. This would allow entities to set
6 their own rules on how to divide up savings and losses and
7 enable them to innovate based on local conditions rather
8 than CMS deciding who gets a share of savings or loss and
9 how much. A single entity would also supply administration
10 for CMS. It would, for example, have a single place to go
11 to collect losses rather than trying to collect from
12 individual clinicians.

13 So taken together, these principles build on one
14 another. Regulatory relief, for example, only follows if
15 the APM is at risk for total spending and is accountable
16 for a sufficient population. Having regulatory relief will
17 allow the entity to be more innovative and provide better
18 care coordination, and this in turn will enable better
19 performance.

20 With these principles in mind, we can think about
21 some of the issues that will arise in the implementation of
22 the APM provisions.

1 The first issue is the definition of risk beyond
2 a nominal amount. The statute specifies that entities be
3 at risk beyond a nominal amount but does not specify how
4 much that is. So CMS will have to do so in regulation, and
5 it will likely comment on that regulation, so we wanted to
6 understand what your thoughts are on this issue.

7 On the one hand, one could define risk beyond a
8 nominal amount as being the investment risk; that is, the
9 cost of setting up and running an entity. This would limit
10 the risk for clinicians forming an entity to the amount
11 they put into it and not expose them to the risk of medical
12 cost. It could also limit possible rewards to the 5
13 percent incentive, unless CMS also wanted to create a one-
14 sided shared savings sort of arrangement.

15 The negative is that risk may be insufficient to
16 motivate clinician improvement and counter fee-for-service
17 volume incentives. For example, if the investment was
18 minimal and the reward is 5 percent of fee-for-service
19 billings, why would participants do anything to limit their
20 fee-for-service billings or coordinate care? Doing nothing
21 would cost little, still get the 5 percent reward, and
22 remove them from MIPS reporting and possibly MIPS

1 reductions.

2 On the other hand, risk could be defined as the
3 difference between expected and actual spending. This is a
4 classic definition of two-sided risk. The pro in this case
5 is that this level of risk could motivate system
6 transformation. The entity would have a powerful incentive
7 to make changes and invest in care coordination. The
8 possible reward could be larger. It would also allow CMS
9 to waive some regulations, as we've discussed, and allow
10 for more innovation.

11 The con for this definition is that it would
12 expose clinicians to more risk and perhaps make them
13 reluctant to form entities.

14 Our draft principles would tend toward defining
15 risk as actual versus expected spending, meaning reward of
16 spending is less than expected and loss of spending is more
17 than expected. This risk could be limited a number of
18 ways, through caps on individual spending or risk
19 corridors, as long as it is a function of total fee-for-
20 service spending. Again, to ensure the difference is
21 meaningful, the APM would need to be of sufficient size.

22 The second issue is beneficiary attestation or

1 attribution. The entity to be accountable for a
2 population, that population has to be attached to the
3 entity in some way. We consider two generic forms,
4 attestation and attribution. By attestation, we mean that
5 the beneficiaries identify who they consider to be their
6 primary clinician. After they do that, they would be part
7 of the population for the entity the clinician participates
8 in. The concept is that identifying one's clinician does
9 not require knowing if that clinician is in an entity or
10 that the entity exists. It, thus, presents a lower bar
11 than enrollment in an entity, which would require that the
12 beneficiary identify itself to the beneficiary and that the
13 beneficiary know what the entity was and want to be in it.

14 Because the beneficiary would have to identify
15 his or her clinician, the beneficiary would have some
16 engagement with the clinician's practice. However, because
17 the beneficiary has to make an active identification, the
18 number of beneficiaries attached to the entity could be
19 limited, and it might make it difficult for the entity to
20 reach a sufficient size.

21 Another method of attachment is attribution, as
22 is done in ACOs. In that method, beneficiaries are

1 passively attributed based on their claims history. This
2 method would not require the beneficiary to make an active
3 choice. The pros and cons here are the flip side of
4 attestation. Because the beneficiaries do not have to make
5 an active choice, it would be easier to achieve a higher
6 number of beneficiaries aligned with the entity. On the
7 con side, there would be even less beneficiary engagement.

8 Our draft principles would tend toward
9 attribution because it's important to have a sufficient
10 number of beneficiaries to achieve reliable measurement of
11 cost and quality. However, one could combine both methods
12 and allow attestation in addition to attribution. Some
13 limits might be required if it was thought that selection
14 could be a problem. The Pioneer ACO program is
15 experimenting with such a design.

16 We conclude with a few discussion items.

17 First, we would be happy to answer any questions
18 about the background material in the paper.

19 Second, we're interested in your discussion of
20 the comparison of incentives for clinicians choosing
21 between alternative payment model entities and MIPS.

22 And in anticipation of CMS' upcoming proposed

1 rule, we are particularly interested in whether there is a
2 consensus on the draft principles and your thoughts on the
3 issues of defining risk and of beneficiary attachment to
4 alternative payment entities.

5 Thank you, and we look forward to your
6 discussion.

7 DR. CROSSON: Thank you, David and Kate. We'll
8 take clarifying questions.

9 DR. COOMBS: So I have a question regarding --
10 you know, we got very interesting information in one of our
11 sessions -- and maybe it was the Executive Sessions --
12 regarding the number of beneficiaries in Pioneers and
13 medical shared savings, somewhere around 9 million or so?

14 MR. GLASS: Yeah, the current estimate CMS just
15 put out for all ACOs and the SRD ACOs and stuff was about 9
16 million.

17 DR. COOMBS: So when we talk about risk for
18 spending for A and B, I was just concerned about the whole
19 nature of the leakage question and if we have information
20 comparing those two entities with, like, an estimate of how
21 much -- because if the provider assumes the risk for
22 spending in A and B, there's a component of that that

1 actually has to do with leakage outside of your purview for
2 which you're still at risk for technically, right?

3 MR. GLASS: Yeah. Of course, most of the ACOs
4 are Medicare shared savings program, MSSP ACOs, in one-
5 sided risk arrangements.

6 DR. COOMBS: So do we have any data --

7 MR. GLASS: So most of them don't have upside and
8 downside risk right now.

9 DR. COOMBS: Okay. So we don't have any data on
10 the leakage from those systems in terms of how much spend
11 goes outside of the system that --

12 MR. GLASS: We can look into it. We've heard --
13 you know, we've interviewed different ACOs, and we have
14 some information on that, but I don't know that we have a
15 good composite number.

16 DR. COOMBS: That would be important for what's
17 supposed to be a near-perfect system or a better system to
18 look at when we talk about transitioning with the kind of
19 risk that might be attributed to you because of the fact
20 that you have a panel that you have a significant leakage.
21 And so that was one of the questions that I had for --

22 MR. GLASS: Yeah, so we can look into the leakage

1 question. And, again, it will depend on the -- you know,
2 do you consider if it's a physician-only ACO and the
3 patient gets hospital coverage -- goes to the hospital
4 someplace, is that leakage or not? So you'd have to think
5 about how --

6 DR. COOMBS: That was my next question.

7 MR. GLASS: Oh, okay.

8 DR. COOMBS: If you look at ACOs, there are ACOs
9 that are physician-only, and they have a relationship with
10 a hospital, and then there's larger integrated systems that
11 they consider the ACO the whole package. So the percentage
12 of the whole package versus the physician ACOs, I think
13 it's an important issue because we're looking at driving
14 the MIPS portion toward -- more the IMPS toward the APMs,
15 and that becomes important because of just the propensity
16 of being able to predict what kind of risk you're going to
17 take, because the infrastructure development, which we can
18 talk about on the second round, that's going to be an
19 important piece of that.

20 DR. NERENZ: Thanks for the good work on this
21 important set of issues, and I think in this case Congress
22 has given us a very tricky set of semantics to work with,

1 so I appreciate your definitions, and my guess is we're
2 going to stumble still all the way to the end of our
3 morning discussion. So let me start with that.

4 On Slide 4, I don't want to pick on Kate because
5 I sympathize here, but on the first bullet, it says "APM
6 participants" but you said "entity participants." And
7 apparently that's an important distinction. And then in
8 the bottom slide, it says "participants and entities," but
9 you said "participants in APMS."

10 Now, here's my sympathetic question: I guess in
11 this particular issue the distinction doesn't matter, but
12 you can't -- a clinician can't be a participant in a model
13 without being in an entity. Is that a fair assumption?

14 MS. BLONJARZ: So that's --

15 DR. NERENZ: It's the only way it can be done,
16 right?

17 MS. BLONJARZ: That's just an error in the last
18 bullet. It should say "will be qualifying participants in"
19 --

20 MR. GLASS: APM [off microphone].

21 MS. BLONJARZ: Yeah, alternative payment entities
22 or subject to MIPS. This is also not like a strict line.

1 There's actually a little -- it's in general. That's how I
2 would say it.

3 DR. NERENZ: But the thing I -- I wanted actually
4 to get you off the hook here. There is no way that you can
5 be in a model without being in an entity. Is that correct?

6 MS. BLONIARZ: Yes, that's right.

7 DR. NERENZ: Okay. So if we just focus on saying
8 who's in an entity, we're on solid ground?

9 MS. BLONIARZ: Yes.

10 DR. NERENZ: In subsequent discussion.

11 MS. BLONIARZ: Yes.

12 DR. NERENZ: Okay. All right. So --

13 MS. BLONIARZ: I'm just hedging because I want to
14 give leeway for CMS on rulemaking, but that is how it looks
15 like the language is drafted.

16 DR. NERENZ: Okay. I just can't imagine on the
17 ground how anything other than that could be true, but I --
18 okay.

19 DR. CROSSON: David, let me just comment. I
20 agree with you from a rational point of view. Having read
21 the law, though, one cannot extract that principle from
22 what's written.

1 DR. NERENZ: Yes. That's why I said, I've read
2 the law also, and it's semantically tricky. So I'm just
3 trying to figure out where's our solid ground where we can
4 have discussion and where is it -- okay.

5 Then in that same vein, the third bullet -- the
6 same slide, third bullet, here's the Bill Clinton question.
7 What does "in" mean?

8 [Laughter.]

9 DR. NERENZ: Because the problem being that in
10 most of these models, particularly the ACO models, the
11 payment to clinicians is pure straight line fee-for-
12 service, and I guess just as a ground-setting question, can
13 you tell us, does that have finite meaning? Or are we to
14 debate that meaning?

15 MS. BLONIARZ: I wouldn't think it would be worth
16 spending time trying to figure out what the meaning is. I
17 think the relevant portion is back on Slide 3 where it says
18 the revenue "were attributed to such services furnished
19 under this part through an eligible alternative payment
20 entity." And, again, this is subject to rulemaking. CMS
21 will have to say what that means to them.

22 DR. NERENZ: Now, is that in our scope of

1 discussion this morning? Because now we just beg the
2 question what does "through" mean.

3 MR. GLASS: And I think we talked about --

4 DR. NERENZ: But these are serious because this
5 is -- this is what the law says, that you're in the APM if
6 such-and-such occurs, and I'm just trying to figure out, is
7 that what we're supposed to be talking about this morning,
8 what these words should mean? Or --

9 DR. CROSSON: David, my sense is this: I think
10 for the reasons that you said, David, you know, when you go
11 through the law, in some parts of it it's very hard to
12 figure out how they fit together, right? I think my guess
13 is -- and I suspect there are people from CMS here at the
14 moment -- CMS also is trying to work that through and then
15 come up with a set of rules that both comport with the law
16 and make sense from the perspective of moving this
17 initiative ahead.

18 Our sense here is we could spend a lot of time, I
19 think, trying to interpret what we think the legislation
20 says, but I think our general sense should be -- and
21 probably hopefully what would be more helpful to CMS in
22 this regard, would be to say what we think makes sense in

1 terms of how this works, even if some of that, you know,
2 rubs up against various interpretations of what the
3 language is in the legislation.

4 DR. NERENZ: Then last clarifying question, I
5 promise. Slide 14, the principles here suggest to me
6 principles for new APMs or at least significantly revised,
7 because these features are not currently true in general of
8 either ACOs or medical homes or other things.

9 MR. GLASS: Yeah, I think that's correct.

10 DR. NERENZ: I just want to clarify again scope
11 of our discussion, because I thought we were talking about
12 sort of how do we logically connect current APMs to this
13 eligibility, but this seems to be more about either new
14 APMs or revised APMs. So how do you want us to think about
15 this bit?

16 MR. GLASS: So this is more of a -- given the
17 principles in the earlier slides where you have APMs that
18 are a two-sided risk and for A and B and that sort of
19 thing, these follow from those. So the entities should be
20 given regulatory relief follows off of an APM at two-sided
21 risk for all A and B spending. So these would be
22 principles that we think would show up given what we've

1 laid out already.

2 DR. NERENZ: Okay, but, again, to clarify, are we
3 to be talking about whether we like these principles as
4 characteristics of yet-to-be-developed APMs?

5 MR. GLASS: All APMs are yet to be developed
6 because there's no rules yet saying what an APM is.

7 DR. NERENZ: Well, but the MSSP exists. It's up
8 and running right now.

9 MR. GLASS: Right

10 DR. NERENZ: And it does not have these features.

11 MR. GLASS: That's correct -- well, certain
12 pieces of the MSSP would, the Track 2 and Track 3.

13 DR. CROSSON: Right, but --

14 DR. NERENZ: Shared savings to beneficiaries, is
15 there?

16 MR. GLASS: Not yet.

17 DR. CROSSON: But if you remember how it's
18 worded, if I remember this properly, in the legislation it
19 does list existing payment models such as the payment
20 models for various types of ACOs. But then at the end, it
21 says "and other models to be developed."

22 MS. BLONJARZ: I guess I would say that maybe,

1 you know, for your discussion, when these incentive
2 payments kick in in 2019, do you as the Commission want to
3 have these principles apply to all APMs that qualify
4 participants for the incentive payment? You could say yes
5 or you could say no. You could say that's something that's
6 aspirational or something in the future. But right now the
7 state of play is some of the models have some features of
8 this; none of them have all of them.

9 DR. MILLER: And just one other thing, because I
10 hate to wade in in conversations like this. The other
11 thing, sort of tossing out the notion that there are APMs
12 out there now, but there has been no determination of which
13 of those is eligible.

14 DR. NERENZ: I don't want to belabor this, but
15 that's -- again, I'm just trying to know the focus of our
16 discussion, because I thought largely what we were being
17 asked to do here is to figure out the connection between
18 current APMs and eligibility for the APM incentive system.
19 This is saying, you know, something -- well, it seems to be
20 saying something different, that we're saying how should
21 APMs evolve or what new APMs should come up, and that's
22 just a different discussion from saying how should the

1 current ones be linked to the incentive.

2 DR. MILLER: I don't agree and in the following
3 way: I think there probably -- and I don't feel like I
4 have a real strong handle on all these definitional issues,
5 David. You know, we've had huge internal conversations.
6 I'm surprised no one has resigned yet.

7 I think we're contemplating both of those things.
8 There has to be -- okay. And I just want to say it out
9 loud, and this is mainly for myself, then, if you're
10 retired -- I mean, if you're find. But CMS has to figure
11 out of whatever's out there is going to be eligible, and if
12 anything new shows up, it's going to have to figure out if
13 those are eligible. And I would go back to Jay's
14 principles that I think the most useful thing you as a
15 Commission can do is articulate -- and this is going to be
16 complicated in and of itself, the vision you have for these
17 things. And I thought he put it well. If it rubs up
18 against either the regulations or the models, you know,
19 then we'll have to deal with that. But I think it would
20 help -- because I think the environment right now is
21 incredibly unclear, and to the extent that any group of
22 people can go, well, here is a path or a vision, that will

1 help to gel; even if people go, no, I disagree, at least
2 they'll have a common point that they'll be talking about.

3 DR. NERENZ: And that's fine. If you say both
4 these are fair game this morning, that's fine. Absolutely
5 fine.

6 DR. CROSSON: This is indeed, David, the essence
7 of our opportunity, I think.

8 DR. SAMITT: So thank you. It's my turn to be
9 excited. This stuff is awesome.

10 [Laughter.]

11 DR. MILLER: This is really worrisome.

12 DR. SAMITT: Sorry.

13 [Laughter.]

14 DR. SAMITT: Right. Slide 4 again, if I may.
15 Can you help me understand sort of the 5 percent additional
16 payment for the revenue allocation? Let's go to your
17 attestation versus attribution. If it's an attestation
18 model and the APM beneficiaries are attested, is my 5
19 percent on the number of attesting beneficiaries? Or is it
20 all of the members, patients that I care for, beneficiaries
21 that I care for under Medicare?

22 MS. BLONIARZ: The way that it works is there's a

1 determination of whether a clinician has a certain share of
2 their revenue in an eligible alternative payment entity --
3 that's like 25 percent in 2019 -- then if you meet that
4 bar, you get 5 percent add-on on your billing for all of
5 your patients. Your total Medicare revenue.

6 DR. SAMITT: Whether they are attested --

7 MS. BLONJARZ: Whether they are attested to you
8 or not.

9 DR. SAMITT: If you go with an attestation model,
10 it really doesn't matter.

11 MS. BLONJARZ: That's right. That's right.

12 DR. SAMITT: Okay. That's helpful. Then my
13 second question also on this slide, why would we not
14 consider MA revenues as counting toward sort of the
15 percentage threshold? If you're in Atrius and you're
16 taking, you know, capitated payments from an MA plan, why
17 would that also not be counted toward whether you're an APM
18 entity or not?

19 MS. BLONJARZ: So the very simple answer is that
20 this is -- the way the law is written, it's only fee-for-
21 service. The fee-for-service, your numerator is fee-for-
22 service, your denominator is fee-for-service. MA plays no

1 role.

2 The nuance is that in later years -- so I think
3 starting in 2021 -- there is an all-payer calculation
4 versus a Medicare fee-for-service calculation. And in that
5 calculation, MA could count as an alternative payment model
6 to the extent that CMS determines that the type of
7 arrangement between the MA plan and the clinician is like
8 the eligible APM definition.

9 DR. SAMITT: And there's no flexibility in that
10 regard because it's written in the law that way.

11 MS. BLONJARZ: That's right. The one other thing
12 I will say is that MA -- the integration of MA into APMs or
13 vice versa, CMS is supposed to do a study that I believe is
14 due at the end of this year to figure out, you know, how
15 they could be incorporated. So both the drafters and CMS
16 are well aware of kind of these questions.

17 DR. SAMITT: Thank you.

18 DR. MILLER: Kate, should we do the -- MA gets
19 paid by fee-for-service, and if people are in -- getting
20 the adjustment in fee-for-service indirectly, it starts to
21 get -- we should do that little patten, just to make it
22 more complicated.

1 MS. BLONJARZ: Yeah. So the other thing I'll say
2 is the MA benchmarks are based on fee-for-service. So to
3 the extent that there are 5 percent incentive payments
4 going out, you know, through the fee-for-service system,
5 that will be in the MA benchmarks, kind of whatever the
6 ambient level of, you know, APM participation is. So the
7 money kind of flows through the fee-for-service benchmarks
8 for MA. But that will take a little while to show up.

9 MR. GLASS: That's a slightly different question.

10 DR. SAMITT: So that's a revenue stream issue,
11 but it's not whether I qualify as an APM --

12 MR. GLASS: Correct.

13 DR. REDBERG: Thank you for this very excellent
14 chapter. We clearly have some interesting and important
15 work, along with others, ahead. Just on the heroic
16 assumptions, as you're willing to make some, on Slide 5, do
17 you have a definition for "exceptional performance"?

18 MS. BLONJARZ: No. I think there's something in
19 the law that says, you know, what groups it can apply to,
20 but I think it just says -- you know what? Let me get back
21 to you.

22 MR. GLASS: But that would probably be in

1 regulation. They'd have to define what that means.

2 DR. REDBERG: Okay. And we have no kind of hints
3 about that? We're not going to make any heroic --

4 MR. GLASS: No, we're not going to.

5 DR. REDBERG: Okay.

6 DR. CROSSON: Scott.

7 MR. ARMSTRONG: Actually, Craig asked the very
8 question I was going to ask, but I would make note that
9 I've rarely seen Craig so excited.

10 [Laughter.]

11 DR. CROSSON: No comment. Jack.

12 DR. HOADLEY: So, my question's a little bit
13 parallel to the questions you've had so far, but slightly
14 different. On Slide 6, I'm looking at the time line and
15 trying to understand sort of where our engagement is, and
16 I'm particularly taking note that the proposed rule is
17 listed here as spring, which isn't very far away, and so it
18 sounds like what you're really doing -- and you've got to
19 tell me if I'm understanding this right -- is trying to get
20 sort of our thinking that will then allow you guys to write
21 comments on the proposed rule, and then presumably later
22 steps, but that actually could happen even almost before we

1 meet again, or at most -- and this would be separate -- I
2 mean, we would presumably -- would we be doing this in a
3 report chapter, as well, to sort of lay out where we stand,
4 but the action step is more comments on the regs?

5 DR. MILLER: So, and we were talking about this
6 this morning, so we were just waiting for who was going to
7 ask, and we have a couple -- well, we've got some Bingo
8 cards and so we're --

9 [Laughter.]

10 DR. MILLER: So, here's the way to think about
11 it. For those of you who were around for the ACO process,
12 think of that process. What the Commission did in ACO, and
13 one of the services, I think, it provided at the time was
14 everybody was using that term and nobody was 100 percent
15 sure what it was, and so we wrote some stuff about what it
16 would mean and then we wrote a letter before the
17 regulations came out, sort of in principle, here's how
18 we're thinking about things, and the regulations came out.
19 And some of that first step stuff I mentioned, that went
20 into chapters. Then we wrote a letter and then the regs
21 came out. Then we wrote another letter, and I think there
22 might have even been one beyond that. Maybe not, but I

1 can't remember.

2 But, my basic point to you is this. We're trying
3 to get your thinking, as gelled as possible -- and it's
4 going to be -- it's all going to be imperfect because this
5 is a very new and unclear area -- which we can use to -- in
6 comment letters. I see this also occurring in the chapter,
7 just because of, like, some of the discussion here. What
8 are we talking about? What are the three principles? Can
9 we say anything about the relative incentives, that type of
10 thing.

11 I see this still heading to a chapter somewhere,
12 and at the same time having material from you guys to use
13 in comment. We will be out of sync, because the regulatory
14 process doesn't schedule around our meetings, and so we'll
15 have to just kind of use what we have at any point in time,
16 tell you guys what's going on. But I would see
17 institutionalizing this in a chapter someplace so that it
18 doesn't just become a letter phenomenon. Sorry.

19 MS. BLONIAZ: I wanted to get back to Rita.
20 Exceptional performance in the statute actually has a
21 definition. It's the top 25th percentile above the mean
22 performance. So, that's who that additional funds are

1 available for.

2 DR. CROSSON: Bill Gradison.

3 MR. GRADISON: I have several questions. The
4 language of the statute appears to indicate that if you
5 have the required percentage of your professional service
6 income from an eligible APM, you're in the program. So,
7 the risk that is involved has to be the risk that you incur
8 by being in that particular APM, in that entity.

9 Wouldn't that suggest that it has to be at least
10 five percent, and probably more than five percent, because
11 if it's four percent, why not go into it? The worst you
12 can do is lose four and gain one. And, I just wonder, am I
13 missing something? I'm not trying to judge what they're
14 going to do, but am I missing something in terms of the
15 moving parts?

16 MR. GLASS: Well, I think you're correct for the
17 professional revenue part. If the -- so, the five percent
18 refers to the clinicians' fee-for-service revenue.

19 MR. GRADISON: Yes.

20 MR. GLASS: You have to be careful, because
21 sometimes people are also thinking about A and B risk,
22 right, and then five percent of A and B risk would be a

1 much larger number than five percent of the professional
2 services risk. So, depending on what the four percent you
3 were talking about, you're absolutely correct. If it's
4 four percent --

5 MR. GRADISON: It would be felt --

6 MR. GLASS: If it's its own, yeah, the person's
7 own billing staff.

8 MR. GRADISON: In general, my understanding of
9 medical homes -- and I know the definitions are not precise
10 -- is that their focus is on primary care, not specialists.
11 I don't mean they couldn't be eligible, but not
12 specialists. If this is correct, what role might
13 specialists -- would it work for a specialist to be part of
14 a medical home type of APM, since it would be presumably
15 very difficult for them to get up to 25 percent initially
16 and then much higher from a particular medical home?

17 I have a related question in a second, but I'm
18 going to try -- I'm really focused here now on primary
19 versus specialists and the relative appeal or lack of
20 appeal of even participating in these. I can see it, just
21 thinking about it, more for a PCP than I can for certain
22 kinds of specialists and I just wonder if you have any

1 thoughts about that.

2 MS. BLONJARZ: So, for the medical home
3 provision, you know, there is a special provision in law
4 that means that the risk above a nominal amount wouldn't
5 apply if there's a medical home model that has been
6 expanded by CMS. That actually hasn't happened, so at this
7 point, it's academic to kind of talk about whether that
8 would be an eligible APM. But, I think the -- I mean, the
9 point is, sure, that medical homes would have -- you know,
10 might have a -- might lean more towards primary care. I
11 know in some of the models there is this concept of the
12 medical neighborhood, which incorporates specialty care, as
13 well. But, each of the models is going to be relatively
14 attractive or not to different types of providers.

15 MR. GRADISON: Well, maybe let me pursue it this
16 way. Do I understand that a PCP can only participate in
17 one particular model in terms of, in other words, a 25 or
18 50 or 75 percent, or can a person be in multiple?

19 MS. BLONJARZ: A person -- a clinician can be in
20 multiple models. I mean, CMS in its administration of the
21 models does sometimes have rules on overlap, both for
22 clinicians and for beneficiaries, but they've set out their

1 own rules on how that works. And there's nothing in this
2 law that prevents a clinician from being in multiple
3 models.

4 MR. GRADISON: And this is a final thing. With
5 regard -- and I'm just using ACOs as an example. In a two-
6 sided ACO, how long after the end of a calendar year is a
7 determination made about whether there are savings or not
8 savings and how they are distributed?

9 MR. GLASS: I think it's, like, six months after
10 the end of the year.

11 MR. GRADISON: The reason I mention that is we've
12 got a situation here where I'm a provider. I join one or
13 more of these. I immediately get the five percent. But I
14 presume that if, at the end of the day, when the numbers
15 are totaled up, particularly with regard to the -- let's
16 say I don't hit the -- I'm 24 percent. Is there a take-
17 back? wouldn't there have to be a take-back, because you
18 didn't qualify in the end. You didn't know you didn't
19 qualify until the end of the year, but you were getting
20 paid in anticipating of hitting the 25 percent, right?

21 MR. GLASS: No. I think the pay is actually --

22 MS. BLONIARZ: Yeah.

1 MR. GLASS: You get it this year looking at last
2 year's --

3 MR. GRADISON: Oh --

4 MR. GLASS: -- situation.

5 MR. GRADISON: Oh. The first year, then, that
6 doesn't work.

7 MS. BLONJARZ: So, the --

8 MR. GLASS: Right. So, 2019 is the first year,
9 so 2018 would be --

10 MS. BLONJARZ: And I think that's why we think
11 2018 is probably going to be a key year for assessing
12 whether clinicians meet the 25 percent threshold.

13 MR. GRADISON: Thank you. That's very helpful.

14 DR. CROSSON: Bill, let me just add one thing.
15 You know, in addition to the issue you brought up about
16 medical homes, there is an issue that I think many
17 specialty physicians have with respect to the whole ACO
18 movement in a sense that not all, but many ACOs are primary
19 care Accountable Care Organizations. There are some that
20 are multi-specialty. But, I think there is a sense in the
21 specialty community that, you know, as this moves forward,
22 maybe there is not a space or a natural obvious space for

1 specialty physicians with respect to alternative payment
2 models.

3 So, my understanding, and the common belief, at
4 least, is that that was the reason in the law why this new
5 commission, I think it's Physician Payment Advisory
6 Commission, was created. And while I assume that
7 commission can do what it feels like, I think that a lot of
8 the energy behind that and within that commission is going
9 to be focused on this issue.

10 MR. GRADISON: That's helpful. Then my concern
11 is not misplaced about the relative incentives of PCPs
12 versus certain kinds of specialty. Thank you.

13 DR. MILLER: [Off microphone.] I also think a
14 question for this Commission is, you know, at the extreme,
15 what are you trying to do with this? So, in some ways, at
16 least your initial comments and discussion were sort of,
17 you know, it should be about A-B. It should be about a
18 population type of thing around the patient.

19 And then to the extent that -- let's just for the
20 moment use an ACO as the example as at least something
21 identifiable out on the environment -- if an ACO came
22 together, even in a multi-specialty type of thing, but

1 said, you know, I don't necessarily need every specialist
2 in the community, I'm going to focus in on certain
3 specialists, is that an outcome that is a problem or not?
4 And I think that's a principle you as a Commission will
5 have to think about.

6 MR. GRADISON: I think that there's a larger, in
7 my view, a larger aspect of this, too. There may be parts
8 of the country where you just can't get any of these
9 started, because -- certain states come to my mind, just by
10 the virtue of the geography of them and, frankly, the
11 hostility to managed care and some of these entities, as
12 well. So, I can certainly envision, from the point of view
13 of a physician, let's say, that would like to participate,
14 that, first of all, they've got to make sure there's a
15 group. Yeah, you could say, well, they've got to form one,
16 but that's not the easiest thing in the world to do. But,
17 first, there may not be one, or there may be well one or
18 more and their panels are already filled.

19 So, the sense that this is a true choice, I can
20 choose whether I want to be in one of these or go under the
21 MIPS, may in practice not really turn out to be, in many
22 cases, a true choice, because you may not have the opening

1 or the option, at least in the short run, to participate in
2 an APM.

3 DR. CROSSON: Rita. No, not Rita? I had Rita.
4 Did I miss anybody? Alice.

5 DR. COOMBS: I just had one question, Jay.
6 Thinking about the specialists, there are large, large
7 groups of different specialties that actually dominate
8 geographic regions, and it might be problematic when we
9 think about these principles to exclude the fact that some
10 large groups might want to consider themselves an APM and
11 not be primary care-based. And I'm wondering if it would
12 be important for us to consider these principles with that
13 in mind.

14 Some areas I'm thinking of are ENT in the
15 Northeast Corridor, also nephrology, for which that impacts
16 beneficiary access. Many of the ACOs might not include a
17 nephrologist and they may have large groups in certain
18 areas, or they may have limited workforce whereby the
19 pulmonologists come together in a certain state or a
20 certain region. And I'm wondering if we are thinking about
21 -- when we think about those principles, are we applying
22 those to if they're not primary care-based.

1 DR. CROSSON: That's a very excellent question,
2 and I think it gets -- it will get into our discussion,
3 which will begin today but will go on, about this set of
4 principles that Kate and David have brought forward.

5 For example, if, in fact, we do believe, as Mark
6 said, that the right direction here eventually is for
7 assumption for -- here we go -- alternative payment models
8 to be constructed in such a way that they incent entities
9 to accept long-term population-based risk for Parts A and
10 Part B, at least, it does raise the question of how a
11 single specialty group of orthopedists or whatever can
12 manage population risk over time, because as you are quite
13 aware, they're seeing patients for a relatively narrow
14 slice of the care of those patients over time.

15 Now, they could become incorporated, either
16 formally or informally, into some other entity that is
17 capable of accepting that risk, or, essentially -- and this
18 is, I think, my guess is, one of the issues that this other
19 commission is looking at -- be carved out into a separate
20 set of constructions about alternative payment models.
21 But, that's yet to be determined and is still work to be
22 done and may in the end not be possible.

1 DR. MILLER: [Off microphone.] And just think of
2 the complication those kinds of things create. If you're
3 saying, I really want you to take accountability for A, B,
4 you know, for the whole perspective -- and I should
5 probably stop saying A, B, and eventually have got to start
6 talking about drugs, too -- then there's a slice of this
7 experience, somebody, you know, has a cancer episode or has
8 a surgical episode or something, and then that's pulled out
9 and dealt with under a different model, are you going to
10 adjust the overall model, because at that point, then, how
11 you're rewarding and penalizing becomes influenced by what
12 happened in the other episode if you leave it in. But if
13 you take it out, you have a huge administrative complexity
14 of trying to attribute between things, and I would feel
15 very sorry for the CMS folks trying to work through that.
16 And that's a very difficult complication that comes.

17 DR. CROSSON: I'd just like the record to show
18 that I did not say Part D. You said it. I just said, at
19 least Part A and Part B.

20 MR. GLASS: Actually, one example, Alice, at the
21 moment is the ESRD ACOs, which are, you know, nephrologists
22 and the dialysis centers, and they are taking

1 responsibility for all A and B spending.

2 DR. CROSSON: Clarifying questions. Kathy.

3 MS. BUTO: I was just going to comment on that
4 point that you and Mark just made, that why not have
5 specialty-based APMs, because, you know, say a cardiology-
6 pulmonology-hematology kind of practice, or dealing with
7 people of primary cardiac issues but also ongoing
8 management that involves obviously primary care, but those
9 physicians are capable of that. The same thing for
10 diabetes. If you really want to do chronic care
11 management, sort of an endocrinology-based sort of
12 practice. I don't actually think that necessarily is a bad
13 thing, so -- and, obviously, they'll define it, but I can
14 imagine those kinds of practices getting together and
15 springing up and doing better continuity of care.

16 DR. CROSSON: Yeah. And, I don't disagree with
17 you. A lot of it depends -- we're getting into definitions
18 again -- by what you mean by an alternative payment model.
19 Bundled payments, for example, and bundled payments could
20 be condition-based, which would in many cases relate to a
21 certain specialty, that's an alternative payment model, and
22 an entity could be created to qualify for an alternative

1 payment model.

2 So, you know, even with the existing models that
3 we have, but I think we also have -- and this is part of
4 where we need to go -- we also have this kind of, and David
5 called it aspirational kind of idea here, that maybe some
6 of these models are transitional, and ultimately -- because
7 that, for example, doesn't get you to full care
8 coordination, right -- maybe these are important and time
9 limited, but we still have this other question and set of
10 principles to answer.

11 DR. MILLER: [Off microphone.] And the only
12 other thing I would say to that is I didn't mean to imply
13 that there were, earlier in my examples, only models that
14 would then not necessarily contemplate all of the
15 specialists.

16 To Alice's point and to David's response, well,
17 by the way, the nephrologists, in a sense, or ESRD, have
18 agreed to take risk for A-B, or at least A-B -- new
19 vocabulary --

20 [Laughter.]

21 DR. MILLER: -- and if your example was -- if the
22 Commission came to a principle of, well, we kind of want

1 comprehensive, and your example was, and the cardiologist
2 says, yeah, I'll do that, my patient has a congestive heart
3 failure, it kind of defines their medical experience and I
4 want to take, you know, the risk for -- then maybe that
5 fits right into the principles and it's not an issue. I
6 was more worried about the carve-out nature and the
7 complexity that that starts.

8 DR. CROSSON: Okay. All right. Good. Thanks.
9 David.

10 DR. NERENZ: Still clarifying.

11 On the bottom of page 3, this last discussion
12 prompts this. The language here about participants sounds
13 like this decision is made on the individual clinician
14 basis. So, for example, in a multispecialty group
15 practice, some may qualify and some not; is that correct?

16 MS. BLONIARZ: That's right. Actually, you know,
17 it's going to depend on how "eligible professional" is
18 defined. I think there's probably -- it may actually
19 trigger off how the provider bills Medicare.

20 DR. CROSSON: As you say, "eligible professional"
21 is defined as an individual or a group of -- as a
22 professionals or group of professionals.

1 DR. CROSSON: Thank you. I didn't see language,
2 so I just wanted to clarify.

3 DR. REDBERG: Jay, you were right. I did have
4 another questions.

5 [Laughter.]

6 DR. CROSSON: Well, okay. I think --

7 DR. REDBERG: It's very tiny.

8 DR. CROSSON: Warner is giving you the go-ahead.

9 DR. REDBERG: The covered professional services
10 in participants, I assume that's just Medicare-covered
11 professional services?

12 MS. BLONJARZ: Yeah. You can just think of that
13 as Medicare Part B billing. That's right.

14 For the Medicare, there's a Medicare threshold,
15 and then there's this all-payer threshold, but we're just -
16 - right now, we're just talking about the Medicare
17 threshold.

18 DR. CROSSON: Okay. Warner.

19 MR. THOMAS: What is the current criteria as far
20 as specialty orientation under the existing MSSP and ACO
21 models? I mean, do they have to be? Can they be single
22 specialty oriented? Do they have to be multispecialty? Is

1 it silent?

2 MR. GLASS: Well, on the ACOs, because the
3 attribution is based off of essentially primary care
4 services, it would be odd to have one without lots of
5 primary care physicians because that's how the people end
6 up in these, how the beneficiaries end up in these.

7 MR. THOMAS: And I guess going into some of the
8 comments on having kind of single specialty orientation,
9 how would you see that working? I mean, could you --
10 because, essentially, you cannot have a member in more than
11 one mechanism, I wouldn't think.

12 MS. BLONIARZ: You can. Currently, CMS does have
13 models where beneficiaries are in both. They have some
14 where they are only in one, and I think the shorthand is to
15 think about it that if you're in a model that's taking
16 responsibility for all A and B services for a period of
17 time, generally you can't be in another model that also
18 does that.

19 MR. THOMAS: Right.

20 MS. BLONIARZ: So the ESRD ACOs, those
21 beneficiaries can't also be in another ACO-type model.

22 MR. THOMAS: And is there -- I mean, I guess

1 somebody could be in, say, a cancer kind of global payment
2 model and then also in an ACO that looked at the global
3 payments for the entire situation.

4 MS. BLONJARZ: We'd have to look. I mean, CMS
5 has so many models under the CMMI portfolio, and they have
6 rules for every single arrangement, every single
7 combination, and I don't know about the cancer bundle
8 demonstration.

9 MR. THOMAS: It would seem as though, you know,
10 that most of these are actually built around primary care,
11 though; is that correct?

12 MR. GLASS: I think the ACOs, you can safely say
13 that.

14 DR. CROSSON: Currently, they are.

15 But you point out, Warner, I suspect --

16 MR. THOMAS: I mean, I'm not advocating going to
17 special specialty because I personally believe a
18 multispecialty approach is a more practical way to handle
19 it. I just think if you're in a situation where you have
20 people in -- I just don't see how you can be in multiple
21 types of entities and really account for this
22 appropriately.

1 DR. CROSSON: Well, you're right. There are two
2 conundrums here. Can a beneficiary be cared for under more
3 than one alternative payment model? Because it's the
4 beneficiary that then triggers the physician's eligibility
5 for the payment. And can the physician or group of
6 physicians be under more than one alternative payment model
7 and/or working in more than one alternative payment entity?
8 And I think these are some of the conundrums that we
9 currently have as we try to interpret what's in the law.

10 MR. THOMAS: And just one other question. So I
11 know under many of the current models, it's pretty limiting
12 as to what type of interaction you can have with the
13 patients around the fact that they're in these models,
14 they're not in these models. I mean, do you -- I mean, as
15 you look at these regulations, as we think about going
16 forward, do you see that as being relaxed? Do you see that
17 being that providers should be having it, or is it
18 contemplated in the regulations or in the law that there
19 should be more interaction from a provider perspective to
20 engage patients?

21 MR. GLASS: I think that goes very much to how
22 you end up defining these things because if there's very

1 little engagement, it's all passive, then there's probably
2 not going to be much communication. And if you make it
3 more coherent and cohesive over the whole spectrum of
4 services, then you could -- as we say, you could have them.
5 In fact, you can give them incentives for staying within
6 the ACO, for example.

7 MS. BLONIARZ: And I think it also -- that
8 question also implicates kind of involving beneficiaries
9 more in the APM. Some of the regulations that we were
10 thinking about that could be lucent were things that are
11 designed to combat overuse, so SNF three-day rule and
12 things like that, but there are also regulations about
13 beneficiary inducement. And we just would have to think
14 through what does that mean that an ATM could deal with the
15 beneficiary, what kinds of inducements would we worry about
16 in that situation.

17 DR. MILLER: Drawing from our older principles on
18 ACOs, which may not be the only model here, what we said
19 was if you're willing to accept two-sided risk, the
20 regulatory burden definitely starts to fall away as much as
21 possible without implicating gaming, and to David's point,
22 just to amplify to make sure that other people didn't miss

1 it, in that context we also said incentives for engaging
2 the beneficiary, such as forgiving their copayment. So,
3 again, I don't know where you were headed, but some of that
4 has been contemplated, at least previously, and you could
5 import as you see fit.

6 The other thing, back to your specialty point,
7 you're definitely right that the current circumstances is
8 that enrollment or attribution gets pulled through primary
9 care, and what the specialist said -- and we spoke to this
10 in some of our ACO work -- is they said, "Because I'm not
11 the driver in this ACO, I want to be sure that I can
12 participate in multiple ACOs," and sort of some ways the
13 specialty looked at the environment was "Well, if there's
14 these pods of activity, I'll be working off of them that
15 way." And that's another way you can think about it, or
16 the reverse, which came out of Alice, Kathy kind of set of
17 comments of "Well, I'm a specialist, but I'm willing to
18 take the A/B on," and you could sort of think about those
19 are not necessarily mutually exclusive.

20 DR. CROSSON: Okay. Now we are going to get into
21 the comments area. We've got Alice and Bill Gradison.
22 Sorry, Craig. All right. Just one second -- are going to

1 lead off, but I want to make a few comments first.

2 First, Jack, did we answer this? In terms of the
3 timeline, I think what we're viewing this as continuous.
4 So to the extent that we arrive at some conclusions, then a
5 letter, comment on the draft regulations when they come up,
6 probably continued work in the spring and in the fall as
7 this area evolves.

8 I think we can tell already from the excitement
9 that exists on the Commission and also the discussion so
10 far that we have both an important issue and an extremely
11 complicated one. I hope that in the end of this process,
12 we can get to the level of clarity that Carol got in her
13 presentation of an equally complicated area.

14 But I think this is also an important opportunity
15 for this Commission. We have a long history here of
16 working on delivery system and payment reform because we
17 believe -- and if you may remember, we've talked about this
18 in our sessions as late as last July -- that, ultimately, I
19 think we see the success of the Medicare program and
20 improving quality and containing cost tied in with both
21 delivery system and payment reform.

22 The ACO concept itself came out of deliberations

1 here at this Commission, well before it was put into
2 legislation. So I think, as Mark said, we have principles
3 that are relevant to ACOs. They may or may not be the same
4 ones that we evolve here in this work, but I think we have
5 an opportunity and an obligation even to try to help at
6 least CMS and potentially down the line even the Congress
7 as it begins to think about maybe the next iteration of
8 this work.

9 Having said that, there is a little inherent --
10 there are multiple levels actually of tension within this
11 body of work. One of them, though, I think it's important
12 to keep in mind is, what do we think we want to happen?
13 This is about physician payment for the most part. Do we
14 want to see physician payment evolve over time away from
15 fee-for-service into some other set of models of payment
16 that create incentives for improving quality and managing
17 costs for both the Medicare program and the beneficiaries?
18 And I think the answer is yes.

19 As it applies to alternative payment models and
20 the creation of alternative payment entities, you have to
21 think about whether or not the best direction is a
22 relatively narrow direction where you end up with a

1 relatively constrained set of payment entities that are
2 really ready for these payment models and perform well on
3 them and are successful and in fact prove the point, or
4 another potential model -- take the other extreme -- a much
5 broader set of alternative payment models which, to get to
6 Bill Gradison's point earlier, many if not most clinicians
7 could find themselves at least on the first rung of that
8 ladder eventually moving up. And so, as we look back 10
9 years from now, we say, well, a large majority of American
10 physicians have transformed their practices, and we have
11 transformed the way they're paid, and we have moved large
12 numbers of physicians along this continuum.

13 Now, I am not saying that we have to choose
14 between the ends of that dichotomy, but I think in
15 formulating our principles, we need to think about that
16 and. as we get into this discussion, decide as a Commission
17 sort of where along that continuum this ought to be
18 directed as opposed to necessarily where the current
19 payment models and organizations are directed or even
20 potentially our interpretation of the intent of this
21 particular piece of legislation. And that's a big bite.

22 I think something like that should inform our

1 thinking as we go through this process, which is much more
2 than the next hour here at the meeting, but what I would
3 like to do for the next hour, he says bravely, is to focus
4 on page 12, slide 12, the draft principles, and let's have
5 a discussion, starting with Alice and Bill Gradison, of
6 what we think about these principles. And to the extent
7 that we're going to communicate initially with CMS, which,
8 if any, of these principles should be incorporated into
9 that communication? Okay?

10 DR. COOMBS: Thank you very much.

11 And so I'll start with the premise that most care
12 occurs not inside the hospital, even though I'm a hospital-
13 based physician, and I think the goals of physician
14 payments should be centered around maintaining a healthy
15 out-of-the-hospital existence.

16 So that being said, for APMs, I am thinking about
17 how we can transition or move physicians from the current
18 fee-for-service in a manner that seems almost seamless into
19 APMs. So the incentive is important, but I was thinking
20 about the infrastructure. And this is the same thing that
21 we dealt with, with global payment in Massachusetts, is
22 that a lot of the providers wanted to come together and

1 form ACOs, but they needed the how-to, and they needed some
2 infrastructure development. How much of that
3 infrastructure is IT? If they're already tied into an IT
4 system, then it makes it very easy for them to transition
5 to an integrated system.

6 It does make a difference whether a group of
7 physicians are aligned with a robust hospital system and
8 they have to have the IT system that goes with the
9 hospital. Epic, as you know, is coming into our hospital
10 and many of the hospitals in the Northeast. It's quite
11 expensive, and any of the IT systems are expensive. So I
12 think the up-front incentive is important for groups of
13 physicians, especially in certain geographic regions.

14 In terms of the draft principles, I agree with
15 most of the draft principles. The problem I have is the
16 nominal risk definition, and the nominal risk could be what
17 it takes for the lift to get into the APM, whatever that
18 lift is. So who bears out the nominal risk, and how is it
19 that providers are going to come together so that they can
20 actually say that "I want to be a part of this APM"?

21 I know that in our state, the one model we had is
22 not one-size-fits-all. So when we do the guiding

1 principles, I think that one thing that is important is
2 imagine it for a group of seven with the covered lives as
3 defined as much as a group of -- a multispecialty group of
4 200-plus people or whatever. So that's one of the things
5 that I think is really important is that not to think of
6 this as just the generic group that has every single
7 specialty in it, and that's why I thought about this whole
8 notion of there are other specialties that take over.
9 Especially in nephrology and end-stage renal disease, I
10 think that's really important.

11 And so the nominal risk has got to be the
12 incentive. Whatever way can be packaged to help the
13 smaller group doctors, I think that's really important.

14 And then looking at condition-based, possibly
15 condition-based entities that care for patients like
16 emphysema, there is one person I know in New Mexico who has
17 a cancer ACO, and she takes care of all of the issues that
18 pertain to her patients, and she assumes the responsibility
19 for them. And she is in the CMMI project. So I think that
20 it's important to understand that there are innovative ways
21 in which people and certain regions can take care of
22 patients outside of what we normally see in terms of a

1 primary care-based entity. So I think the geographic
2 differences are really important, and we should take that
3 into consideration as well.

4 I agree with the draft principles on performance
5 as well.

6 In terms of assignment attribution and how we go
7 about with attestation, how we count who is under whose
8 purview, when you get to specialty groups, it becomes very
9 difficult I think because there is involvement with other
10 specialists, and I do have a problem in that sometimes in
11 specialty groups, they tend to consult a lot more outside
12 of their purview. And it may be the comfort level with
13 some of the other issues. The dialysis patients are many
14 diabetics and severe hypertensive as well, so they may be
15 more likely to get outside consults. That can be
16 problematic. So those are the issues that I see that are
17 important.

18 I think going forward, we have to begin to reward
19 high-value, low-cost services, and APM does it, such as
20 end-of-life discussions, shared decision-making around
21 intubations and resuscitation. I will actually on the
22 first day in the ICU actually go to the patient's family.

1 I will meet them the first time to better understand
2 where's their reference point. The second day, I am coming
3 in talking to them about "These are the things that are
4 going on. You've got five organs that are failing," and
5 the next time I speak with them, we're talking about shared
6 decision-making around end-of-life care, whether or not
7 they would want aggressive measures. And I could very well
8 go seven days without talking to the patient about
9 anything, keeping them on the ventilator, on pressors, and
10 doing everything, but I think this whole notion of putting
11 the time in early to say does this patient want this and
12 talking to them about resuscitative measures, that actually
13 does more -- that has more value to that family, to that
14 patient, and it doesn't get paid for in the sense that
15 you're not putting in a PA line or anything. But the big
16 picture is it's better care, and it probably has more value
17 than some of the things that we do that has more -- we see
18 medical intervention. So I think that the APMs do that,
19 and they should do that. I think that's important.

20 And then the last thing is the whole notion of
21 virtual APMs. I think there is a role for us to consider
22 virtual in all of the consideration for guiding principles.

1 I don't see anything that directly -- I mean, maybe someone
2 else does -- that would counter any of that, except the
3 covered lives might be problematic. I think the covered
4 lives, you could aggregate them over geographic regions or
5 over a series of groups.

6 DR. CROSSON: Thank you, Alice.

7 I think one of the major takeaways you're saying
8 is you would advocate for broader access for physicians to
9 alternative payment models.

10 Jon has pointed out to me that I was somewhat
11 cavalier when I said an hour. We have, in fact, by the
12 schedule 15 minutes left, which is going to be inadequate
13 for this discussion. But let's do the best we can.

14 MR. GRADISON: I can help with the timing since
15 I, as artfully as possible, worked in most of my questions
16 under Round 1.

17 [Laughter.]

18 MR. GRADISON: But having said that, I'm struck
19 by the continued dominance of fee-for-service, even as I
20 understand it in entities which themselves are at risk, and
21 I'm talking about ACOs and hospital-employed physicians and
22 a fair amount of managed care, too, as far as I understand

1 it. Certainly the incentives for volume haven't gone away
2 as new doctors are brought on board by hospitals and work
3 out some kind of a salary arrangement. And the reason I
4 mention this is that the way I view this overall is it's an
5 attempt to sort of jump-start a movement in the direction
6 of risk taking from a group which I don't think is very
7 thrilled about taking financial risk and has shown it by
8 their actual practice in the face of efforts at least to
9 nudge them in this direction.

10 Having said that, I wish I had a better
11 understanding of the motivation of physicians in terms of
12 what might move them in this direction. The assumption
13 here is that the money will move them. And maybe it's that
14 simple, but I'm not too sure about that.

15

16 In terms of the specifics, to be a little more
17 specific -- and I just have one more point -- I think as we
18 move forward in trying to analyze this -- and part of it's
19 in the paper. I'm not saying it hasn't been touched at
20 all. But it's to get a clearer idea of what is the real
21 choice a physician faces. I mean, we've talked about what
22 the APM -- even though we're not, you know, and won't for

1 some time be real clear what they are, but in general, we
2 have an idea about them. And we have some indication from
3 two-sided ACOs, what they'll probably -- something like
4 what they'll look like. But the MIPS is something else
5 again, and I think that there may be opportunities for
6 further analysis of just what -- and maybe some focus
7 groups or something, or talking to the professional groups
8 that represent various specialties or various parts of
9 medicine to try to get a sense of how will physicians look
10 at the choice which this statute provides between two
11 different mechanisms. It isn't just the APMs.

12 Now, I think in some of the discussion -- I don't
13 mean our discussion but some of the discussion that I've
14 read about and participate in -- the assumption is, well,
15 you know, only the laggards, the people who stand for the
16 status quo are going to go for the MIPS. I think it's a
17 hell of a lot more complicated than that. And as I pointed
18 out earlier, it may be a challenge to provide enough
19 opportunities in APMs, at least initially, even for those
20 who want to go into it.

21 So those are my main -- my main thought is I
22 think we need to maybe, if we can, monitor the MIPS -- and

1 you'll probably do this anyway, but monitor the MIPS part
2 just as closely as we monitor the APM part as the comments
3 come in and draft regulations and all that.

4 Thank you.

5 DR. CROSSON: Thank you, Bill. I'm going to ask
6 for -- so aim your comments at those principles, if you
7 can.

8 DR. SAMITT: Let me talk about principles first.
9 So the last one, an entity must assume risk, I would argue,
10 if the intent here is to really see some significant
11 behavior shifts to value, that it can't just be nominal
12 risk. It needs to be sufficient risk. And so what I'm
13 worried about is that there's the potential here that we're
14 just going to pay 5 percent more for no change, unless the
15 risk is substantive enough to really drive alternative
16 practice linked to alternative payment. So we don't talk a
17 lot about that, and so that would be a piece that I would
18 think should be a principle that we should underscore. We
19 don't talk about amount of risk, but I think it has to be
20 sufficient.

21 DR. CROSSON: I'm sorry, Craig. But that
22 principle, part of the principle you just elucidated, that

1 payment is a function of performance, which is different
2 really from what's in the law, is in number one.

3 DR. SAMITT: Yes.

4 DR. CROSSON: But the degree of payment is a
5 second issue.

6 DR. SAMITT: Yes, that's what I'm trying to
7 reference. The second principle a lot of people have
8 referenced. I also agree with a more broader leeway
9 regarding who can accept risk. So, yes, we predominantly
10 focus on primary care, but whether it's ESCOs or whether
11 it's cancer ACO or even the consideration of bundled
12 payment, if there's risk associated with it, it feels to me
13 that we want to move people in the direction of
14 performance-based reimbursement and that we should be free.
15 And so it may challenge the third bullet, that the entity
16 must be at risk for Part A and Part B, because there may be
17 some sub-risk that we think should count toward APM --
18 again, as long as there is sufficient amount of risk for
19 the entities taking risk. So that would be the second
20 principle that I would underscore.

21 And then the third is -- it's sort of alluded to,
22 because I would imagine that we're going to see people who

1 will want to move from MIPS to APMs, that there really
2 needs to be a lot of consistency and measurement
3 expectations, reporting requirements, to sort of allow the
4 freedom to somewhat simply move from one to the other as
5 the organization is climbing a higher run on the ladder.

6 Just quickly, I believe in the attribution, not
7 the attestation. We've talked about that in prior
8 meetings, I think in other -- as it relates to ACOs.

9 And then you know where I'll fall out in terms of
10 the definition of risk. I don't think investment risk is
11 sufficient. I think it does need to be the difference
12 between actual and expected spending for the reasons I
13 underscored earlier.

14 DR. CROSSON: Thank you. Very clear.

15 MS. BUTO: I think Principle 1, incentive payment
16 for participants only if the entity's successful in
17 controlling cost, improving quality, or both, is a critical
18 principle. And I actually would come down in favor of
19 let's keep the initial round and definition tight, and
20 actually demand a track record before we qualify something
21 as an alternative payment mechanism, because once you open
22 this up, you can't close it down. You cannot walk it back.

1 And so I would say start with a good track record. We're
2 talking about, you know, paying a lot more money, 5 percent
3 more, and if the definition is too loose and too many
4 entities get into it, you can never walk it back, and
5 you'll be just adding to the expenditures, is my view.

6 So I would start with -- I don't know what the
7 quality and cost parameters would be, but I would just
8 start with the notion that let's get a good track record
9 and then allow that. Okay, so that's just on the
10 principles.

11 The second one is the Commission has talked about
12 per beneficiary primary care payments, sort of, if you
13 will, a bundled capitated payment for primary care. And so
14 one of the things I hope is that any alternative payment
15 mechanism definitions that evolve will allow for that kind
16 of arrangement within the entity. We might even want to
17 say you get an extra point if you have some of that kind of
18 risk, back to Craig's point, as opposed to just, you know,
19 are you willing to come up against some kind of a threshold
20 of spending over last year kind of thing.

21 So I don't know how that would work out, but I
22 just want to make sure that our other interests in

1 increasing payment and accountability at the level of
2 primary care doesn't get lost in this other calculation and
3 structure and that we allow for that to come into this.

4 DR. CROSSON: I just want to do a check here
5 because I may have missed something, but I have Rita, Herb,
6 Jack, and Warner. Is that correct? And Mary. Sorry. Did
7 I say anybody who hadn't raised their hand? Jack's looking
8 stunned. Okay.

9 DR REDBERG: Thanks. First, I want to say now
10 that we're in Round 2 that I'm very excited about this as
11 well.

12 [Laughter.]

13 DR. REDBERG: And really because, you know, for
14 many years, many of my colleagues, when we talk about
15 health care, have said that we really need to get rid of
16 fee-for-service to make real progress and improvement in
17 our health system. And, you know, the Secretary's goals
18 and the alternative payment models I think give us that
19 opportunity, because fee-for-service really just rewards
20 high volume, not high value. You know, as we know, we get
21 paid well for doing unnecessary, even harmful procedures,
22 and the same is for doing beneficial and life-saving

1 procedures. And so I think there's tremendous opportunity
2 here.

3 I think really since SGR clearly wasn't working,
4 you know, more than 10 years ago, we -- you know, so I
5 don't think that we're rushing. I think this has clearly
6 been a long time in coming, and, therefore, I endorse all
7 of the draft principles and think, you know, this is our
8 time to be bold and try to achieve real system
9 transformation, because we really are at a point when we're
10 all concerned about, you know, the future of Medicare, the
11 solvency of the trust fund, and there's an opportunity, I
12 think, to do really good things for the program and for
13 beneficiaries.

14 And so I would -- you know, I agree with what
15 Kathy and Craig have already stated in detail. You know,
16 certainly in terms of the risk in excess of a nominal
17 amount, I think we have to go for the difference between
18 actual and expected spending, because to really see a
19 difference we have to put something at risk. You know, I
20 think we could have -- we've learned from what we've done
21 in the past, but we shouldn't repeat those mistakes.

22 DR. CROSSON: Thank you.

1 MR. KUHN: So, quickly, just two thoughts.

2 One, all the principles I think make sense for
3 all the reasons cited, so I won't go through those again.
4 I just wanted to touch base on the broader access issue,
5 and for two reasons. One is when we kind of go through our
6 payment systems, as we did in December and then here, you
7 know, whether we look at MA plans or home health or SNF or
8 others, we talk about how many are in a community. We say
9 99 percent of the zip codes have access to one, and 95
10 percent have access to three, or whatever. I really would
11 want us to really bear up on this principle of broader
12 access to make sure that we have the maximum opportunity
13 from the beneficiary side -- because we're really talking
14 about the provider entity, but let's really think pretty
15 hard about the beneficiary side. And then to reinforce
16 that, you know, when you look at the paper and on page 24
17 where there's the appendix with additional information
18 about various risk models that are out there -- and I don't
19 know if this is all inclusive but, you know, just some
20 rough math there. There's only about 2 million
21 beneficiaries in these entities now.

22 So if you look at this -- you know, if you really

1 take the MSSP Track 2 and not all ACOs but just the Track
2 2, you know, it's a limited set. So I do want us to think
3 a little bit broader.

4 And then the second thought is, as we move into
5 these entities -- and I don't know if they can be captured
6 in these principles or this is something that's outside
7 them -- is that ultimately there probably will be
8 accrediting organizations that will be looking at these
9 entities and determining whether they meet or not. And
10 there have been times in the past where accrediting
11 agencies have disagreed with CMS and don't accredit an
12 entity, and then it creates problems with getting them in
13 the game, so to speak. So some way to think about
14 harmonization between accrediting agencies and where CMS
15 goes on this I think would be important as part of the
16 principles, too.

17 DR. CROSSON: Thank you. Those are good and two
18 new perspectives, important perspectives.

19 DR. HOADLEY: So I want to engage on two of these
20 principles. One is the at-risk aspects, and I mean, I
21 certainly agree that too little risk tends to create
22 situations where there's no real impact on behavior. We've

1 all seen examples of, you know, physicians are in some
2 situation where they get a bonus, but they don't even know
3 what the bonus relates too. It's too small, it just falls
4 somewhere in the accounting.

5 The flip side of it is, you know, if more risk is
6 to be assumed and we want to create this with an adequate
7 amount of risk, and especially the downstream risk for a
8 larger set of services like hospitalizations, you know,
9 what's the right set of structuring of that risk? What's
10 the right set of protections that goes with that risk?

11 One of the things I tried to think about, I think
12 about the discussions many years ago of provider-sponsored
13 organizations who were going to take capitation for
14 everything, and there the enrollees, the beneficiaries,
15 were potentially at significant insurance risk if their
16 coverage suddenly wasn't there anymore if the PSO goes
17 under. I don't think we're in that situation, but I do
18 want us to make sure to think about are there scenarios
19 where the beneficiaries could be harmed, are there
20 situations where the way risk is structured that, you know,
21 you say, okay, at the end of the term you've got to -- you
22 owe a bunch of money back.

1 There was an alternate model that was discussed
2 in the paper which seemed interesting because it didn't
3 necessarily involve that paying back. It was more advance
4 pay, you know, different kinds of things, and I think maybe
5 looking at some of the models by which risk can be
6 structured so it puts plenty of money on the line but it
7 doesn't do it in a way that's going to get complicated in
8 terms of physicians owing money back and are there then
9 implications for beneficiary services.

10 The other one I wanted to talk about was the
11 engagement with beneficiaries more generally, and I think,
12 like a couple of others have said, I think, you know, the
13 notion of attribution probably is going to work better than
14 some kind of enrollment or attestation model. We've had
15 that discussion around the ACOs. You know, how do you
16 educate beneficiaries to make them understand what this
17 thing is?

18 On the other hand, if you really want to engage
19 the beneficiaries, we are going to have to think about
20 educating a beneficiary. This is not going to be obvious
21 to a beneficiary what this is about. You know, there's a
22 discussion in the paper about opt-outs. We've seen in some

1 of the dual demos, you know, very high levels of opt-out.
2 You know, normally we thought opt-out is a way most people
3 get engaged. It's a lot harder to get people to opt in
4 than opt out. But there was a lot of opt-out in the dual
5 demos, sometimes for confusion, sometimes provider-driven.
6 So I think, you know, figuring out how to educate the
7 beneficiaries on what these will mean for them -- and I
8 don't -- you know, I would have a tough time right now sort
9 of walking down that logic, but I haven't spent a lot of
10 time thinking about it. But how do you explain to them --
11 I mean, we can do it in broad generalities. This is about,
12 you know, aligning your care better and thinking about the
13 whole course of care and not just about individual
14 services. But what is it really going to mean to you? You
15 know, what does it mean in terms of if we're going to
16 engage with some kind of financial incentives? You know,
17 what would those be? How do you make sure to understand
18 them? What does it to cost sharing that's based on a
19 percentage of fees if there's bonuses or reductions? Does
20 that somehow adjust cost sharing? I think there's just a
21 bunch of issues; we need to make sure we think of them.

22 DR. CROSSON: Thank you, Jack. Again, important

1 beneficiary perspective to take in.

2 MR. THOMAS: So I'll preface my first comment
3 with I understand this is very complicated, but I think one
4 of our first principles should be to try to simplify this,
5 because it's very complicated for providers to try to
6 understand what path to take and how to play in these
7 situations. So I understand that's probably heroic, to use
8 your term, a heroic effort. But I think it's an important
9 one from a principle perspective because we want providers
10 to engage in this, and I think there's a lot of aversion
11 because folks don't understand it and they're not sure kind
12 of where to play and where not to play. So I would use
13 that as the first one.

14 The second piece -- and I agree with Craig, I
15 think there has to be a significant amount of risk here in
16 order to earn the dollars. With that being said, I think
17 we also need to be thoughtful about what is the path to
18 that. You know, if you think about things today, you
19 probably have maybe 25 to 30 percent of providers that are
20 trying to lean in and work on these new payment systems,
21 and they'll continue to go down this road. The question
22 is: How do we get the next 30 percent to opt in? And if

1 there's not some sort of path or transition, if they just
2 have to step in day one and take, you know, significant
3 downside risk, they're probably not going to play, even
4 with the 5 percent.

5 So I would encourage us to be thoughtful about
6 how do we move the 25 to 30 percent kind of into the
7 downside risk and how do we get the next group to play,
8 understanding that, you know, if they ultimately want the 5
9 percent, they've got to have the risk.

10

11 The final piece, and maybe it's under the
12 regulatory relief component, but this idea of being able to
13 engage with the beneficiary in an appropriate way and to
14 have the right dialogue with them around things like -- I
15 know this may be a bad thing, but health risk assessments
16 and having the right interaction around preventative types
17 of measures is, I think, a really important component to
18 make sure that we can generate the savings opportunities.
19 And if there's not the right interaction with
20 beneficiaries, that's going to be a challenge. So I
21 appreciate the opportunity.

22 DR. CROSSON: Thank you. Good points as well.

1 On this, David?

2 DR. NERENZ: I think as we go forward -- and I
3 agree with those points -- it's going to be important to
4 clarify are we talking about the entity having risk or the
5 provider having risk. That's not the same thing, because
6 you can be a provider and you can be part of an entity but
7 you have no risk whatsoever. So I think we just need to be
8 clear as a group as this goes forward which one of those
9 two things do we want to require.

10 DR. CROSSON: Warner, do you want to comment?

11 MR. THOMAS: Yeah. David, I think that's a good
12 point. I guess the mental model I have on this is you
13 likely have -- I mean, if you have an entity that has risk,
14 say that they have a negative pool of \$1 million, that's
15 going to somehow -- that entity has to decide how that's
16 going to get pushed down to the providers, whether it be
17 hospitals or physicians, and maybe that is guidance that
18 should be in here, but I think that's probably what ends up
19 happening, is you're going to have an entity that takes
20 whatever upside or downside, and there's going to have to
21 be a distribution mechanism with that entity as to how they
22 play.

1 DR. NERENZ: Well, just to sharpen the point a
2 little bit, I agree, but since this is only about
3 physicians, you can have a hospital-led ACO, the hospital
4 can be the at-risk entity, the physicians can sign
5 contracts that do not put them under any risk. They get
6 the 5 percent. They themselves bear no risk. We just have
7 to decide. Is that okay or not okay?

8 DR. CROSSON: I completely agree with both of you
9 that, A, it's complicated, but B, Warner's point is that
10 if, in fact, most of this five percent is going to flow
11 through the entity, then, in fact, you know, unless the
12 entity has got somewhere else to come up with the money, if
13 there's a downside, or another place to come up with the
14 money to pay the individual eligible professionals, it
15 pretty much should line up that the entity that's bearing
16 risk will transfer that risk more or less one-to-one to the
17 eligible professionals. But, as you say, David, it depends
18 a lot on the nature of that entity and the governance
19 process and the role of physicians, particularly with
20 respect to hospitals.

21 DR. NERENZ: I assume that the five percent we're
22 talking about here flows directly from CMS to the

1 providers. It has nothing to do with the entity.

2 MR. GLASS: Yes, the five percent does, yes.

3 DR. NERENZ: As written in -- as the law states
4 now, I mean --

5 MR. GLASS: Yes.

6 DR. CROSSON: But, the eligibility -- here's the
7 question. But, the eligibility for the five percent, we
8 are positing, should be a focus of whether or not the
9 entity actually meets the performance standards or goals in
10 terms of quality and cost.

11 MR. GLASS: Just different point.

12 DR. CROSSON: And, Mary.

13 DR. NAYLOR: So, David, it's not only about
14 physicians.

15 [Laughter.]

16 DR. NAYLOR: Someday, I'll become excited when we
17 all get that.

18 [Laughter.]

19 DR. NERENZ: I'm sorry.

20 DR. NAYLOR: No, no, no, it's to all of us.

21 I want to build on Kathy's point and wonder
22 whether or not a principle, since the selection of the

1 models is going to be so important, whether or not there
2 should be a principle that there is a strong, rigorous
3 evidence base in the selection at least of the initial
4 models that are going to be part of this, that enable the
5 creation of the entities.

6 On beneficiaries, first of all, I support these
7 principles, but I wonder if even the language should be
8 changed to suggest that beneficiaries should participate,
9 not can, to be aligned with our principles as a Commission
10 that beneficiaries are a central focal point of these
11 changes. And, I would really encourage thinking about
12 spending -- defining quality in the context of, on the
13 second one, quality as defined by those performance metrics
14 that matter to the beneficiaries. As we think about
15 specialists and all of the other models, we really need to
16 be putting the attention on care continuity, coordination,
17 the things that matter to a beneficiary.

18 So, those are my recommendations.

19 DR. CROSSON: Thank you. Excellent point again.

20 So, thank you to the Commissioners for helping
21 me, helping us catch up a little more closely to what we're
22 trying to do on the schedule.

1 This is not the beginning but the, you know, the
2 beginning of an intense discussion in detail and not the
3 end, and so we're going to be spending, I would guess, the
4 better part of a year working on this, hopefully in
5 cooperation with CMS and others who are working on these
6 issues.

7 David and Kate, thanks very much. Excellent
8 presentation and discussion.

9 I think our discussion is concluded and we are
10 now ready for public comment. If there are any individuals
11 in the audience who wish to make comments, please come to
12 the microphone.

13 [Pause.]

14 DR. CROSSON: I see none, so we are adjourned --
15 whoa, whoa, somebody had trouble getting out. Sorry.

16 MS. LEE: Hi. My name is Teresa Lee with the
17 Alliance for Home Health Quality and Innovation. I want to
18 thank the Commission and the staff for some really
19 interesting presentations.

20 I found today's discussions both around post-
21 acute care payment reform and this discussion around
22 alternative payment models to be fascinating, and just a

1 couple of observations.

2 The first is that I find myself thinking in the
3 context of post-acute care payment reform about the
4 significance of home health care in the context of the
5 post-acute care continuum, and it sort of intersects in a
6 way with what you've been talking about related to
7 alternative payment models in that CMS has been very
8 interested in bundled payment approaches, not the least of
9 which is comprehensive care for joint replacement. And in
10 a recent JAMA piece, Patrick Conway and his colleagues at
11 CMMI pointed to the fact that home health care is an
12 important strategy in terms of modifying clinically
13 appropriate and cost effective placement of patients
14 towards home health care.

15 So, I just wanted to point out that in that
16 context, in the context of payment reform for post-acute
17 care writ large, it would be great to see the Commission
18 recognize the importance of home health care and that while
19 there may be concerns about cost overall in the health care
20 system, home health care occupies a really important place,
21 and that if we're going to be shifting patients towards the
22 home, towards the community, and potentially towards home

1 health care, it will be important to make investments to
2 better enable coordination of care, which can be costly and
3 may be something that's being taken up in greater measure
4 in years past 2013, which is the year that we're using for
5 modeling.

6 So, I'd like the Commission to consider the fact
7 that we need to invest dollars into coordination of care,
8 including the need to invest in things like discharge
9 planning, which CMS is addressing now in the context of
10 conditions of participation.

11 In addition, post-acute care providers were left
12 out of the high-tech meaningful use payments, so if we're
13 going to be able to better coordinate care, we need to be
14 able to make investments in things like HIT. Many
15 providers are already doing that, but we're still a long
16 ways off.

17 So, I thank this Commission for the opportunity
18 to provide a public comment.

19 DR. CROSSON: Thank you very much.

20 I did not do my introductory comments. I see
21 another speaker. Identify yourself, please, and then limit
22 yourself to two minutes. Thank you.

1 MS. BRENNAN: Sure. Hi. My name is Allison
2 Brennan. I'm with the National Association of ACOs.

3 And, one of the speakers made the comment that
4 we've seen about 20 to 30 percent of providers kind of lean
5 in to alternative payment models and pursue going down that
6 path of moving away from fee-for-service. And I guess the
7 comment I would have is just that if you do really narrowly
8 define what would qualify as an eligible APM, if 28 of that
9 30 percent are excluded, I feel like a lot of people who
10 have really embraced this in recent years are going to feel
11 like they've kind of had the rug pulled out from under
12 them. You know, they've pursued all these things, and then
13 if they aren't eligible would be kind of thrown into the
14 MIPS side of things. So, I definitely encourage you to
15 take a broad approach to kind of recognize the work that a
16 lot of providers have done to pursue alternative payment
17 models to date.

18 And then the other comment that I would just make
19 is the complexity of this, I think, is really overwhelming,
20 as we've all discussed. But, thinking about being a
21 provider who has to make a decision and kind of sees that
22 fork in the road, is it going to be a true fork in the road

1 where they pursue one thing or not, or are they going to go
2 down one path only to find out that they got 24 percent
3 revenue. Now, they're in another bucket and they have been
4 being evaluated under different criteria that they weren't
5 even focused on because they were focused on kind of that
6 path.

7 So, thank you very much.

8 DR. CROSSON: Thank you very much.

9 We are adjourned until the March meeting.

10 [Whereupon, at 11:43 a.m., the meeting was
11 adjourned.]

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