

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
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Thursday, November 2, 2017  
9:20 a.m.

COMMISSIONERS PRESENT:

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[9:20 a.m.]

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DR. CROSSON: Okay. Let's see if we can get together.

Let me welcome our guests to the morning session. Our first order of business is continuing our discussion, which has been going on for well more than a year, on MACRA but specifically on the issue of MIPS payment and more specifically on refining and addressing questions that Commissioners had in the October meeting about a potential alternative to MIPS. And we have Kate and David, and David is going to begin.

MR. GLASS: Yes, thank you. Good morning. We are back again.

[Laughter.]

MR. GLASS: As background to today's discussion, let's first review what MACRA did. It repealed the SGR, something the Commission had been recommending for several years. It set statutory updates for clinicians going forward. It created a 5 percent incentive payment for clinicians with a substantial involvement in advanced alternative payment models, or A-APMs. And it created

1 MIPS, a new value-based purchasing program for clinicians  
2 who are mainly in fee-for-service, and that is the part of  
3 MACRA we are going to talk about today.

4           So SGR stays repealed, the updates are what they  
5 are, A-APM incentive payment continue. We are focusing on  
6 MIPS.

7           We are focusing on MIPS because we have some  
8 major concerns about MIPS. It will not identify or reward  
9 high-value clinicians and presents a significant burden to  
10 the program and clinicians -- a burden CMS estimated at  
11 more than \$1 billion in the first year and \$800 million per  
12 year in following years. We have raised these concerns  
13 over the last several years in public meetings, comment  
14 letters, and in our June reports to the Congress. And we  
15 are not the only ones who are concerned.

16           CMS has delayed full implementation in the first  
17 two years and allowed reporting one measure for one patient  
18 to be sufficient to avoid a penalty. This policy, coupled  
19 with very low thresholds, will make any rewards in the  
20 first two years very small.

21           Providers, academics, and others have weighed in  
22 as well, pointing out difficulties with measures, the

1 burden of reporting, and the random nature of any rewards  
2 that might eventually transpire. Some have asked that CMS  
3 be allowed to continue to delay full implementation. This  
4 background is what brought us to last month's discussion.

5           Last month the Commission discussed the state of  
6 MIPS. We reviewed the concerns I just mentioned and  
7 pointed out that time is of the essence because payment  
8 adjustments under MIPS begin in 2019. There seemed to be  
9 general but not unanimous agreement to eliminate MIPS. But  
10 there was also some desire to keep a value component for  
11 clinicians in Medicare fee-for-service.

12           To that end, we presented an outline of a  
13 potential voluntary value program, or VVP, as an  
14 alternative to MIPS, and you raised a series of questions  
15 about that alternative and asked for a fuller description.  
16 So today Kate will address your questions about the VVP.

17           First, however, I will take a few minutes to  
18 address some questions that arose about how the VVP fits  
19 with the advanced alternative payment models, or A-APMs.  
20 These models are the other path for clinicians set up by  
21 MACRA. Clinicians in A-APMS are exempt from MIPS and get a  
22 5 percent bonus payment on top of their clinician fee

1 schedule billing to Medicare.

2           So the basic question Jay raised last month is:  
3 Are A-APMs available for clinicians to join? If we  
4 eliminate MIPS, is there someplace for clinicians to go in  
5 addition to the voluntary groups in the VVP?

6           CMS has taken a number of actions to make A-APMS  
7 more accessible to clinicians, and we have commented on a  
8 number of them and agree on many:

9           For example, prospective attribution of  
10 beneficiaries to ACOs; that is, letting ACOs know who their  
11 beneficiaries are at the beginning of the year. This is  
12 important because it creates certainty for clinicians of  
13 who they are responsible for. It also makes it possible to  
14 for CMS to give the ACOs more flexibility by waiving  
15 certain regulations.

16           Allowing aggregation of smaller organizations not  
17 necessarily contiguous into larger national entities, which  
18 has proved useful for several ACOs including some in rural  
19 areas.

20           Making models available to any willing provider  
21 as in MSSP and Track 1+. In contrast, most demonstrations  
22 require entities to apply. Then there may be a competition

1 to choose winners adding up to possible delay and  
2 uncertainty.

3           Incorporating asymmetric risk, as we discussed  
4 last year, to change the risk equation and make A-APMs more  
5 attractive. This is being done in Track 1+ ACOs.

6           Allowing beneficiaries to be rewarded for using  
7 ACO providers as in the Next Generation ACOs. This is  
8 something the Commission has supported.

9           And, finally defining risk as a share of revenue  
10 rather than as a percentage of benchmark, which can lower  
11 the risk for clinician groups by making it more  
12 proportionate to their ability to bear risk.

13           So the answer is yes, there are many A-APMS for  
14 clinicians to join, some such as ACO Track 1+ which are  
15 designed for clinician groups.

16           However, we do want to add that there needs to be  
17 a balance between availability and capability. The  
18 Commission's principles for A-APMs, which we laid out in  
19 the June 2016 report to the Congress, make it clear that A-  
20 APMs need to be rigorous and help lead to meaningful  
21 delivery system reform. For example, guaranteed payments  
22 shouldn't exceed the maximum risk levels in models because

1 there would no longer be any risk for the providers and  
2 less incentive to change.

3           There is also the question that Craig has raised  
4 of: How would the new VVP interact with A-APMS? And would  
5 it encourage or discourage clinicians from moving into A-  
6 APMS?

7           We think that on balance the VVP would encourage  
8 clinicians to form voluntary groups and start taking  
9 responsibility for population-based outcomes. That is true  
10 by design. If they don't form voluntary groups big enough  
11 to assess population-based outcome measures, they lose  
12 their withhold.

13           This would mean that clinicians would be better  
14 positioned to form or join A-APMS because they would be  
15 familiar with being in groups and they would be familiar  
16 with the type of outcomes-based measures that we propose  
17 would also be used in A-APMS.

18           Finally, clinicians would still want to be in A-  
19 APMS because the VVP rewards would be limited, as Kate will  
20 discuss, and they would still not be eligible for the 5  
21 percent incentive on their billings.

22           In sum, there should be A-APMS to join, and the



1 VVP should function as an on-ramp for clinicians to join  
2 them.

3 Now that I am done with that preamble, let's  
4 return to where we left off last month. This was the  
5 policy option under discussion.

6 Eliminate the current Merit-based Incentive  
7 Payment System. That is Part 1, which met with general  
8 consensus. There was a recognition that the current MIPS  
9 program will not accomplish the goal of differentiating  
10 among clinicians based on their value, will require a great  
11 deal of burden on clinicians to report, and will create the  
12 illusion of doing something while actually accomplishing  
13 very little if implementation is delayed, or potentially  
14 moving money around in essentially random ways if it is  
15 fully implemented. Further, there is a sense of urgency  
16 because MIPS will start making payment adjustments in 2019.

17 Under this recommendation we are only talking  
18 about MIPS. The other provisions of MACRA would continue.  
19 Clinicians would get their regular fee-for-service payments  
20 and the updates specified in MACRA. The SGR would not  
21 return.

22 Part 2 was proposed in case the Commission wanted

1 to create a new value-based program for clinicians  
2 remaining in fee-for-service after MIPS was eliminated.

3 That option was: establish a new voluntary value  
4 program in fee-for-service Medicare in which clinicians can  
5 elect to be measured as part of a voluntary group; and  
6 clinicians in voluntary groups can qualify for a value  
7 payment based on their group performance and on a set of  
8 population-based outcome measures.

9 This is the part that raised a lot of questions  
10 and required some more elucidation. Kate will now take us  
11 through that.

12 MS. BLONJARZ: The elements of the voluntary  
13 value program are as follows: A withhold on all fee  
14 schedule services would fund a value pool. Then clinicians  
15 could elect to be measured in a voluntary group (and  
16 potentially be eligible for a value payment). They could  
17 join an advanced alternative payment model and receive  
18 their withhold back. Or they could make no election and  
19 lose their withhold.

20 I just want to reiterate something David said.  
21 It's generally our goal to illustrate the general  
22 parameters of a new voluntary value program, give an

1 illustrative way of implementing the program, and allow for  
2 flexibility in design to incorporate feedback from  
3 Congress, CMS, and stakeholders.

4           So while I will answer some of the policy  
5 questions you raised over the next few slides, these would  
6 only be described as potential policy tradeoffs in the text  
7 surrounding the recommendation.

8           A key question raised by a number of you was the  
9 size of the voluntary groups that would be needed. It will  
10 depend on the specific measures, specialties, and  
11 attribution methodology.

12           But one estimate is that a voluntary group of 10  
13 or more clinicians may be sufficient to assess performance  
14 on avoidable hospitalizations and emergency department  
15 visits if the group has a specialty mix similar to MSSP  
16 ACOs. This is based on our work with the MSSP program as  
17 well as the experience with the first two years of the  
18 physician value-based payment modifier.

19           Dana, you asked for ballpark estimates of how  
20 many clinicians might already be in a formal group of this  
21 size. From the work I did last fall, about a third of  
22 Medicare-billing physicians work with 10 or more clinicians

1 in the same practice in their immediate office location; 40  
2 percent of Medicare-billing physicians report a hospital or  
3 health system affiliation. Those aren't additive. There  
4 is some overlap there.

5 And, Warner, you asked about MSSP Track 1 ACOs.  
6 They could also be a voluntary group, and there are about  
7 190,000 clinicians in those models.

8 We have generally described a process where there  
9 would be no restrictions on the size or makeup of the  
10 voluntary group beyond a minimum threshold. CMS could  
11 provide technical assistance on referral networks to help  
12 clinicians form voluntary groups, and they do something  
13 like this currently in the physician quality reporting  
14 program.

15 Jon and others, you asked about whether there  
16 would be a voluntary group option for clinicians that wish  
17 to join one, but can't find one.

18 We thought a little bit about a CMS-established  
19 voluntary fallback group. The benefits of a policy like  
20 that is for isolated or low-volume clinicians to have a  
21 guaranteed voluntary group that they could join. But if  
22 there's very little barrier to joining a group, then

1 everyone would almost likely do so, and the value pool  
2 would likely be smaller. This means there would be smaller  
3 rewards for high-performing voluntary groups.

4           With respect to measures, our preference is to  
5 not identify the measures in detail but, rather, give  
6 criteria for Congress and CMS on selection. Those criteria  
7 are as follows:

8           The measures should focus on population-based  
9 outcomes, patient experience, and cost. They'd be patient-  
10 oriented, encourage coordination across providers and time,  
11 and promote change in the delivery system. They should be  
12 unduly burdensome for providers to report (either extracted  
13 from claims or CMS-administered surveys), and would be  
14 risk-adjusted for patient health risks.

15           David Nerenz, you suggested some additional  
16 criteria here. We added that the measures should be  
17 reliable and valid using a defined minimum number of cases  
18 and that we can distinguish meaningful differences among  
19 voluntary groups.

20           David Grabowski, you raised issues of both risk  
21 adjustment and social risk factors and a general concern  
22 about making sure that the program doesn't unduly penalize

1 clinicians treating a high share of vulnerable patients.  
2 We do agree that that's a concern, and approaches such as  
3 peer grouping might be one way to address it.

4           Craig and Dana raised the point that this is kind  
5 of a miniature A-APM process, and that's by design. The A-  
6 APM measures would also be aligned with our quality  
7 principles, and so by construction, it would give  
8 clinicians an opportunity to get familiar with the measures  
9 before joining or forming an A-APM.

10           Pat, you asked about attribution. CMS currently  
11 uses a number of different attribution methods, depending  
12 on the purpose of the program. Generally, there's two  
13 approaches: single and multiple. Single -- the model  
14 generally used in ACOs -- attributes all of a beneficiary's  
15 outcome or spending to one provider. Multiple attribution  
16 allocates responsibility proportionally across all the  
17 providers involved in an episode of care.

18           In work we did about a decade ago, we found that  
19 multiple attribution results in more specialty clinicians  
20 being attributed to an episode than single attribution.  
21 This may be a reason to use multiple attribution as the  
22 default option, with special consideration for certain

1 measures.

2 Alice and Dana, you both asked whether  
3 specialists would see a connection to their work in the  
4 population-based measures that we envision for VVP. I  
5 should note as well that we've gotten a lot of concern on  
6 this point from the physician community in the last month,  
7 and we do understand the concern here.

8 A point on specialist participation in  
9 alternative payment. Although the MSSP attribution process  
10 prioritizes primary care, about two-thirds of physicians in  
11 MSSP are specialists. Three out of seven of the advanced  
12 alternative payment models in 2019 focus on conditions  
13 largely managed by specialists: comprehensive care for  
14 joint replacement, ESRD ESCOs, and the oncology care model.  
15 This isn't to say that all specialists or all clinicians  
16 have access to models, so we plan to keep an eye on this.

17 With respect to VVP, we thought about the  
18 relationship between the measures and the specialists.  
19 Avoidable emergency department and admissions measures  
20 might be most cleanly linked to primary care and some other  
21 outpatient medical specialties. With respect to  
22 readmissions and Medicare spending per beneficiary, the

1 linkage is most direct with surgeons or hospital-based  
2 clinicians. Patient experience and cost could be relevant  
3 for most clinicians.

4 Sue, Kathy, and Craig all asked about the amount  
5 of the withhold. We described an illustrative withhold of  
6 2 percent, and one reference point is that the hospital and  
7 SNF VBPs are both also 2 percent.

8 But this is a policy choice. It's generally  
9 small, unlikely to change clinician behavior, and so you  
10 could make it bigger or have it grow over time. But,  
11 again, this goes to the question of the purpose of the VVP.  
12 If it's just to get clinicians comfortable with joining  
13 other clinicians in continuing to assume responsibility for  
14 population outcomes, then maybe the withhold shouldn't be  
15 that big, and clinicians who want more risk or reward could  
16 join advanced alternative payment models.

17 A policy we would emphasize in the text is that  
18 the total value payment should be capped to be less  
19 attractive than joining an A-APM. This comes from a  
20 general sense among Commissioners that clinicians should  
21 not be able to receive large bonuses while remaining in  
22 Medicare fee-for-service.



1           Next up is a point that Jack and Craig raised,  
2 and that's whether getting rid of clinician-reported  
3 quality measures and the attestation process for EHRs would  
4 mean that Medicare would result in a loss of meaningful  
5 information or backsliding in EHR adoption.

6           In terms of individual quality performance  
7 reporting, other organizations such as ACOs, health  
8 systems, or specialty societies could measure and report  
9 individual performance to clinicians or the public. With  
10 respect to EHR policy around interoperability, this might  
11 be a continued role for the Office of the National  
12 Coordinator or a condition of participation in Medicare.

13           I'd like to clarify, too, that a lot of  
14 organizations have developed registries, and those could  
15 still help with internal quality control and help voluntary  
16 groups improve their performance. But Medicare would no  
17 longer be involved in certifying them or collecting data  
18 through them.

19           I would again reiterate our concern that MIPS is  
20 unlikely to achieve the goal of identifying or rewarding  
21 high-value clinicians in Medicare. This has led us to the  
22 policy option under discussion, which is printed again on

1 the slide. Recall that the issues I presented will be  
2 discussed in the text as one potential approach. We  
3 envision a process that allows for CMS, congressional, and  
4 stakeholder input. The question for you all at the end is  
5 whether we should move to a draft recommendation in  
6 December and the nature and form of that recommendation.

7 We are happy to answer questions and look forward  
8 to your discussion.

9 DR. CROSSON: Thank you, Kate and David.

10 We'll now open the floor to clarifying questions.  
11 I see Craig and Bruce.

12 DR. SAMITT: So if we can go to Slide 4, I would  
13 love to go a little bit deeper in terms of the availability  
14 of A-APMs. Have we done an analysis to specifically  
15 understand what percentage of physicians have access to an  
16 A-APM? So somewhat distinctly, actually, between primary  
17 care and specialty, I'd be interested in that. You know,  
18 there have been a lot of levers to expand access, but it's  
19 still hard to tell the materiality of availability for each  
20 of those groups. Do we have a sense of that?

21 MR. GLASS: Well, we did note that in MSSP, two-  
22 thirds of the clinicians are specialists and one-third are

1 primary care, so --

2 DR. SAMITT: Well, but it's the reverse that I'm  
3 interested in. For those that are not in MSSP that are  
4 still in fee-for-service, what percentage could join an A-  
5 APM -- it's available, it's accessible, but the physician  
6 chooses not to -- versus it's just simply not available?

7 MR. GLASS: Right. I don't -- no, we don't have  
8 -- I don't think we have a way of particularly knowing. I  
9 mean, we can identify what states have them and don't have  
10 them, but I think you also might want to wait to see what  
11 happens in Track 1+ because I think there could be a lot of  
12 entry into that program.

13 DR. MILLER: Yeah. And the question is kind of a  
14 chicken-and-egg because remember the physicians can choose  
15 to form them. We might be able to say here is where the  
16 existing ones are, and there might be physicians located  
17 near these people. But whether that represents access or  
18 whether that's what you even want to happen as opposed to  
19 people forming new ones, it's a bit of --

20 DR. SAMITT: So there's always a de novo creation  
21 opportunity wherever you are.

22 DR. MILLER: And I think that's some of the

1 contemplation of what the legislation is about, is that  
2 physicians would come together and say, "I'm going to  
3 create one of these things," that type thing.

4 MS. BLONIARZ: I would just clarify that I think  
5 they're generally available for MSSP. I would not say that  
6 about the other ones, which are run as demos and only in  
7 certain states --

8 DR. MILLER: That's a good point, right.

9 MS. BLONIARZ: -- or subject to application  
10 processes.

11 MR. GLASS: So Track 1+ is interesting in that  
12 it's a demonstration, yet anyone can join who meets the  
13 conditions of participation, basically.

14 DR. SAMITT: Another way to look at it is  
15 physicians that may actually be in commercial ACOs but not  
16 in an MSSP. So, in many respects, they're in an A-APM  
17 through the commercial environment but perhaps not through  
18 Medicare.

19 DR. CROSSON: Bruce.

20 MR. PYENSON: Thank you very much.

21 I am wondering if you could summarize the top one  
22 or two differences between MIPS and the VVP. What do you

1 think are the biggest differences?

2 MS. BLONJARZ: So I think the two biggest  
3 differences are every clinician is measured on the same set  
4 of measures, and that the assessment of performance is at a  
5 voluntary group level, not the individual level.

6 MR. GLASS: And the other big difference is the  
7 burden. There is no reporting under the VVP as we have  
8 outlined it. There is a \$1.8 billion worth of reporting  
9 under MIPS.

10 MR. PYENSON: Thank you.

11 DR. CROSSON: Dana.

12 DR. SAFRAN: Could you remind us the parameters  
13 around earnings available to physicians under MIPS? So, as  
14 we understand it, starting 2019, with 2017 that we're in as  
15 the measurement period, some physicians will be able to  
16 earn. Some may lose. Just remind us of the scope at the  
17 physician level.

18 MS. BLONJARZ: So I'll make a distinction here  
19 between what's in the statute and how it's been implemented  
20 by CMS because they've used flexibility to set certain  
21 performance threshold.

22 So statute is 2019, up and down 4 percent. There

1 is also an additional MIPS exceptional performance bonus of  
2 \$500 million. When I looked at the numbers, I think that  
3 could add up to about 5 percentage points on top of that,  
4 and that's only on the plus side.

5 The way that CMS implemented the first share of  
6 the program, they kind of did a delayed implementation, pay  
7 for reporting year, and they did that by setting a very low  
8 threshold to basically not get a penalty.

9 And so what we think and based on what CMS says,  
10 they expect that about 10 percent of physicians,  
11 clinicians, most eligible clinicians will get a penalty  
12 because they don't report. Everyone else will get either a  
13 zero or minimal positive payment adjustment because there's  
14 so many more people kind of above the threshold, that clear  
15 the threshold.

16 So I think it will turn out that 10 percent get a  
17 minus 4 percent penalty, and then most other people, the  
18 basic MIPS adjustments are between zero and 1 percent.

19 DR. CROSSON: Kate, let me just ask you to  
20 expand. So that's in the short run, but if this -- if I  
21 understand, the statute, if that plays out, it's not  
22 altered by congressional action, then when is it? 2022?

1 MS. BLONIARZ: Yeah.

2 DR. CROSSON: You have a potential swing of nine  
3 positive and nine negative. So physicians could see an 18  
4 percent difference from one practice to the other based  
5 upon what they report and how CMS adjudicates that. Is  
6 that correct?

7 MS. BLONIARZ: That's right. Yeah. It changes -  
8 - kind of the expectation changes dramatically from the  
9 first two years where CMS is kind of phasing it in, the way  
10 they've done that, where we think the adjustments will be  
11 very compressed, to later years when we think they could be  
12 quite magnified. And there's actually a provision in the  
13 law that allows for increases, potential increases that are  
14 well above 9 percent because of the exceptional performance  
15 bonus and if there's more revenue on the penalty side than  
16 on the bonus side. Yeah.

17 DR. CROSSON: So the potential differential in  
18 the end game could be even greater than 18 percent is what  
19 you're saying?

20 MS. BLONIARZ: That's right.

21 MR. GLASS: Yeah. So kind of the two parameters  
22 that affect this are the threshold, that set, which is

1 what? Three points out of a hundred the first year, 15  
2 points out of a hundred the next year? And then, by law,  
3 that goes up to either the median or the mean.

4 MS. BLONIARZ: That's right.

5 MR. GLASS: And that's where you'll suddenly get  
6 lots of losers, so you'll be able to fund a bigger pool for  
7 the winners, and the problem is that once you set it at  
8 that higher threshold, it could be very compressed at the  
9 top in that if the mean is 80, 90. Everyone is going to be  
10 -- a lot of them are going to -- or half of them are going  
11 to be compressed up into between 90 and 100, and we don't  
12 think that the measure is being reported since everyone  
13 gets to report different measures. It will be very  
14 meaningful at distinctions between people between 90 and  
15 100, and a lot of money could get swung, essentially,  
16 randomly.

17 DR. SAFRAN: But just to be sure I understand,  
18 because that was really helpful, and it feels very  
19 important to this discussion, for the '17 and '18  
20 measurement periods, which pay out in '19 and 20, the  
21 estimated 10 percent of physicians getting the negative 4  
22 percent and the rest getting somewhere between zero and 1



1 percent is what's expected, those two measurement years  
2 paying out in those two payout years. Do I have you right?

3 MS. BLONJARZ: Yes. And the only caveat I will  
4 make is that that's the basic budget-neutral MIPS  
5 adjustment. There is also \$500 million available for  
6 exceptional performance. When you add that in, I think  
7 some people could get up to 4 or 5 percentage points, on  
8 the positive side. But the basic adjustments, 90, getting  
9 -- or 10 percent, negative 4, 90, zero and 1.

10 DR. MILLER: And we're just saying that that's  
11 roughly what we think the payout is or that's an estimate  
12 that CMS or someone --

13 MS. BLONJARZ: This is in CMS's proposed and  
14 final rules.

15 DR. MILLER: Okay.

16 DR. CROSSON: Other clarifying questions?

17 Paul.

18 DR. GINSBURG: Just to conclude this discussion,  
19 it sounds like there is potential under MIPS today to have  
20 very large rewards and penalties down the road which would  
21 both probably way beyond our confidence and the data that  
22 underlie them and could interfere with the A-APMs because

1 some groups could find that they're going to consistently  
2 do better under MIPS than they would do as an A-APM.

3 DR. CROSSON: Yes. And I agree with that, and  
4 I'd also point out the other side of it, which is that  
5 since -- and again, this is a projected analysis. Since  
6 the measures are different and the comparisons then become  
7 very difficult, it would be -- it could be -- turn out to  
8 be essentially impossible for a physician or a practice to  
9 make a judgment as to whether or not in any given year that  
10 physician's reported measure ends up resulting in a  
11 significant underpayment, from their perspective, or a  
12 significant overpayment.

13 DR. GINSBURG: Yeah, that's possible.

14 I actually worry more if it becomes predictable  
15 in a sense if a group says, "Well, you know, under MIPS, we  
16 can get a consistent 8 percent bonus, and with an A-APM,  
17 we're not so sure. And so why should we go to this new  
18 world when we're going to do just fine under MIPS?" So I  
19 think some of the predictability of MIPS is one of its  
20 shortcomings, particularly as it can undermine A-APMs.

21 DR. CROSSON: Okay. I think we're ready for the  
22 full discussion.

1 I think, Craig, you want to lead off.

2 DR. SAMITT: Sure.

3 I want to harken back to our September meeting.  
4 I think I made a comment that when we review the Medicare  
5 context chapter, it seems depressing every year in that  
6 we're not seeing the advancement that we had hoped in  
7 either improving quality of care or reducing cost of care,  
8 which I think is what we're all about. And what we've  
9 discussed in numerous meetings is we need to change  
10 incentives to shift more toward value and away from our  
11 dependency on fee-for-service fragmented reimbursement.

12 And so I want to start there because I want to  
13 remind us all what this is all about, which is moving  
14 forward, not standing still or not preserving the status  
15 quo.

16 And so for all those reasons, I am in favor of  
17 what's written in this recommendation. I worry that the  
18 existing framework with MIPS without any change allows us -  
19 - or even a delay of several years, of three to five years,  
20 just sustains the status quo and doesn't advance the value  
21 of care for beneficiaries that we're supposed to advocate  
22 for.

1           I also would weigh in -- I don't remember who  
2 said it on the other side of the table . In a prior life  
3 when we evaluated the various MSSP programs, we did exactly  
4 what was suggested. This wasn't about performance. It was  
5 about maximizing reimbursement and risk avoidance, and so  
6 which of the calculated scenarios would ultimately produce  
7 the best net return? I don't think that's what this should  
8 be about.

9           This should be about which of the models will  
10 most encourage us to improve the quality of care and total  
11 cost of care, and I believe what's written in this  
12 recommendation has several key elements that are going to  
13 move us forward.

14           With that being said, I do have a few  
15 recommendations. One is less on the MIPS side and more on  
16 the APM side. I'd like to see us accelerate the  
17 development of specialty APMs. I feel the concern that  
18 APMs may not be available on the specialty side really  
19 resonates with me, and I think that we need to assure that  
20 specialists have a home for A-APMs, and that if there's any  
21 encouragement, if we can include that in the chapter, that  
22 we must accelerate and advance that opportunity so that

1 those homes exist for specialists as much as they do for  
2 primary care.

3           The other recommendations that I would make, I do  
4 have concerns about the size of the voluntary groups. Ten  
5 seems too small to me, and while that may work for  
6 ambulatory care-sensitive metrics, I worry for measures  
7 like readmission rates that the population size would be  
8 too limited, and I would encourage us to think larger  
9 numbers and not smaller numbers. And I also worry that if  
10 we think about differential numbers, it starts to get very  
11 complex. So I think the minimum requirement should be a  
12 common number, and it should be higher.

13           In terms of the quality measures, I think we  
14 should consider local benchmarks, not national benchmarks,  
15 to reflect regional differences in the voluntary groups,  
16 and so if there's an alternative or an option in terms of  
17 local versus national, I would suggest local as a measure  
18 for these -- for at least the benchmarks for these metrics  
19 we pick.

20           And then the last is I would reconsider the  
21 multiple attribution option versus single attribution. I  
22 worry that multiple attribution undermines both the

1 measurement and the accountability and just creates  
2 confusion and doesn't drive the accountability that we  
3 seek. So I would be more in favor of single attribution,  
4 not multiple.

5 But all that being said, I am in favor of the  
6 recommendation. As I've said in the prior meeting, I also  
7 worry that 2 percent may not be sufficient to draw the  
8 attention to the importance of this transition and  
9 encourage organizations to shift to A-APMs, and I would be  
10 in favor of larger over smaller numbers in that withhold.

11 DR. CROSSON: Thank you, Craig.

12 So let's open this up to discussion. Can I see  
13 hands for people?

14 Let's start with Jack.

15 DR. HOADLEY: Thank you.

16 So I thought this was a really very clear update  
17 for us, and I really appreciate that. And I am also very  
18 encouraged with the direction that we're going. I'm  
19 supportive of this overall approach.

20 I think what I'd like to talk about for a moment  
21 is sort of fleshing out a little bit of the notions of what  
22 we mean by the potential kinds of things that could be

1 these voluntary groups, and it seems like in some of the  
2 feedback we've gotten, there is a sense that, well, groups  
3 won't be available to a lot of physicians. And I want to  
4 just sort of go through a few types of groupings and really  
5 just make sure that you agree that these are reasonable  
6 possibilities for what a group might look like and in one  
7 case sort of a notion of where it might go a step too far.

8           Obviously, you have already talked about the  
9 notion that there are the MSSP Track 1 ACOs that are  
10 already a clearly formed group. They don't qualify as an  
11 A-APM. So that one seems easy, and that actually, as you  
12 point out, has quite a few clinicians already engaged.

13           It seems like another possibility are various  
14 kinds of group practices, whether it be a single specialty  
15 group, whether it be a multispecialty group, whether it be  
16 a cluster of single specialty groups. So the local group  
17 of endocrinologists might team up with the rheumatologists  
18 and the gastroenterologists or whatever and make themselves  
19 a group.

20           It seems like the biggest issue there is risk  
21 adjustment and whether some of the measures -- if you're a  
22 group of oncologists and you've got a measure about the

1 total cost of care that isn't adequately risk adjusted,  
2 you're not going to fare well next to the primary care  
3 practice down in the other side of town. So it seems like,  
4 again, these are logical groups but points out the need --  
5 and it's achievable. We know risk adjustment isn't easy,  
6 but it can be done -- to get some kind of risk adjustment  
7 work or think about what measures so that they're not  
8 measures that will overly penalize a group that's formed  
9 that tends to be people who are sick.

10           It seems like another potential group is those  
11 affiliated in some loose or not-so-loose way with a  
12 hospital, so it might even be a bunch of doctors or other  
13 clinicians who have admitting privileges or who are  
14 otherwise involved in the work of a hospital, and  
15 obviously, in a small community, that might be many of the  
16 physicians in the area. In a large metro area, it might be  
17 a more selected group. But again, a group that has some  
18 affiliation, there's some overlapping sense of patients.

19           It seems like another potential one -- and this  
20 one isn't quite as obvious to me, but would be a regional  
21 medical society. Could they create a group or make their  
22 membership a group or an option to be a group?



1           And then sort of the last thing was what about  
2 things that go beyond a geographic area, and it seems like  
3 maybe that's where it doesn't make as much sense to say a  
4 set of practices that are in different parts of the country  
5 or a national specialty society, because then you suddenly  
6 don't have that sense of a common set of patients. And if  
7 this is about population measurement, it seems like that  
8 doesn't make sense.

9           So I don't know if you want to react to any of  
10 those sort of types of categories of groups or whether we  
11 want to think about -- and again, we don't have to -- we're  
12 not necessarily in the game here of spelling out all the  
13 rules, but whether we want to make a suggestion that there  
14 needs to be some sort of geographic constraint in what  
15 should be a group.

16           MR. GLASS: Well, I think so far, we're pretty  
17 agnostic about what group, and I think you could throw in  
18 IPAs as well.

19           But the geographic, there are ACOs that have  
20 noncontiguous groups in them, and I think the way they do  
21 it is they -- because they are going to start doing  
22 geographic-specific benchmarking sort of, I think they are

1 going to weigh it by the percent of patients in each, you  
2 know, proportion to the set of patients. So I think even  
3 that would be possible. I mean, it would get away from one  
4 feel of local benchmark, local that sort of thing, but in  
5 order to bring together enough, it would be possible. And  
6 I think in rural areas, maybe it would make sense.

7 DR. HOADLEY: It seems like those are kinds of  
8 points that we could make, talking about, you know, a  
9 variety of these kinds of illustrations, a group could look  
10 like this, could look like this. We're not necessarily  
11 drawing strict boundaries to say it has to look like one of  
12 these four, but those are four, and maybe by the time we're  
13 done we have eight kinds of examples of ways groups could  
14 be formed that make it less intimidating, the idea that  
15 you've got to go out and essential re-create something that  
16 looks like an ACO.

17 DR. CROSSON: Rita.

18 DR. REDBERG: Thanks for this really excellent  
19 chapter on a really tough topic, and just to reiterate, I  
20 agree with a lot of what Craig has said in terms of I think  
21 we're all in agreement that MIPS doesn't really get us to  
22 what our goals are to improve quality, improve care, and

1 improve value. You know, costing \$1 billion to put in  
2 MIPS, having something like one measure for one patient is  
3 clearly meaningless. I don't think anyone is going to go  
4 on record defending that and saying that's going to improve  
5 value of care.

6           Clearly, the details are difficult, and you have  
7 really, I think, moved us a long ways in this proposal.  
8 I'm thinking about, you know, what Craig suggested as  
9 changes, and I understand wanting larger groups, and maybe  
10 that's right. My only concern is, you know, I think life  
11 has gotten so much harder for individual practitioners, and  
12 we all, I think, don't want to make it more difficult if we  
13 can avoid it.

14           And I just wonder also, again, just on the local  
15 benchmarks, because in general we sort of like national and  
16 -- you know, we think variation usually reflects -- you  
17 know, perhaps we look at overuse and inappropriate care.  
18 So I have some concern, but I don't know what else you were  
19 thinking of with local benchmarks. But I really appreciate  
20 the work on this, and I think that it's really important to  
21 get towards the alternative payment models and have the VVP  
22 kind of help as a step to that.

1 DR. CROSSON: Further comments? Brian.

2 DR. DeBUSK: First of all, I'd like to  
3 congratulate the staff on a very well written chapter. I  
4 enjoyed the work that's being done here. It's nice to see  
5 that we haven't lost momentum for the -- or it doesn't  
6 appear that we've lost momentum for the repeal of MIPS. I  
7 just also want to compliment you on continuing to try to  
8 develop and refine that compelling alternative. Even if in  
9 December it still is somewhat conceptual, it would be nice  
10 to see increasing specificity over time.

11 But having said that, I also have a little bit of  
12 concern. I don't know that we want the VVP -- to try to  
13 make the VVP do too much, especially when you get into the  
14 specialties that are very, very episodic, sort of the  
15 classic example would be, say, a joint replacement. But to  
16 Craig's point, I could not agree more that I hope to see  
17 some specialist APMs developed in parallel, and I think  
18 that's going to take some of the pressure off to try to  
19 make the VVP be all things to all people, particularly  
20 specialties.

21 And with that said, one final point. As we  
22 encourage more of the episodic, specialist-friendly APMs --

1 and, again, I think we need a lot more of those. I'm  
2 excited to or would like to see how advanced BPCI works  
3 out, for example. I do think even those should be done  
4 with broader population health ideas and -- you know, I  
5 don't see them as competing ideas. I see them as  
6 complementary. And even then those models need to be  
7 subjugated to population health models. I don't think they  
8 need to be competitive. I think they need to be  
9 complementary.

10 But, again, I just applaud you, and it's exciting  
11 to see this work continue to evolve, and I hope we keep the  
12 momentum up.

13 DR. CROSSON: Pat.

14 MS. WANG: I think that the issue that a few  
15 people have commented on here is what about specialists,  
16 whether they're episodic, hospital-based, like they seem to  
17 be left out, and there's a struggle. I think there's a  
18 general embrace and appreciation for the concept of the VVP  
19 and the higher-level population health metrics.

20 I agree with the comments that were just made by  
21 Craig and by Brian around finding a home for specialists,  
22 but I would suggest that we try to think about doing that

1 in the context of something that is a little bit perhaps  
2 not full-bore APM but the VVP for specialists with their  
3 own metrics that are not the big gigantic, you know,  
4 readmissions. I mean, those are very broad population  
5 health metrics, and I think they're too big.

6 I think there's an opportunity, if there could be  
7 work done, to, you know, define the appropriate grouping of  
8 specialists so you don't have hundreds and hundreds. But  
9 those are actually the component parts of a successful A-  
10 APM and could actually inform better functioning for an A-  
11 APM. A lot of things have to go right to reduce  
12 readmission rates, for example, and it's not just how well  
13 a surgeon does in the OR. It has to do with all the care  
14 that happens, and it has to do with, you know, what happens  
15 at discharge. It has to do with follow-up. It has to do  
16 with resources in the community and medication  
17 reconciliation, the whole thing.

18 So, you know, I think it's too broad a metric, in  
19 fairness, for many specialty groups, and I would encourage  
20 us to maybe think about, in addition to building on this  
21 really good work and the concepts of VVPs, to try to  
22 develop concepts of specialty VVPs with their own simple,

1 uniform metrics that apply to all of the VVPs in the  
2 country that are that specialty as opposed to self-  
3 selected, et cetera, et cetera. And maybe the specialty  
4 societies have a role that could be constructive there in  
5 suggesting what those are.

6           As far as risk adjustment is concerned and the  
7 small number, I am very concerned about just conceptually  
8 it sounds good, you risk-adjust all, but for a group of ten  
9 and how many patients are we talking about there, I don't  
10 know what the validity is, and also just the amount of work  
11 that somebody would have to do to be calculating that. I  
12 don't know. I mean, to me it sounds very burdensome. And  
13 so whether it's, you know, larger numbers or a different  
14 way of getting at the importance of not penalizing people  
15 for taking sicker populations or populations with  
16 socioeconomic status challenges. I don't know what the  
17 answer is, but I do have a concern that it might not be  
18 practical to think that you could cut it that fine.

19           DR. CROSSON: Brian, on Pat's point?

20           DR. DeBUSK: I think Pat makes a great point, but  
21 it also moves us into a philosophical question, too, of do  
22 you have the VVP as just a core -- sort of, you know, as a

1 catch-all, almost like MIPS was originally intended? And  
2 at what point, if you do a VVP -- which, by the way, is a  
3 good idea; I am on board. But if you do a specialist VVP,  
4 at what point does it really become an APM? And should it  
5 be dealt with through the EAPE payments, not necessarily  
6 through MIPS? And I think that may be something that's  
7 worth our time to think of do you have core VVP and then a  
8 couple of specialist bolt-ons that, again, are specialist-  
9 friendly? Or do you try to punt those over into A-APMs and  
10 just let MACRA do the heavy lifting there around the QP  
11 bonuses and things like that? I hope that's clear, but  
12 it's a really interesting point that you brought up,  
13 because I could see us approaching it really from either  
14 side.

15 DR. MILLER: Can I just say something about that?  
16 Because I think it implicates a couple of philosophical  
17 issues, and I'm just going to say it a little bit different  
18 than you did.

19 You made your comment, the preceding one, before  
20 we bounced back to Pat, where you said if you created  
21 something for the specialist, you made it -- I can't  
22 remember the word -- subservient to the overall



1 organization. And I took that to me that you were -- and,  
2 you know, you're here so you'll comment. I took that to  
3 mean that you still wanted a population-based incentive  
4 even if you built something around the specialist. And so  
5 I want you guys to be tracking on that concept, because the  
6 other way to take comments that are being made down at --  
7 all over the table, but I'm just going to point at Craig at  
8 this moment, of saying I wish there were more homes for  
9 specialists, are you talking about homes in which it's just  
10 specialists or specialists with other physicians? And,  
11 again, you know, so when you're thinking about how to  
12 include the specialists, are you thinking ways to get the  
13 specialists in with other physicians? Or are you doing  
14 this separate thing? And if you're doing a separate thing,  
15 how does it relate to your overall population thought  
16 process? That's what I'm trying to track from a  
17 philosophical point of view.

18 DR. SAMITT: Yeah, I mean, from my perspective I  
19 thought it would be either of those two things. What I  
20 think is important is that there are options. If I'm a  
21 specialist and I want to become part of an A-APM, whether  
22 it's with --

1 DR. MILLER: I hate to interrupt you, but then I  
2 think you enter -- I'm really sorry. But then I think the  
3 other metrics or vectors I want you to have in your head is  
4 are you talking about the MIPS side of things or the APM  
5 side of things? And I think what Brian was saying is, wait  
6 a minute, maybe some of that all happens over there on APMs  
7 -- I think this is what you were saying -- and, you know,  
8 that's a fine conversation, no objection. We're still  
9 talking for this session about what do you what to happen  
10 on the MIPS side. Ultimately that's our landing point  
11 here.

12 DR. SAMITT: My comments were on the A-APM side.

13 DR. MILLER: Okay. I just want to make sure  
14 people are following, you know, each other's comments.  
15 That's all I'm --

16 DR. DeBUSK: And that's where, again, my mind-set  
17 is we know we need to get rid of MIPS; we know that we need  
18 a better -- an idea that's really more compelling. You  
19 know, we can't just say, well MIPS is bad, it needs to go  
20 away. We need a compelling idea.

21 I think the crossover point for us is when do you  
22 say, oh, wait a second, this new model, this specialist-

1 friendly model that doesn't have a pop health component to  
2 it is an A-APM? It isn't just an extension. It isn't a  
3 piece of VVP -- which, by the way, again, there is merit in  
4 that approach. Do you look at VVP and try to build it out  
5 over time to accommodate specialists? Or do you just say,  
6 oh, no -- let me go back, say, to interventional cardiology  
7 because I wear joints out, so I'm going to change horses  
8 here.

9           Let's say interventional cardiology,  
10 interventional radiology, don't we really want those  
11 specialists thinking episodes, individual patients? You  
12 know, their world really isn't a lot bigger than placing  
13 that stent, for example. The concern there and the  
14 elephant in the room is serial bundling. You know, what do  
15 you do when -- I know, this is plowed ground. And that's  
16 where I think that subservient concept, if you had some  
17 type of pop health model like an ACO, let's say you're part  
18 of -- this APM is running within a next-gen, could you go  
19 to those private practice interventional cardiologists and  
20 say here is your model, here is your world, but we're not  
21 going to just turn you loose to start triggering these  
22 episodes. You're part of a population health model that

1 requires the right referrals, the right steps.

2 DR. MILLER: But, again, in your comment, they're  
3 all about what's happening on the APM side.

4 DR. DeBUSK: Yes. I'm trying to offload a lot of  
5 that into APMS.

6 DR. MILLER: And that's what I want people to  
7 keep track of.

8 DR. DeBUSK: Because I'm afraid that we're going  
9 to pile too much on VVP. Having said that, Pat, I keep --  
10 Pat's comments have merit. I mean, if you really wanted a  
11 complete VVP solution, you would build out those --

12 DR. MILLER: And no dismissal of her comments,  
13 and I just want to -- your vocabulary VVP is synonymous  
14 with MIPS.

15 DR. DeBUSK: Yes.

16 DR. MILLER: Okay. Just so everybody follows  
17 that.

18 DR. DeBUSK: Yes.

19 DR. MILLER: And, two, I'm not dismissing Pat's  
20 comments. I want you guys in this conversation, when  
21 you're making your comments, to be clear whether you're  
22 talking about the MIPS idea or the APM idea, so that when

1 we walk away today we know where you're building.

2 DR. DeBUSK: And even if I lean toward APM for  
3 specialists, if it gets us rid of MIPS, I'm okay with  
4 either packaging.

5 DR. CROSSON: Paul.

6 DR. GINSBURG: I certainly support the  
7 elimination of MIPS, and I'm very supportive and intrigued  
8 by the VVP proposal. What I like about it is that I  
9 believe the future of better delivery of care in Medicare  
10 and throughout the system is to have physicians organized  
11 into entities, whether it's virtual or otherwise, and they  
12 both push in that same direction. So it means that the  
13 pressure to come up with more meaningful APMS, particularly  
14 for specialists, which I'm really glad Craig brought up,  
15 that's not diminished by all this messing around trying to  
16 take this unwieldy MIPS structure and trying to get it to  
17 work a little better than what is in law. I think a lot of  
18 the energy that can go into work along the lines of A-APMs  
19 would be very consistent with what would basically support  
20 the VVP approach.

21 One thing that David mentioned, very quickly, was  
22 the potential that IPAs could be a virtual group for VVP,

1 and thinking about IPAs in many areas of the country,  
2 certainly California, they're very valuable organizations,  
3 I think limited by being able to only function in  
4 commercial HMOs and Medicare Advantage. And to give them  
5 this additional scope to function in Medicare fee-for-  
6 service I think would be a positive all around.

7 DR. CROSSON: Dana.

8 DR. SAFRAN: Thank you. So I'll add my thanks  
9 for the great work and, in particular, for answering the  
10 many questions that we had last time so well.

11 I also favor the recommendations that are being  
12 considered here of moving away from MIPS and moving toward  
13 the VVP, though I do have some concerns about how we do  
14 that. So, you know, I think there's no question -- others  
15 have said it really well -- that we've got too many  
16 physicians left outside of the A-APMs to do nothing, which,  
17 you know, we were contemplating last time.

18 I agree that groups need to be local in order to  
19 actually have the reality of collaborating around better  
20 care, and agree -- and I'll say a little more about, you  
21 know, my own knowledge and work on sample size  
22 requirements. But I agree that ten is probably going to be

1 too small, particularly given the recommendation, which I  
2 agree with, of the three domains of measures, one of which  
3 being cost. We know that for cost measurement you need  
4 about 10,000 individuals to get a stable, reliable number.  
5 So I think that desire to measure total cost of care at the  
6 entity level, whatever that entity is, is going to be the  
7 rate limiter on size.

8           So I think we have a timing issue, and, you know,  
9 Kate, you were really helpful in laying out that in the  
10 current measurement period of 2017 and '18, I feel better  
11 knowing how limited the upside is, quite frankly. And so  
12 I'm wondering whether what we want to do is leverage the  
13 exceptional bonus as a way to help us bridge getting from  
14 the current MIPS set of measures to the VVP structure that  
15 we're proposing. And so let me explain what I'm  
16 envisioning to add on your ideas of the three domains for  
17 VVP, and then maybe that will make clear how that bridge  
18 could work.

19           So I totally agree with your suggestion about,  
20 you know, three domains -- population-based outcome  
21 measures, patient experience, and cost. So on population  
22 out measures, I had two thoughts to share. One is to make

1 the reporting burden as low as you're trying to in VVP. I  
2 wonder about starting to leverage CPT II codes, which are  
3 there and could help us -- my understanding is could help  
4 us measure some of the clinical outcome measures that  
5 specialty societies have endorsed, but that currently we  
6 can't measure because we don't have the data in claims  
7 because nobody's using CPT II. And we don't have access to  
8 the clinical data, so we're stuck.

9           So if we encourage over this, I will call it,  
10 two-year transition period that folks start using CPT II  
11 codes, and maybe that's part of what earns you an  
12 exceptional bonus, that might help create a bridge toward a  
13 new set of measures for specialists.

14           The other in the outcome space that I have talked  
15 about in this group before and that I really want to  
16 consider using this period of time to move us along is  
17 patient-reported outcome measurement. So starting -- and  
18 for specialists, for most specialties, particularly where  
19 there's an intervention, where before and after you can see  
20 a difference in how the patient feels or functions, we  
21 should be encouraging the adoption and use of longitudinal  
22 patient-level, patient-reported outcome measurement as a



1 way to know are we helping people. And so can we, as part  
2 of VVP, encourage the adoption of that? We wouldn't, let's  
3 be clear, be able to pay based on performance, based on the  
4 change scores. But we would be able to pay based on  
5 adoption, and we would through that -- and data sharing  
6 into CMS, through that begin to have a really significant  
7 amount of data to help us with shared decisionmaking for  
8 patients, because we'd begin to know for people like you  
9 with this starting point, if we intervene by treatment  
10 pathway A versus B, what can you expect in terms of  
11 functional improvement, pain relief, et cetera.

12           On the patient experience piece, that's in some  
13 ways the easier part because we know how feasible it is to  
14 measure that at the physician level with very small sample  
15 sizes, 45 patients per doctor have been demonstrated over  
16 and over again to be highly reliable, stable, pieces of  
17 information. So that wouldn't be hard to do. The question  
18 is: Who's implementing the survey? And, you know, in the  
19 ACO programs, at least, CMS did it in the early years. So  
20 I'd offer that as an idea. And total cost of care, you  
21 know, I think I've already shared my thoughts there.

22           So I just wonder whether we can use this two-year

1 period where things are already in motion on MIPS to start  
2 to bridge and to begin to use that exceptional bonus as a  
3 way to reward those who will engage with either CPT II  
4 codes or PROMs or both.

5 DR. CROSSON: Thank you, Dana.  
6 David.

7 DR. GRABOWSKI: Great. Thanks. Thanks, Kate and  
8 David, for a great chapter and presentation.

9 Like others, I am in favor of repealing MIPS, and  
10 I really like the way the VVP is shaping up.

11 I really appreciate how you went through a lot of  
12 our questions in your remarks, and I want to return to kind  
13 of the two big questions I asked.

14 On slide 9, I and others raised the issue. Given  
15 the VVP is voluntary, how do we get clinicians to  
16 participate, especially in those lower-resource areas?

17 And I think, first, I really like the call for  
18 technical assistance. I think that's going to be really  
19 important here.

20 I wanted to push you a little bit on this  
21 fallback, voluntary groups. I do like the concept, but I  
22 really worry about, in practice, how those will work.

1 There's a big literature suggesting when you have a payment  
2 incentive, you don't just need the payment incentive up  
3 top, but you need delivery-level change on the ground. And  
4 you really need to pair those two.

5 I can see how this voluntary group would have  
6 that same payment incentive as any other group, but you can  
7 imagine even -- I like Dana's point of making certain these  
8 are local. But two docs who are in a local area, who have  
9 no other tie, other than being in this voluntary group, are  
10 they going to participate in a readmission reduction  
11 program? Are they actually going to take actions on the  
12 ground to move the needle in terms of quality? I think we  
13 will want to be very careful about that. I think we will  
14 want to think about how do we pair them.

15 I like the idea of having a group for everyone,  
16 and I do like the idea of having kind of a default group,  
17 but thinking about what that actually means and how do we  
18 encourage providers that end up in that voluntary group to  
19 actually engage.

20 The second issue I raise -- and you really  
21 respond to this on slide 10 -- how do we set up a system  
22 that doesn't penalize those physicians in lower-resource

1 areas? I share other Commissioners' concerns. Ten is too  
2 small of a number for a group, I think. I think it really  
3 does have to be larger. We've already talked about the  
4 importance of risk adjustment.

5 I think this is the first time I had seen  
6 anything about the peer groupings. I really like that idea  
7 here. I think that could be really important, so I would  
8 just want to put forth my support for that idea.

9 Thanks.

10 DR. MILLER: And if I could just make a couple of  
11 quick comments.

12 I want the public to be sure to follow. We  
13 weren't saying 10 for every one of these measures. We were  
14 acknowledging that depending on which measure you were  
15 talking about, you would get a different size, but that for  
16 certain measures, it could be as small as 10, just so  
17 everybody out there writing news reports doesn't say that  
18 it's 10. We acknowledge that depending on the mix of  
19 measures and measure by measure, it might be somewhat  
20 different.

21 We also had a lot of internal conversations about  
22 the fallback group ourselves and lots of pros and cons,

1 like it says there, and that's just a summary.

2           One thing, Kate, am I remembering this, or did I  
3 black out? We were saying that if -- because we were  
4 getting mixed signals. Some Commissioners wanted them;  
5 some Commissioners didn't. You could create them, and then  
6 your reward wouldn't be as high. And I think Kate said  
7 something along -- or somebody, who shall be unnamed, whose  
8 named Kate --

9           [Laughter.]

10           DR. MILLER: Maybe you let them get their 2  
11 percent back, but you don't let them get more than that,  
12 that type of thing, because of the things that you're  
13 saying. So some ideas like that, we're kicking around in  
14 the kitchen.

15           DR. CROSSON: Okay. Bruce.

16           MR. PYENSON: Thank you very much for a terrific  
17 presentation and work.

18           I am in favor of repealing MIPS, and I am also in  
19 favor of developing the VVP. I really like the way this is  
20 presented and think it would be very helpful to contrast  
21 the micromanagement approach of MIPS to the population  
22 health approach that you're using, and that micromanagement

1 approaches are, of course, very good for the vendors, who  
2 would be getting the billion dollars, but are not good for  
3 the goal of reducing cost and the goal of improving  
4 quality.

5 I am, in particular, supportive of the potential  
6 that VVP has to be a model for the commercial world because  
7 when we talk about physicians in the health care system  
8 from the standpoint of Medicare, it's big, but it's not the  
9 whole story. And to the extent we can create models that  
10 are useful and adoptable by the private sector, by the  
11 commercial payers especially, I think we've helped make the  
12 system move in the right direction, and I think we have  
13 that in the structure of VVP. But to the extent we can  
14 make that a little bit more explicit on how some of these  
15 approaches could be used by commercial payers, I think that  
16 would add to the support of the proposal.

17 I'm particularly intrigued by integrating MSSP  
18 Model 1 into VVP, and I think there's potential, to some  
19 extent, to think about whether the ACO shares in that. The  
20 administrative capability of ACOs and hospital ACOs is  
21 significant compared to the administrative capability of  
22 most physicians and physician practices. So to the extent

1 there is a way to leverage the relationship there to move  
2 the population health agenda, I think that could be very  
3 helpful.

4 Finally, to add to Craig's list of additions --

5 DR. CROSSON: You might want to patent that name.

6 [Laughter.]

7 MR. PYENSON: This is the last thing.

8 If we could consider how participation in the  
9 Medicare Advantage could somehow be integrated into VVP, I  
10 think that would be potentially very helpful, very useful.

11 Thank you.

12 DR. CROSSON: Thank you, Bruce.

13 Kathy.

14 MS. BUTO: So I support repealing MIPS and moving  
15 toward a VVP-type model. I wanted to just re-raise the  
16 question of can we consider making the VVP side of the  
17 equation between VVP and the A-APMs not budget-neutral; in  
18 other words, taking -- let's say a 3 percent withhold and  
19 only 2 percent would be available back to the VVP side, 1  
20 percent would go over to help fund or stimulate more  
21 interest in the A-APM. I think because -- mainly because I  
22 think the VVP side of the equation is going to be huge, and

1 so it's just another way to create more incentives on the  
2 other side.

3 I think we have to ask the question or answer the  
4 question or try to answer the question whether we think all  
5 physicians who stay on the VVP side of the equation could  
6 eventually be in a VVP group without our fallback option.  
7 Do we think that's really necessary?

8 My own preference is that we don't have a  
9 fallback group, but I think we have to realistically face  
10 the question of whether we think it's going to be possible  
11 to create a group.

12 I think the specialty group issue that's been  
13 raised by Pat and by Craig and others is really important  
14 on both sides, and I'm particularly thinking about certain  
15 specialties, not so much surgeons or even interventional  
16 cardiologists, but really endocrinologists and other  
17 specialties focused on more chronic conditions and  
18 realizing that they -- we may need to treat them  
19 differently to encourage their forming either A-APMs or  
20 joining in the VVP approach in a more robust way. So I'm  
21 just not sure how to tackle that.

22 It feels like there would have to be some



1 population-based measures that are different for those  
2 kinds of physicians, and we ought to think about  
3 particularly managing chronic disease patients, whether we  
4 need to look at different kinds of population-based  
5 measures.

6 DR. CROSSON: Thank you, Kathy.

7 David.

8 DR. NERENZ: Thanks.

9 DR. CROSSON: Excuse me. Did you have a comment  
10 on Kathy?

11 MR. THOMAS: No. I wanted to make a comment.

12 DR. CROSSON: Oh, okay. Then David. Sorry.

13 DR. NERENZ: Thanks.

14 I will try to be brief here. I don't think it  
15 will surprise anybody that I have very serious concerns  
16 about the VVP part of this proposal, and I also want to  
17 make it very clear that they are such that if it comes to  
18 us as a recommendation in, more or less, its current form,  
19 I will not support it. So I'll just try to list the  
20 concerns.

21 At the top, I think we're talking about some  
22 pretty significant social engineering in the structured

1 medical practice, and I think we're doing it in the absence  
2 of what to me would be compelling evidence that this large  
3 group structure we're talking about is good. A lot of us  
4 believe it. I work in an organization that's been built on  
5 that model for a hundred years, but that's not the same as  
6 saying there's evidence.

7           And I have looked for it on many occasions. I  
8 haven't found it. So I would think that would be an  
9 important part of any fundamental foundation for something  
10 like this.

11           I also don't see any evidence that beneficiaries  
12 find value in the set of measures we're talking about,  
13 particularly at this level of analysis. We talk about  
14 measures that are meaningful to beneficiaries, but I know  
15 of no such evidence, and I'm happy to see it if it's out  
16 there.

17           I don't know that these measures have been shown  
18 to be able to differentiate meaningful levels of  
19 performance. Again, at the level of analysis we're talking  
20 about, maybe that's out there, but I'd like to see it if  
21 it's there. We may end up with compressed distributions on  
22 these scores, just the way we're talking about being

1 concerned about that in MIPS.

2           We use the word "voluntary," but I don't think  
3 it's very voluntary if there's a financial penalty for  
4 nonparticipation, and if the penalty gets bigger, it's less  
5 voluntary. So maybe if we really mean voluntary, we should  
6 take the 2 percent penalty completely away and let people  
7 do it if they want to, but don't penalize them if they  
8 don't.

9           We talk about all of ways groups conform. We  
10 talk about fallback groups, but there's no discussion of  
11 what it takes to make a group really function and to do the  
12 necessary work to improve these measures.

13           Now, Dana and David have both hinted on this, but  
14 I want to make it clear. Good performance doesn't just  
15 fall out of the sky. You have to do things, and just  
16 putting people together and saying they're a group doesn't  
17 accomplish that. So I think there's got to be a lot more  
18 attention to that.

19           And related to that is the cost of doing the  
20 work. I brought this up many times in our discussions of  
21 ACOs. There is a cost -- data, data analysts, care  
22 coordinators, care managers. Whatever is built in as a

1 reward has to acknowledge and potentially cover the cost of  
2 doing it, and I don't see any discussion of that.

3 I feel that there really, as currently  
4 configured, is no meaningful role for specialists in this.  
5 I'm not convinced by numbers; for example, the number of  
6 specialists in the current MSSP. I'd want to understand  
7 how many of them are meaningfully involved, not just  
8 listed, but how many of them actually in their day-to-day  
9 practice thinks about the population measures that underlie  
10 these programs? I don't think that program or this  
11 program, as proposed, engage a specialist in any meaningful  
12 way.

13 We talk about applying a uniform set of measures  
14 or the same measures to all physicians. It means we  
15 measure a primary care physician in the same way we measure  
16 a trauma surgeon. Really? Why? It doesn't make sense to  
17 me.

18 In my interactions, friends, neighbors, others,  
19 individuals, who want information about quality, they want  
20 quality at the much more micro level. Who is a good  
21 surgeon? Who is a good cardiologist? Who's good this?  
22 Who's good that? This approach will completely mask and

1 make it impossible, at least through Medicare, to get that  
2 information. Yelp will do it, but CMS won't.

3           This looks a lot like an ACO. We don't use that  
4 name, but that's kind of fundamentally what it's about. So  
5 maybe the thing is just make the MSSP program more  
6 attractive and easier to get into and let that be the  
7 pathway.

8           And two things on size. There's no mention that  
9 we talk about maximum size. I want -- looking at numbers,  
10 and it seems to me that if this actually went forward in  
11 this way, if all the physicians in Idaho made a group and  
12 all the physicians in Montana made a group, they do really  
13 well, and they'd get rewarded for essentially doing nothing  
14 beyond just practicing where they are, doing what they do.  
15 Now, maybe that's good. Maybe you say, well, we should  
16 reward them for their past excellent performance, but there  
17 will be groups that form simply to capitalize on where they  
18 are, who they serve. They won't do anything different.

19           And then minimize size, I wasn't going to say  
20 this, but we keep saying, well, 10 might do it for some  
21 measures. But I asked in our last meeting. We're not  
22 talking about forming a group for this measure and then

1 forming a different group for that measure. We're talking  
2 about forming a group for the whole package. It means you  
3 have to have a group big enough to be meaningful on the  
4 least sensitive measure in the package, not just the most  
5 sensitive measure. So 10 is never going to work.

6 DR. CROSSON: Thank you, David.

7 We have got Alice and Warner, and then I think we  
8 -- sorry?

9 DR. MILLER: Let me just get one other thing.  
10 You have gone through those before, and we tried to address  
11 some of them. But also, before you said -- but you do  
12 support repeal.

13 DR. NERENZ: Yeah, except that if -- I did say  
14 last time and I'll say it this time. I don't think this is  
15 a better alternative.

16 DR. MILLER: No. But you do -- I just want it on  
17 the record.

18 DR. NERENZ: I said it last time. I agree.

19 DR. MILLER: Yeah.

20 DR. CROSSON: Alice and Warner, and then I think  
21 we need to conclude the discussion. Alice.

22 DR. COOMBS: Yes. I'm not on Craig's list.

1 [Laughter.]

2 DR. CROSSON: How about Yelp?

3 DR. COOMBS: But I like Craig.

4 So I want to go on record as voting against  
5 repealing MIPS, and I think MIPS has a lot of problems.

6 But that being said, I think that right now where  
7 we are, there are some measures that are in MIPS, and you  
8 talk to the various -- my various colleagues that actually  
9 speak about not necessarily being completely ready to do  
10 all of this required with MIPS, but there are some things  
11 that are coming out of MIPS that are actually good. And if  
12 Medicare abandons that without something for adequate  
13 replacement, the VVP program, I am totally not in support  
14 of. I think it's a problem at this time, and so I'm giving  
15 you a temporal kind of "not support." And that's basically  
16 because I think the replacement for it is inadequate, and  
17 without some of the process measures that we do -- same-  
18 side infection, wrong-side surgery -- you're not going to  
19 die from it, but you sure are concerned about it.  
20 Beneficiaries should be concerned about that.

21 I'll give you an example of a patient who's taken  
22 care of by a primary care doctor, comes in, gets screened.

1 He actually has a colonoscopy and gets screened and has  
2 colon cancer, and he seems the gastroenterologist. He sees  
3 -- all of the next group of people that he sees and gets  
4 his definitive care are actually specialists.

5 So with this proposal, you might be in a  
6 community setting where you're not necessarily under lead  
7 institutions. All of the people that we talk about, past  
8 the primary care doctor now, may or may not be a part of  
9 this fallback voluntary group.

10 And I am concerned about the specialists. I  
11 voiced that the last time. The answer was not really  
12 appeasing right now for me, and I'll be honest with you.  
13 Because there's nothing to address that concern in terms of  
14 population measures, but there's so many other things I see  
15 as a practicing physician, day in and day out. They're not  
16 death. They're not readmission. But they sure as heck  
17 count, and those are the things that really kind of compel  
18 me to say we should be measuring some of the things.

19 Yes, MIPS has a lot of problems, but there are  
20 some good things with MIPS. Giving an antibiotic within an  
21 hour of incision, that cuts down on perioperative  
22 infection. There's so many of those kind of things that



1 are really important.

2           Now, I'm not going to argue statins. I'm not  
3 going to argue PSAs, but inside of my world, it makes a  
4 difference, and you can see a difference in terms of  
5 postoperative outcomes that are not necessarily readmission  
6 rate back to the hospital and not necessarily mortality.

7           So for me, what I see on a day-to-day basis,  
8 working in the hospital at night and during the day, it  
9 matters to us to move the pendulum, and it matters to the  
10 beneficiary if they know that this hospital has a low  
11 nosocomial infection rate. Guess what? They don't have  
12 much C. diff here because they use a good handwashing  
13 technique. All of those things are process measures, and  
14 so unless you do some of these measures, you wouldn't want  
15 to wait until the ninth hour to find out are our  
16 mortalities increased from toxic megacolons from C. diff  
17 because we had so many cases. You would want to intervene  
18 long before that. So in terms of making an intervention  
19 within the landscape of health care, I think that something  
20 is needed.

21           This VVP program, I am in total disagreement  
22 because you are eliminating somewhere between 60 and 65

1 percent of the providers. They're not going to be  
2 addressing population measures. Under an umbrella of an  
3 APM, yes, if that were to happen.

4           And so the other thing that I would tell you is  
5 that from colleagues who are like in the trenches, there's  
6 some doctors who may not be a part of an APM, and then if  
7 you were to put them in the fallback group, you get all the  
8 doctors with high-risk patients, and their risk profile  
9 looks different. Their performance looks different. You  
10 know, the patient's adherence to medication is in  
11 compliance. All of that looks very different.

12           I think you have to consider those things. Those  
13 are things that for a practicing physician -- and it  
14 doesn't mean you're in an academic setting. It could be  
15 that you're just a group practice trying to make things  
16 happen for your community.

17           So for me, I think those are some of the things  
18 that I'm concerned about, and then the whole notion of how  
19 you base performance and reliability and this cross-section  
20 of having multiple specialists being evaluated, and you  
21 throw, as mentioned already, an oncologists and a  
22 rheumatologist and an endocrinologist all together versus

1 what other kind of specialties might be in there, that's  
2 going to skew those population measures tremendously, and  
3 how do you compare group with group and apples with apples?

4           And so I am very concerned -- I don't want to  
5 belabor the point -- about the 60 percent or so of doctors  
6 that are not included in the whole thing, that may be left  
7 out.

8           And one last thing, and that is the LAN report  
9 actually showed that there was a 6 percent progression to  
10 APMs, just between 2015 and 2016. So maybe getting rid of  
11 MIPS may not be the thing that moves people towards APM  
12 because it's already happening while we're sitting here  
13 discussing it.

14           DR. CROSSON: Thank you, Alice, and thank you. I  
15 understand your concerns.

16           I just want to make one point sort of for the  
17 record, particularly as an infectious disease physician  
18 myself.

19           I don't want it to read our proposal as MedPAC  
20 retreating from the importance of measuring things like  
21 surgical infection outcomes and the like. I think the  
22 thrust of what we're saying, though, is that doing that at

1 the individual doctor level for the purpose of Medicare  
2 payment is probably not the appropriate direction to go in  
3 -- and for a lot of reasons, including simply the problem  
4 of small numbers.

5 But in terms of other entities -- and I'm talking  
6 about hospitals, I'm talking about ACOs, I'm talking about  
7 entities who are accountable for the health of their  
8 population -- aggressively pursuing those measures and  
9 particularly processes improvement, we're all for it.

10 DR. COOMBS: And the other piece I was saying is  
11 that even at -- even measuring that at the individual level  
12 influences the masses, so that I think you might have the  
13 specialists come forward with protocols that will actually  
14 change the paradigm for larger landscapes, and that's --  
15 and I've seen that happen.

16 DR. CROSSON: Thanks. Warner, last comment.

17 MR. THOMAS: I'll be brief. I actually agree  
18 with -- number one, I agree with, essentially, eliminating  
19 MIPS and I agree with Kathy's comment of not necessarily  
20 having us be budget neutral but taking a withhold that is  
21 slightly larger than the dollars that are being reinvested  
22 and reinvest more dollars into APM to get folks to continue

1 to transition more into advanced APMs.

2 I hear David's point around individual measures  
3 versus group measures, but I just think that getting groups  
4 working in a more collaborative way around the entire  
5 patient's need and moving from a reactive to a proactive  
6 model, which I believe the APMs do, is a much better  
7 direction. I think essentially the fallback voluntary  
8 group, I don't agree with that. I think the idea that  
9 David actually brought up, around having people go into  
10 MSSP and having people organizing within MSSP is the  
11 fallback group, and those options are there today.

12 I frankly think we have people that are not  
13 organizing because they don't want to, not that they don't  
14 have the opportunity to and that they just don't want to,  
15 and they want to go it alone and go on their own. And I  
16 think changing this methodology will certainly create the  
17 right incentive for people to organize and to move in the  
18 direction of being proactive and working together as a  
19 group and not reactive and working individually.

20 I hear Alice's point around MIPS, but, you know,  
21 there's such ability, I think, to gain MIPS and to, you  
22 know, this idea of one patient, one measure. We need

1 people thinking bigger and we need our physicians, you  
2 know, being creative and working towards a proactive model.  
3 So I would like to see us do it in a non-budget-neutral  
4 fashion, use MSSP has a backdrop, and really try to get  
5 people to move further down the road of advanced APMs and  
6 in that direction.

7 I know that people would say that there are still  
8 mixed results there, but I think the incentives are in the  
9 right direction and the creativity will be there to be --  
10 to generate, I think, better results down the road.

11 DR. CROSSON: Okay, thank you. Jack.

12 DR. HOADLEY: I just want to make a process  
13 point. I mean, it seems like we've had two very  
14 interesting perspectives that by the chance of the draw  
15 ended up at the end of the discussion, and so I hope maybe  
16 when we queue this up next month we make sure we've built  
17 in some chance to really engage these issues that Alice and  
18 David have raised, so that we can fully sort them through  
19 before we are at the point of making a decision.

20 DR. CROSSON: Well, a point well taken. So I  
21 just want to take the opportunity to thank Kate and David  
22 for the presentation, and the content of that, in

1 addressing, very ably, questions that have been brought up  
2 in the October discussion. It was very helpful. A number  
3 of Commissioners commented on that.

4           So as we have mentioned before, we will proceed  
5 and present a draft recommendation for consideration by the  
6 Commission at the December meeting, re-presenting it again,  
7 as we customarily do, in January. It will take into  
8 consideration the points that have been made here today as  
9 well.

10           Thank you very much and we will proceed with the  
11 next item.

12           [Pause.]

13           DR. CROSSON: Okay. We can proceed with the next  
14 discussion, presentation and discussion. So here we are  
15 talking about issues with respect to freestanding emergency  
16 departments, and there are really two pieces to it. I  
17 won't give your presentation for you but we've got Jeff,  
18 Sydney, and Zach, and I guess Brian in the bullpen. And  
19 who is going to start out? Sydney?

20           MS. McCLENDON: Good morning. Today we revisit  
21 our discussion on ways to improve efficiency and preserve  
22 access to emergency care in both small rural communities

1 and urban areas. Before we begin, I would like to thank  
2 Brian O'Donnell for his work on this project.

3 For this presentation we will be focusing on a  
4 growing phenomenon, stand-alone emergency departments. We  
5 have discussed stand-alone EDs on multiple occasions over  
6 the course of the last few cycles, including in our June  
7 2016 and 2017 Reports to the Congress. While those reports  
8 discussed stand-alone EDs in separate contexts, such as in  
9 urban and rural environments, today we would like to bring  
10 together those discussions and also consider how stand-  
11 alone EDs interact with our site-neutral principles.

12 To begin, I'll review the current ED payment  
13 system, and then provide some background information  
14 regarding stand-alone EDs. From there, we will review the  
15 growth we've seen in stand-alone EDs in urban markets, and  
16 then discuss some concerns regarding site neutrality and  
17 urban stand-alone ED payments. We'll then consider rural  
18 emergency department payment concerns, and finish with  
19 potential policy options for each of these issues.

20 Currently, ED visits that do not result in an  
21 inpatient admission generate two claims: one for physician  
22 services and one for the facility. Physicians' claims are



1 paid through the physician fee schedule, and facility  
2 claims are paid through the outpatient prospective payment  
3 system, or OPPS.

4 On the slide is an example of the physician fee  
5 schedule and OPPS payment amounts for a patient that  
6 presents with a similar, mid-level non-life threatening  
7 medical condition at different facilities.

8 Type A hospital EDs, displayed on the far left,  
9 are EDs that are open 24 hours a day, 7 days a week and  
10 they receive the highest total payment of \$264. This  
11 number includes both the physician and the facility  
12 payment. Type A hospital EDs can be both on and off of the  
13 main hospital campus, and they generally account for about  
14 99% of all Medicare emergency department claims.

15 The less common Type B hospital ED, which is an  
16 ED that is open less than 24/7, would receive a total  
17 payment of \$188, as seen by the middle bar in the chart.  
18 We will be discussing Type B rates later in the  
19 presentation, but it is worth noting now that the Type B ED  
20 rate is typically lower due to lower standby capacity  
21 needed for fewer hours.

22 Finally, on the far right, we have included the

1 payment amount for a similar visit at an urgent care center  
2 or physician office, which would be \$109. We included the  
3 urgent care center payment amount for additional  
4 comparison, as urgent care centers' patient mix often  
5 overlaps with lower severity patients seen in EDs.

6 I will now provide some background information on  
7 stand-alone EDs. As a quick review from our previous  
8 discussions, not all emergency departments are located on  
9 the main hospital campus. These facilities, which I have  
10 been referring to as stand-alone EDs, come in two forms:  
11 hospital-owned off-campus EDs, or OCEDs, and independent  
12 freestanding emergency centers, which are independent  
13 facilities and not affiliated with a hospital.

14 As of 2017, we have identified 580 EDs operating  
15 apart from a hospital campus, and about two-thirds of these  
16 facilities are affiliated with a hospital and therefore  
17 considered off-campus EDs.

18 Currently, only OCEDs, if deemed off-campus  
19 provider-based departments, are allowed to bill Medicare.  
20 The facilities receive the same payment rates as on-campus  
21 EDs, and many independent freestanding centers are now  
22 converting to off-campus EDs in order to receive payment

1 from Medicare. Stand-alone EDs are still a fairly new  
2 phenomenon, and last year we raised concern that these  
3 facilities, especially the independent centers working to  
4 gain payment from Medicare, might be creating excess  
5 emergency capacity and unnecessarily increasing program  
6 spending.

7 On this slide, we've included an example of how  
8 Medicare pays different facilities based on their  
9 geography.

10 There are three types of facilities presented on  
11 the slide: on-campus hospital EDs, represented by the  
12 middle, purple circle, off-campus hospital EDs, represented  
13 by a white circle, and urgent care centers, represented by  
14 the dashed, yellow circles. Each facility's Medicare  
15 payment amount for either a level 3 ED visit or level 3  
16 office visit is included within the respective circle.

17 The slide also includes a 35-mile radius  
18 surrounding the main hospital campus, which is indicated by  
19 the large, red dashed circle on the slide.

20 As you can see, the yellow urgent care centers  
21 are paid the same amount, regardless of whether they are  
22 inside or outside of the 35-mile range of the hospital.

1 Off-campus EDs, however, are paid different amounts based  
2 on their proximity to the main hospital campus. Off-campus  
3 EDs within the 35-mile radius of the main hospital campus  
4 are paid the full on-campus hospital ED amount, \$264, while  
5 an off-campus ED more than 35 miles from the main hospital  
6 campus cannot currently receive payment as an ED, and would  
7 instead have to bill as an urgent care center.

8           The number of stand-alone EDs in several urban  
9 markets has grown rapidly in the past few years, and  
10 multiple studies, in addition to our own analyses, indicate  
11 that these facilities tend to locate in higher-income  
12 areas. The growth of these facilities in Texas is well-  
13 documented, but in the last few years the literature shows  
14 increases in the number of OCEDs in places like Florida,  
15 North Carolina, and Ohio.

16           Studies examining the stand-alone ED phenomenon  
17 in states like Texas, Maryland, and Colorado show that they  
18 also tend to see lower-severity patients than on-campus  
19 EDs. Although the data is somewhat limited, we believe the  
20 severity of patients treated at stand-alone EDs falls  
21 somewhere between on-campus hospital EDs and urgent care  
22 centers.

1           We also believe these facilities have lower  
2 standby costs than on-campus hospital EDs, due to not  
3 having to maintain an operating room or full trauma  
4 capabilities. Some stand-alone EDs assert that they can  
5 treat stroke and cardiac cases, but most stand-alone EDs do  
6 not have operating rooms, trauma teams, or specialists on  
7 call. In addition, representatives of the ambulance  
8 industry and researchers in Maryland have found that when  
9 patients require trauma services, ambulance drivers often  
10 bypass stand-alone EDs in favor of the on-campus hospital  
11 ED.

12           Despite seeing less severe patients and having  
13 lower standby costs, hospital-affiliated OCEDs that are  
14 located within 35 miles of the main hospital campus receive  
15 equal Medicare payment to on-campus EDs, making them a  
16 profitable expansion option for hospitals.

17           Related to the topic of stand-alone EDs is an  
18 additional concern that we have regarding site neutrality  
19 under Section 603 of the Bipartisan Budget Act of 2015.

20           Section 603, which established site neutral  
21 payment rates for some facilities, prevents off-campus  
22 hospital departments from receiving higher OPPS payment

1 rates and instead pays them the lower physician fee  
2 schedule rates.

3           Emergency departments were exempted from these  
4 site-neutral payment changes, however, which means that  
5 hospital-affiliated EDs -- including off-campus EDs -- can  
6 receive higher hospital OPPS rates for both emergency and  
7 non-emergency services, which could include services like  
8 imaging and scheduled physician office visits that are not  
9 related to emergency care. While we understand the logic  
10 of providing emergency services this exemption, the logic  
11 seems to make less sense for non-emergency services.

12           The concern here is that this non-emergency  
13 exemption creates an incentive to build OCEDs and then co-  
14 locate physician offices, because in doing so the physician  
15 office receives higher hospital OPPS payment rates than if  
16 they were a separate off-campus physician office. We will  
17 next discuss a potential policy option to address this  
18 issue.

19           As I just mentioned, current law exempts  
20 emergency departments from Section 603's site neutrality  
21 and allows OCEDs to bill facility fees for scheduled visits  
22 to co-located physician offices.

1           An alternative policy could be to pay the co-  
2 located physician office the same rate that they would get  
3 if they were in a free-standing physician office.

4           The net effect of this new site neutral policy  
5 would be lower rates for physician practices co-located  
6 with OCEDs, lower cost-sharing for beneficiaries, and less  
7 incentive to build an off-campus ED in areas where an  
8 urgent care center would sufficiently serve community  
9 needs.

10           I will now turn it over to Jeff to discuss a new  
11 policy option for urban stand-alone EDs.

12           MR. STENSLAND: All right. Now we will shift  
13 gears to talking about setting off-campus ED rates in  
14 Medicare.

15           As Sydney explained, resource needs of off-campus  
16 ED patients appear to be between those of an urgent care  
17 center and the on-campus ED. And as we explained in your  
18 mailing materials, off-campus EDs tend to get fewer  
19 patients arriving via ambulance and tend to get more walk-  
20 ins. In our interviews with hospitals, ED operators, and  
21 ambulance companies we heard that off-campus EDs near an  
22 on-campus ED will often be bypassed by patients with more

1 complex needs.

2           So how would we set payments to better reflect  
3 the resource needs? We could set up a whole new rate for  
4 off-campus EDs. However, that may be unnecessary.  
5 Medicare already has Type B rates for EDs that are not open  
6 a full 24 hours and thus have lower stand-by costs. We  
7 could pay off-campus EDs this lower Type B rate. For  
8 example, The lower Type B rates could apply to all off-  
9 campus EDs that are within 25 miles of an on-campus ED, the  
10 rationale being that the most difficult cases will often  
11 end up bypassing the off-campus ED for that on-campus ED  
12 that is nearby.

13           If the Type B rates were adopted, it would  
14 modestly lower rates for off campus EDs. The rate would  
15 drop from \$264 to \$188 for a level 3 ED visit. Payments  
16 would more closely align with patient resource needs.  
17 Second, the lower payment rate would mean lower cost-  
18 sharing for beneficiaries.

19           The key change is it would reduce the difference  
20 between payment rates to urgent care centers and off-campus  
21 EDs. This would reduce the incentive to build an ER when  
22 the communities' needs could be met adequately with an



1 urgent care center.

2           Now we will shift to discussing rural issues.

3 You may recall that we discussed rural ED issues over past  
4 years and published a chapter on preserving access to rural  
5 ED services in our June 2016 report.

6           The key concern we discussed in that chapter was  
7 preserving access to emergency care in areas with low  
8 population density.     Historically, the Medicare payment  
9 system has supported small rural hospitals by paying higher  
10 inpatient rates.   When the sole community hospital program  
11 was started in 1983, inpatient services dominated hospital  
12 finances and this model of inpatient subsidies may have  
13 made sense at that time.   However, 35 years later, rural  
14 hospitals are now much less inpatient focused, and trying  
15 to indirectly support emergency services by paying higher  
16 inpatient rates has become problematic.

17           There are now two key problems with inpatient-  
18 centric rural payment policies.   First, using inpatient  
19 subsidies to assure emergency department access is  
20 increasingly inefficient.   The volume of inpatient services  
21 declined markedly at many small rural hospitals.   Given the  
22 fixed costs of running an inpatient department, as volumes

1 decline the cost per discharge goes up. The result is an  
2 inefficient provision of inpatient care. Second, higher  
3 inpatient rates have not always resulted in financially  
4 viable hospitals, and let's look at the data to illustrate  
5 these problems.

6 The decline in inpatient volume is illustrated in  
7 this graphic. The top yellow line shows that the median  
8 CAH saw its volume of admissions fall from 624 per year in  
9 2003, to 365 in 2016. This is more than a 40 percent  
10 decline.

11 The lower red line shows admissions for the CAH  
12 at the 10th percentile of inpatient volume. This tells us  
13 that in 2003, 10 percent of CAHs had fewer than 170  
14 admissions. By 2015, 10 percent of CAHs had 81 or fewer  
15 admissions per year. This is more than a 50 percent  
16 decline.

17 Having 80 admissions a year, or less than 2 per  
18 week, creates a cost per inpatient day problem. It can  
19 also create quality concerns if clinicians in these  
20 hospitals do not have the advantage of gaining experience  
21 with a large number of inpatient cases.

22 You may ask why the community just doesn't close

1 the inpatient units. The problem is if they closed this  
2 low-volume inpatient units they could no longer bill as an  
3 emergency department under the current payment policy.  
4 They would also lose some particularly high rates they  
5 receive for providing post-acute care in hospital beds.

6           The second problem is that the current programs  
7 do not always preserve access. Twenty-one Critical Access  
8 Hospitals closed between 2013 and 2017. Some of these  
9 hospitals closed due to excess capacity, and in these  
10 cases, volume could be consolidated at neighboring  
11 hospitals. But two of the closures were more than 35 miles  
12 from the nearest hospital, creating access concerns.

13           Among the CAHs that closed in 2014, the average  
14 CAH received cost-based payments in the year prior to  
15 closure that were about \$500,000 above PPS rates. But the  
16 supplemental payments provided little in the way of  
17 subsidies to cover uncompensated care in the emergency  
18 room. The high Medicare payments received for post-acute  
19 care at these hospitals, in large part, were spent covering  
20 the high inpatient costs per day at these low volume  
21 hospitals.

22           So this raises the question: If a hospital closed

1 its expensive inpatient units, would there be a way for  
2 existing rural hospitals to convert to financially viable  
3 outpatient-only facilities? And rural health researchers  
4 and hospital associations have shown interest in this type  
5 of outpatient-only model. However, what is missing at this  
6 point is a new payment model to match the new  
7 organizational structure.

8           Next we will outline a Medicare payment model to  
9 support outpatient-only hospitals.

10           The idea is to set up a 24/7 outpatient-only  
11 facility with an emergency department. The policy change  
12 is focused on isolated providers, and the reason is that  
13 under current policy, hospitals that close and are more  
14 than 35 miles from another hospital do not have the option  
15 of becoming an off-campus free-standing ED. Recall from  
16 Sydney's graphic that the picture showed that EDs located  
17 more than 35 miles from the main campus cannot receive ED  
18 rates from Medicare. They would have to bill like an  
19 urgent care center. This new payment policy could be  
20 targeted at these isolated hospitals that currently lack  
21 another option.

22           To help fund the new program, Medicare would do

1 the following. First, outpatient-only hospital would get  
2 full Type A PPS rates for ED services. Second, there could  
3 be an annual fixed payment amount to help cover the  
4 facility's fixed costs. To receive the fixed payment and  
5 assure that the community is buying into the new model, the  
6 local government or hospital district could be required to  
7 contribute some type of matching grant to the new  
8 outpatient-only hospital.

9           The goals of an outpatient-only model could be as  
10 follows. First, the model should preserve access to  
11 emergency services. Second, the cost of the program could  
12 be offset with savings from efficiency gains. The  
13 efficiency gains I've talked about come from closing low-  
14 volume inpatient operations. As low-volume inpatient units  
15 are closed, acute inpatients would be shifted to other low-  
16 volume hospitals in the area. This may help neighboring  
17 hospitals that are also struggling.

18           The main savings will come from shifting patients  
19 receiving post-acute care in critical access hospitals.  
20 Currently, CAHs receive an average payment rate that is  
21 about \$1,400 per day more than the rates received by  
22 skilled nursing facilities for the same care. By closing

1 the expensive post-acute care provided at CAHs inpatient  
2 beds and shifting those patients to SNFs, significant funds  
3 could be freed up that could be used to subsidize emergency  
4 care in these communities. Now the idea is not to reduce  
5 overall spending but to redirect dollars away from  
6 inpatient subsidies and toward funding emergency services  
7 that are needed in isolated communities.

8           For providers there would be three key effects.  
9 The first thing to remember is that this is an optional  
10 program, so if they want to continue as a critical access  
11 hospital they can do just that. Second, this could serve  
12 as a way to preserve the rural ED when inpatient volumes  
13 are so low that a traditional inpatient focused hospital is  
14 no longer practical.

15           Third, hospitals often play a key role in the  
16 recruitment of physicians to small communities. If a  
17 hospital converted to an outpatient-only facility, some  
18 rural hospital boards may be concerned about who would  
19 recruit the physicians. Under this model, the outpatient  
20 facility would still be there to recruit physicians into  
21 the community, and that work may be seen as a more  
22 desirable, given the financial stability provided by the

1 annual funds to the hospital and the more limited duties  
2 the physician would have.

3           There would be three potential effects on  
4 beneficiaries. First, it would preserve access to  
5 emergency services. Second, patients would need to travel  
6 for inpatient care, but many are already bypassing their  
7 rural hospitals for inpatient care. Recall, that we have  
8 130 CAHs have fewer than two admissions per week. Finally,  
9 as we showed in your mailing materials, coinsurance will be  
10 substantially lower than at critical access hospitals.  
11 Shifting from CAH level coinsurance to PPS level  
12 coinsurance would often reduce the coinsurance owed by a  
13 rural Medicare beneficiary by over 50 percent.

14           So this brings us to the discussion topics.

15           First, the issue is the technical fix to the  
16 site-neutral policy outlined in Section 603 of the Balanced  
17 Budget Act of 2015. The fix would set payments rates for  
18 scheduled physician office visits at clinics that are co-  
19 located with EDs to an amount that is equal to independent  
20 physician offices.

21           Second is moving toward paying Type B rates to  
22 urban off-campus EDs within 20 minutes of an on-campus ED.

1           The third policy option is to retarget existing  
2 rural subsidies that are currently used to prop up  
3 hospitals' inpatient services. Those subsidies could be  
4 redirected to support emergency services at stand-alone  
5 rural EDs.

6           Depending on the outcome of your discussion,  
7 these three policy options may be refined further and  
8 presented as draft recommendations at a future meeting in  
9 the spring of 2018.

10           Now I will turn it over to Jay, or Jon.

11           DR. CHRISTIANSON: In this case it would be Jon.  
12 So questions? Clarifications? Round 1.

13           DR. SAMITT: So a quick one. In terms of the  
14 second topic, the rural stand-alone EDs, would this only  
15 pertain to critical access hospital conversions and this  
16 would not be available for organizations that want to  
17 create a new freestanding ED in a rural environment?

18           DR. STENSLAND: The way it's structured, the way  
19 we talked about it, it would just be available to critical  
20 access hospitals or isolated PPS hospitals that want to  
21 convert into a freestanding ED or maybe a location that  
22 recently closed. So you wouldn't be creating new



1 operations.

2 DR. COOMBS: So what wasn't clear is that if a  
3 for-profit wanted to move in the area and set up a  
4 hospital, is there a grandfather, a cutoff for when this  
5 program would be implemented? In other words, new  
6 hospitals to the scene, would they be able to do the same  
7 thing going forward?

8 And, secondly, how much of the post-acute care in  
9 the rural setting, just thinking about what has happened in  
10 the past, so it's a 10 percent closure, you say, per year?  
11 Or is it 5 percent closure for rural hospitals? That graph  
12 looked like it was...

13 DR. STENSLAND: Well, the graphic was the volume  
14 of the --

15 DR. COOMBS: Oh, admission.

16 DR. STENSLAND: Admission.

17 DR. COOMBS: So how much would be generated by --  
18 what percentage of revenue would change based on the number  
19 of closures with post-acute care?

20 DR. STENSLAND: For every closure -- I wouldn't  
21 call them a "closure," but every conversion of a hospital  
22 to an outpatient-only facility, on average they would cease

1 getting paid their current cost-based rates for their post-  
2 acute care because those current rates are very high, often  
3 about \$2,000 a day. And eliminating that and paying PPS  
4 rates to a SNF for those same patients would save about  
5 \$500,000 per closure. So that's where all the savings come  
6 from, and you just take that amount and give it to the ED.

7 DR. COOMBS: And so we could project from past --  
8 the curve of closures in the past what roughly the number  
9 of hospitals closing going forward? How many of these  
10 small critical access hospitals can we project that this is  
11 going to impact?

12 DR. STENSLAND: Well, I think that is hard to  
13 project because that's really a community decision. But I  
14 think we had, what, 130 of these small isolated places that  
15 have fewer than two admissions per week. So they could all  
16 be potential candidates for doing this. You know, they  
17 have the option of doing it. Whether they would actually  
18 do that or not would probably depend in part on, you know,  
19 local community perceptions of their hospital and also  
20 partially probably from a practical standpoint on what the  
21 physicians in the community wanted.

22 DR. CHRISTIANSON: David, did you have any

1 clarifying questions? Okay. Kathy.

2 MS. BUTO: So I'm wondering whether we've gotten  
3 any indication of interest on the part of some of these  
4 small, rural, isolated hospitals in this option. In other  
5 words, it sounds good, but I'm wondering if any of them  
6 would take -- it would be voluntary. Would they take it up  
7 or would they only take it up if they were really truly not  
8 getting enough revenue from post-acute care and other  
9 sources? In a sense, would it be -- is it really the most  
10 efficient approach? And does it appeal?

11 DR. STENSLAND: We did go out and do some site  
12 visits, and we do see some places -- usually, it's when the  
13 hospital is in financial trouble, so it's basically, you  
14 know, we're losing our patients, we don't have customers,  
15 now we don't have money, now we need to do something else.  
16 And in some of those cases, we've seen some of those  
17 convert to off-campus emergency departments of a  
18 neighboring hospital, like they'll approach their  
19 neighboring hospital 15 miles away and say, you know, "Can  
20 we become your outpatient department and be part of you so  
21 we can still have an emergency room? Because, otherwise,  
22 we're just going to have nothing."

1           In some cases, people that we've talked to said  
2 they've also been contacted by places that are more than 35  
3 miles away, and they said, "Would you do this?" And they  
4 said, "From a practical standpoint, it doesn't work because  
5 then we're not getting any emergency department facility  
6 fees for having this emergency department that is way out  
7 there." And the secondary effect was and these places that  
8 are really far away from us, they're actually less likely  
9 to be bypassed by the difficult cases because they need to  
10 give them somewhere than the place that's, you know, 10  
11 miles away from the main hospital.

12           DR. MILLER: The only thing I would also add to  
13 that, Jeff, just to make sure I get this right, there was  
14 some discussion about this in the rural community like the  
15 Kansas Hospital --

16           DR. STENSLAND: Sure, there's discussion of this.  
17 If the Kansas Hospital Association, the Washington Hospital  
18 Association, Kansas has gone through and done some  
19 financial modeling of saying who could become outpatient-  
20 only facilities. So the model of being an outpatient  
21 facility is very in the forefront of a lot of the hospital  
22 associations' mind and certainly the systems seeing some of

1 this. I think the step that's missing is, well, we don't  
2 have a payment model yet to match the organizational model.

3 DR. MILLER: And one other thing I really don't  
4 like to do with Sue not being here, but I also thought Sue  
5 was saying, "I really want us to pay attention and talk  
6 about this model." I don't want to express her opinion,  
7 but she has encouraged us to bring this forward.

8 DR. CHRISTIANSON: Yeah, go ahead.

9 MS. BRICKER: This is an interesting chapter, so  
10 thanks for that. What's going on in Texas?

11 [Laughter.]

12 MR. GAUMER: There's a lot. Actually --

13 MS. BRICKER: With respect to this issue.

14 MR. GAUMER: -- the Astros just won the  
15 championship last night.

16 [Laughter.]

17 DR. MILLER: [off microphone] really good.

18 MR. GAUMER: Was that good? All right.

19 So there's been a huge surge in stand-alone EDs,  
20 and what's happening there is in 2010 the state decided to  
21 start registering or licensing these facilities for  
22 payment. And so there was a bit of a boom, an

1 entrepreneurial boom, and we've got I think something like  
2 190 or 200 of these independent freestandings out there.  
3 And as a reaction, the hospitals have opened their own off  
4 campus, the OCEDs, so you've got even more of those popping  
5 up. And I would say that it seems to be that it's reached  
6 a saturation point in markets like Houston and Dallas where  
7 we're starting to see a lot of the independents that cannot  
8 bill Medicare because they're not provider-based as  
9 Medicare defines it starting to partner with the hospitals  
10 so that they can become an OCED and start billing Medicare.

11 In Dallas and in Houston in particular, there's  
12 been a lot of that converting going on. In fact, I think  
13 there was one organization where 40 IFECs now became OCEDs  
14 and started billing Medicare. And just to jump back up on  
15 the soapbox again, Medicare can't really determine who  
16 these entities are when they're billing because they're  
17 billing as part of a hospital. So we're kind of flying  
18 blind, but we know that they're billing somehow.

19 MS. BRICKER: That's interesting. This reference  
20 to 20 minutes or 20 miles, in an urban setting 20 minutes  
21 could be 5 miles. So what -- why --

22 DR. STENSLAND: I think that was probably a

1 result of me misspeaking, but I think in the urban areas,  
2 we were thinking 20 minutes or some minutes as opposed to  
3 miles. I think in the rural areas, the 35 miles is pretty  
4 straightforward because that's usually pretty close to your  
5 travel time. But in urban areas, it would make sense to be  
6 minutes.

7 MS. BRICKER: Okay.

8 DR. MILLER: Amy, did you get your answer there  
9 [off microphone]?

10 MS. BRICKER: Yeah, I didn't know if he meant  
11 that, but I think he did mean that, and I'm just wondering  
12 what incentive that gives entities in New York or L.A. to -  
13 - 20 minutes isn't -- you know, you could be -- you could  
14 count the miles on one hand in those communities. And is  
15 that what we intend to do?

16 DR. MILLER: Yeah, I mean, as I think about it,  
17 Jeff and Zach and Sydney, what we're saying is you want --  
18 these freestanding EDs seem to be behaving not quite like  
19 an on-campus ED. And so then you draw a circle, and we're  
20 saying for the purposes of discussion, let's call it within  
21 20 minutes of an on-campus, then they're going to get the  
22 lower rates because they're not acting as a full-fledged

1 emergency room. Perhaps if they were further out and  
2 really addressing an access issue, maybe they would. The  
3 20 minutes is the proxy for us to have this conversation,  
4 and there is this difference between miles in a rural area  
5 and minutes within urban, because miles don't really matter  
6 as much in an urban.

7 MS. BRICKER: I see. Thank you.

8 MS. McCLENDON: I will say one more point on  
9 that, that we did do a little bit of analysis looking at a  
10 couple of markets where these freestanding EDs are popping  
11 up, and in a lot of the urban markets that we did look at,  
12 this 20-minute marker really encompassed a lot of them.  
13 There were very few that were more than 20 minutes away  
14 from an on-campus ED. So in that case, it's are they  
15 really bridging an access need or are they just there for  
16 the profitability?

17 MS. BRICKER: That is helpful. Thanks.

18 There's a reference throughout, when you then  
19 switch to the rural critical access hospitals and a policy  
20 recommendation to have this community funding. Is there  
21 precedent for that?

22 DR. STENSLAND: I can't think of any precedent



1 off the top of my head, but the rationale there is to make  
2 sure that the community actually sees this as a need, and  
3 so they're actually willing to put some of their own money  
4 into the ED as opposed to saying that they just want this  
5 for economic reasons for the community as one more business  
6 or one more source of Federal funding coming in. That's  
7 the rationale with the matching --

8 MS. BRICKER: I just think --

9 DR. GINSBURG: In some sense, when you say the  
10 community, perhaps you're referring to the town government  
11 or something like that.

12 DR. STENSLAND: It would be, I'm guessing, the  
13 county government, maybe the -- a lot of these places now  
14 currently have funding for the hospital under a hospital  
15 district, and they could just take that same tax funding  
16 they have for the hospital district and have it go to this  
17 outpatient-only hospital.

18 MS. BRICKER: That sounds good in theory; I just  
19 fear that in a lot of these rural communities, you know,  
20 they're pretty poor and is there infrastructure there to  
21 put an additional burden on them as part of this policy?  
22 That's my concern. I'm just thinking about towns, you

1 know, where I grew up. I don't even know how much from a  
2 tax perspective they're even getting, you know,  
3 socioeconomic status of much of these towns, I just don't  
4 know if they would be able to support that. So just a  
5 question. I don't have any data.

6 And, lastly, you referenced that there are  
7 quality concern because of the hospitals that are seeing  
8 very low admission. Is that based on data that we have or  
9 is it assuming that?

10 DR. STENSLAND: So a few years ago, we did a  
11 report on rural hospitals, and so we looked at our own  
12 data, and it does tend to be a risk-adjusted mortality and  
13 volume outcome relationship. And this is not only us, but  
14 the literature is pretty strong on the history of that  
15 relationship. There is also some weaker relationship with  
16 respect to the process of care and the outcomes.

17 MS. BRICKER: Thanks.

18 DR. GRABOWSKI: Thanks. Amy actually asked my  
19 question, but I just wanted to push as well on this  
20 community funding and matching funds. I find that also  
21 problematic, this idea of -- I was just curious if you had  
22 any sort of background on the willingness and ability of

1 these communities to actually sort of come up with those  
2 matching funds. Thanks.

3 DR. CROSSON: Paul.

4 DR. GINSBURG: Yeah, on page 25 of what you sent  
5 us, I was very alarmed by the data because, you know, first  
6 you made the point that it looks like there's been some  
7 movement out of urgent care centers into EDs. And you  
8 would think that that would make the mix of visit levels  
9 less intense, but in a sense the data showed a striking  
10 increase in intensity, which I suspect is due to something  
11 else that is happening at the same time.

12 I know that there has been some significant  
13 change in the employment relationships with ED physicians.  
14 They're increasingly employed by national companies and  
15 presumably who can counsel the physicians about how to code  
16 differently. So I'm just concerned about this issue and  
17 whether this should be something on our agenda at some  
18 point.

19 DR. CROSSON: Questions? Pat.

20 MS. WANG: For the urban situation of an OCED, do  
21 you think it would be feasible or have you considered there  
22 are situations, I think, even in urban areas where an

1 inpatient facility that may be underutilized or in trouble,  
2 the idea of closing it meets with tremendous community  
3 opposition, and sometimes the solution is we'll replace it  
4 with an OCED with a new operator so that the community will  
5 still have access to robust, et cetera, et cetera. That  
6 sort of OCED would fall within the definition of the within  
7 20 miles and be subject to the proposal here for Type B  
8 rates. Do you think that it would be feasible to kind of  
9 nuance that a little bit and say "except if the OCED was  
10 created as a result of the closure of an inpatient  
11 facility"? You know, you don't want to create  
12 countervailing incentives of a new operator saying, "I  
13 can't do it," and so instead you wind up leaving a failing  
14 inpatient facility open that costs everybody a lot more  
15 money. Do you think that would be feasible?

16 MR. GAUMER: So one thing I'd say is the 20-  
17 minute thing was put in there with the idea that there are  
18 probably isolated urban facilities that are serving a  
19 purpose out there. And we've found our way across a couple  
20 of them around the country, and we've seen that they do  
21 exist. And so that's why that's there.

22 But in terms of what the urban -- you know,

1 whether the urbans could be a part of kind of the rural  
2 idea, I'll let Jeff speak to that.

3 DR. STENSLAND: You know, I think it would be  
4 hard to actually do that regulatorily. But the way it's  
5 structured now is they would still get more than an urgent  
6 care center. So, you know, they could go ahead and say  
7 we're going to convert this into an emergency department,  
8 and they would still get more than they would if it was  
9 just an urgent care center there. They would get whatever,  
10 the 188 rather than the 90 per visit. And I think that  
11 might -- the rationale being that that might be  
12 appropriate, because even if they are close to another  
13 hospital, the ambulances are going to know now that this is  
14 just an independent emergency department, and they probably  
15 aren't going to take their heart attacks there. They'll  
16 probably bypass it and go to someplace that has reperfusion  
17 capabilities. That place will no longer have to have an  
18 operating room standing by to do trauma surgeries, because  
19 those will also probably be bypassed there.

20 And so we're trying to kind of become more  
21 equitable between the off-campus ED that's getting the  
22 difficult cases bypassed and the on-campus ED that has to

1 have these standby capacities such as getting their OR  
2 bumped when an emergency comes in or, you know, they have  
3 their own stroke team available, those kind of things.

4           So I think in the end, we're not saying that it's  
5 just going to be like an urgent care facility, they're not  
6 getting any extra money. They would still get extra money,  
7 but just not as much as if they maintain that on-campus  
8 capability.

9           MS. WANG: It's hard to cut it so fine. I get  
10 it. On the rural proposal, can you just go through, is the  
11 idea of sort of, you know, convert, you get a higher bump,  
12 there's money saved from avoided -- you know, inefficient  
13 inpatient care, et cetera, et cetera. Is this a budget-  
14 neutral proposal in your mind? Or how do the offsets --  
15 there's a statement in here that higher ED rates would be  
16 offset by lower inpatient subsidies or what have you. Just  
17 in general, is this -- are you thinking it's budget-  
18 neutral, you know, budget-negative, budget-positive?

19           DR. STENSLAND: I think end score -- you know,  
20 CBO would do the end scoring, so we're not going to  
21 actually score it. But the cost of this I think would be  
22 quite small, because you'll have the -- the majority of

1 these things are operating as critical access hospitals  
2 now, and so if you have an existing critical access  
3 hospital that converted to an outpatient-only hospital,  
4 that would be about a wash. Okay?

5 Now, there may be some that otherwise would  
6 close, and there would be no access, and it's going to be  
7 cost here because we're going to prevent this closure, so  
8 there will be a little bit of cost there. Then there might  
9 be a few PPS hospitals that are isolated out there that  
10 aren't critical access hospitals that would take advantage  
11 of this. There would be a little bit of cost there. But  
12 the costs, you know, are going to be low costs per year,  
13 maybe in the single millions of dollars type net cost.

14 MS. WANG: Thank you.

15 DR. MILLER: And just to answer it just a little  
16 bit differently, it's not designed to save money. It's not  
17 designed to cost money per se. It just works out that it  
18 looks like it's a little bit on the positive side.

19 MS. WANG: [Comment off microphone.]

20 DR. MILLER: Right, no. I got your question.

21 DR. CROSSON: Warner.

22 MR. THOMAS: On the physician offices collocated,

1 how prevalent is that situation?

2 MR. GAUMER: So we don't have a good read on  
3 that, actually. We know that, you know, this is a flaw in  
4 Section 603 and that it could be done, and it would be  
5 logical that this could develop. We haven't seen a lot of  
6 examples of this, but we don't have a great idea of how  
7 common it is.

8 MR. THOMAS: And I guess how different is this  
9 from, essentially, if you're a hospital-based clinic? I  
10 mean, is that the same thing if you're a hospital-based  
11 clinic and you're within the 35 miles or whatever? Is that  
12 the same phenomena, or is it different?

13 MR. GAUMER: No. This is the same as the off-  
14 campus physician office issue, and really, the subtle  
15 difference here is that the exemption in Section 603 said  
16 for emergency department services, they can get the higher  
17 hospital outpatient department rates. But also, those non-  
18 emergency services can get that higher rate, and we think  
19 that that extra incentive or extra exception provides the  
20 incentive for these things to proliferate a little bit.

21 MR. THOMAS: And on the rural situation, as you  
22 talk to constituents, are you hearing pushback around this,



1 this idea of being able to have the conversion? Do they  
2 like the idea? Do you have any feedback on that?

3 DR. STENSLAND: I think in general, they like the  
4 option because this is just an option. They don't have to  
5 do anything. They don't lose anything whatsoever.

6 I think there's going to be -- still, it's kind  
7 of a -- these are places that have had this inpatient  
8 facility for years and years, and it's going to be a  
9 difficult transition for them. Even if the medical  
10 community and the community knows this, it will still be  
11 difficult for the community to say, "Okay. We're not going  
12 to have post-acute care in our town. We're going to have  
13 to go 20 miles away to visit our people in the snow."

14 DR. CROSSON: Rita.

15 DR. REDBERG: Thanks.

16 On table 3 in the mailing materials, I noted  
17 level 5 visits were the ones that had the biggest increase  
18 in the last 5 years, and I'm wondering if you could tell us  
19 what makes a level 5.

20 MR. GAUMER: So the levels of ED visits, the  
21 definitions are somewhat vague, and I think that that might  
22 be part of the issue here.

1           It's not based on time like other services are in  
2 the CPT codes, but it's more other -- this is more kind of  
3 a -- generally how much time did you spend with this  
4 patient and how much information did you have to extract  
5 from them and what was -- yes. I'm sure Alice can talk to  
6 this a lot better than I can.

7           So it's kind of a vague concept, and the hospital  
8 as well as the physician is left to kind of determine where  
9 this falls, and so there is kind of risk of coding creep in  
10 there, and I think that that might be one of the reasons  
11 why we're seeing this creep. There could be other reasons  
12 in there like ICD-10 or other things.

13           And to Paul's point, this is something that we  
14 haven't had as much time to drill down in yet.

15           DR. REDBERG: Right. Okay. Well, that would be  
16 an interesting area to look at.

17           I'm also wondering, in the introduction in the  
18 mailing materials, you mentioned that some private insurers  
19 are not paying for care deemed non-emergent, and I'm  
20 wondering, do you have any info on how that is going, that  
21 program?

22           DR. STENSLAND: We don't have much information on

1 how it's going. These are just the initial news reports.

2 DR. CROSSON: Jack.

3 DR. HOADLEY: So just two questions. We talked  
4 about the rural option back in the 2016 report, and I guess  
5 I'm wondering, is there anything substantively different in  
6 the way you're presenting it now from what we talked about  
7 back then?

8 DR. STENSLAND: I think the fundamental idea is  
9 the same.

10 DR. HOADLEY: Okay. And in 2017, you referenced  
11 in the mailing materials, the recommendation about  
12 tracking, the recommendation to the Secretary for tracking  
13 OCED visits separately. I got the implication was nothing  
14 has happened on that. Any feedback? Any possibility? Any  
15 negative reaction to it?

16 MR. GAUMER: Actually, we have seen nothing on it  
17 in the final rules that have come out since. I think the  
18 outpatient rule just hit yesterday. The final hit  
19 yesterday, but we didn't expect to see anything in there.

20 DR. HOADLEY: So it might be something where if  
21 we end up with a recommendation on this to kind of  
22 reference, re-print that one, we still believe that's

1 important.

2 DR. CROSSON: Okay. I've got Alice and Dana, and  
3 then we'll proceed with the discussion.

4 DR. COOMBS: Thanks.

5 So Paul nudged me in that area, something, and I  
6 wanted to ask the question, and that was to follow up with  
7 the -- one of the things that Rita just mentioned is a  
8 level 4 and 5 increase. One of the proxies for that is how  
9 many of those level 4 and 5's got admitted to the hospital,  
10 and that's something that's easily trackable, because if  
11 you saw the number of level 4 and 5's increase suddenly and  
12 all of them went home, then you say, "Okay. Something is  
13 at work here, other than the severity of illness."

14 And just to answer a question earlier that you  
15 will be down-coded, if I up-code in the ICU to a 99292, I  
16 will be down-coded if that patient is going to a LTCH that  
17 day. It indicates that that patient is not critical ill,  
18 doesn't have any pending deterioration of cardiac status or  
19 life-threatening. So that they can read from the note to  
20 down-code, probably something like that might happen here  
21 as well.

22 DR. CROSSON: Thank you, Alice. That's a good

1 point.

2 Dana.

3 DR. SAFRAN: Yeah. Just a quick question. So I  
4 understand that Medicare is not dealing with OB care, but  
5 on the rural proposal, I'm wondering, do we imagine that  
6 these hospitals that become just an emergency room would  
7 also be able to handle OB care, and does that affect our  
8 proposal in any way?

9 DR. STENSLAND: I think they generally wouldn't  
10 be doing OB care, and I would guess that the majority of  
11 these are not doing OB care already.

12 If you look at the share of rural, isolated small  
13 hospitals that are doing OB care, it's gone down pretty  
14 dramatically, just with the number of fewer and fewer  
15 family practitioners out there delivering babies.

16 DR. CROSSON: Okay. Thanks for the presentation.  
17 Good questions.

18 Let's put up the last slide 18, if we have.  
19 You've got it.

20 So there really are two somewhat connected but  
21 distinct problems here that we're trying to address. In  
22 the last bullet point, as Jack pointed out, we're coming

1 back to an issue that we have discussed before and as a  
2 matter of fact have written on, and that has to do with  
3 providing an option for rural communities to have the  
4 financial resources redirected to create a level of  
5 services there, which they would not have if they just  
6 closed the hospital and walked away from services.

7           Second issue is the first two bullet points, and  
8 it kind of relates to the fact that we have a concern that  
9 off-campus emergency departments may be costing the  
10 Medicare program more than is reasonable, either as a  
11 consequence of the rates that they're paid or as a  
12 consequence of the collocation of physician offices. So  
13 they're both connected because they're related to emergency  
14 departments, but they're kind of distinct in some way.

15           So what I'd like to do if we could in the  
16 discussion, again, is provide direction to staff. The kind  
17 of notion here is that we would be heading towards  
18 recommendations in the spring, and as Jack pointed out,  
19 depending on what we say and want to do, it's that the  
20 discussion -- or the recommendation with respect to the  
21 option 4 rural hospitals converting to emergency  
22 departments may be the same as the one in the set of

1 discussions that we've had before.

2           So to the extent that people are concerned with  
3 that direction, I'd ask you to say "I kind of like this" or  
4 "I don't like it, but I have concerns about the rural  
5 piece."

6           And with respect to the first two bullet points,  
7 do you have a preference? Do you feel we should move in  
8 one direction or the other? Do you feel we should move in  
9 neither direction, so that we can further elaborate that  
10 set of issues with respect to Medicare costs later in this  
11 cycle? Is that at all helpful?

12           So let me see hands for comments. Okay. Let's  
13 start with Craig this time.

14           DR. SAMITT: So in terms of the overall  
15 recommendations, I would say that I am in support of the  
16 first and the third, and I have some concerns about the  
17 second.

18           I'd start with the notion that when we've looked  
19 at the utilization of freestanding EDs, we see a  
20 significant amount of inappropriate use of emergency  
21 departments for non-emergency services. It may have been  
22 included in the materials that the Center for Improving

1 Value in Health Care did a study in Colorado and found that  
2 7 of 10 visits in freestanding EDs were for non-life-  
3 threatening conditions versus 3 of 10 visits in traditional  
4 EDs.

5           So I would imagine that our recommendations would  
6 seek to temper some of the profit-seeking in this space and  
7 address some of the inappropriate use of freestanding EDs  
8 for urgent care-related services.

9           So I worry that the middle bullet doesn't quite  
10 capture the disincentive that we would want to put in place  
11 for the creation of these freestanding EDs. I may make a  
12 somewhat unorthodox recommendation here, but I wonder  
13 whether what we should say for these OCEDs is if it's a  
14 level 1, 2, or 3 visit, it is a site-neutral payment equal  
15 to urgent care. If it's level 4 or level 5, then it  
16 actually could be type A.

17           Now, I recognize this would encourage even  
18 further up-coding scenarios, and so I'm offering an  
19 unorthodox and probably inappropriate recommendation, but I  
20 wonder whether we want to think about some other  
21 alternative that essentially says if your freestanding ED  
22 is being used predominantly for non-emergency services that



1 you shouldn't even get type B rates for these types of  
2 visits, that there should be another option.

3 DR. MILLER: So just to clarify, the coding shift  
4 you're worried about just happened, I'm sure in response to  
5 your comments.

6 [Laughter.]

7 DR. MILLER: But what I do hear you saying is you  
8 don't like -- or you may not be on board with No. 2 because  
9 you don't think it goes far enough. You need it to be more  
10 aggressive.

11 DR. SAMITT: Yeah. I worry when I hear the Texas  
12 story --

13 DR. MILLER: Yeah, I hear you.

14 DR. SAMITT: -- about ongoing proliferation of  
15 these facilities. I would rather we create incentives for  
16 the proliferation of urgent care centers, not freestanding  
17 EDs, where the demand truly is, the rural issues aside. I  
18 just worry that even with type B rates, we're going to see  
19 proliferation of EDs that we don't need.

20 DR. CROSSON: Rita, on that point?

21 DR. REDBERG: Yes. I was thinking maybe we  
22 should add incentives to sort of primary care or ACOs on

1 not refer -- or triaging. There's a lot of people who call  
2 their primary care doctor for atypical chest pain, and they  
3 say, "Go to the ED." And it's not really appropriate to go  
4 to the ED for that, but there's every incentive to say that  
5 and no incentive not to say that in our current system  
6 because who wants to miss a heart attack. But now we're  
7 talking about your chances are greater getting probably hit  
8 by a car crossing the street going there than actually  
9 having a heart attack, with a lot of the things that get  
10 referred.

11           And so I was thinking we should put incentives to  
12 sort of accomplish the same thing, but on the ACO or  
13 primary care side, it's not to discourage that, what I  
14 think is a lot of inappropriate triage, because so many  
15 times when I see people that I don't think should have ever  
16 come to the ED with -- a lot of times, chest pain is what I  
17 see. They were referred by their primary care practice.  
18 Usually, it's not their own doctor. They reach someone,  
19 you know, a mid-level who was covering, and it's a  
20 complicated issue, but I think there is a lot of potential  
21 to do a lot better if we discouraged triage to EDs and  
22 encouraged primary care, sort of accessibility and

1 availability for these kind of low-risk issues.

2 DR. SAMITT: Yeah, I'd support that. I just  
3 wonder whether those incentives already, to some degree,  
4 exist as being part of an ACO. It's something that ACOs  
5 would already be paying attention to. The question is, Is  
6 the incentive adequate?

7 DR. CROSSON: Okay. Coming up this way, Alice.

8 DR. COOMBS: So I support the three, but the  
9 first one, it's analogous to an HOPD? Really? Jeff, I  
10 think they're the same thing as a physician and a hospital-  
11 associated PD--outpatient department, right? Would you say  
12 it was the same?

13 DR. STENSLAND: Well, that is the idea, is that,  
14 you know, we had --

15 DR. COOMBS: Okay.

16 DR. STENSLAND: The whole site-neutral thing we  
17 talked about was saying --

18 DR. COOMBS: Right.

19 DR. STENSLAND: -- well, if you buy a physician  
20 practice out here and you convert that physician practice  
21 to part of your hospital HOPD over here, well, then you  
22 start to get to build facility fees for your office visits

1 for your physicians out there. Your payments double.

2 So then there with the law that was passing --

3 DR. COOMBS: Right.

4 DR. STENSLAND: -- no, we're not going to do this  
5 anymore.

6 DR. COOMBS: So they're the same category?

7 DR. STENSLAND: Yeah, it's the same category, but  
8 they were saying, "We're not going to do it anymore," but  
9 there is this exception. If you happen to locate it with  
10 the ED, then you get around it. It's kind of like a  
11 loophole, and we're basically saying close the loophole.

12 DR. COOMBS: Right. So I agree with that.

13 In terms of the second bullet, I was thinking,  
14 well, it's possible that an ambulance took a person to an  
15 off-campus ED that's within 20 minutes or, as Amy said,  
16 maybe four miles from the primary. But I would link that  
17 capacity with whether or not they were later transferred to  
18 a hospital with inpatient capacity, and that would be the  
19 real -- because there is a deterrent in that because it is  
20 a \$500 ambulance ride, and many of the patients -- just the  
21 ambulance in itself may not transfer the patient if they  
22 didn't really need to be transferred.

1           So I would link it to whether or not they  
2 actually got transferred to the mother ship hospital or the  
3 mother ship facility.

4           DR. CROSSON: Okay. Comments? Amy.

5           MS. BRICKER: I concur with what Craig said and  
6 pick up on the thread that Rita just mentioned around No.  
7 2.

8           So if there's a way to tie actual admission -- so  
9 it's either an issue with the levels. I think that's been  
10 addressed already, and then tying, as Rita suggested, maybe  
11 the 4 and 5's to admissions, or, okay, leave the levels,  
12 but for this discussion, more urgent care like  
13 reimbursement for lower acuity and maybe type A,  
14 reimbursement for those that actually end up getting  
15 admitted or something then that allows the correlation  
16 between the type of folks that you're treating in those  
17 facilities to actual inpatient visit.

18           I still want to protect the rural communities.  
19 As part of the question-and-answer session, I'm concerned  
20 about the burden on those communities and would not endorse  
21 a policy that would require a community to come up with  
22 funds. I think that's counter to the realities in many of

1 those communities.

2           So other than that, in support of the  
3 recommendation.

4           DR. CROSSON: Okay. Paul. Oh, sorry. I missed  
5 -- oh, I didn't? Dana. Sorry.

6           DR. SAFRAN: Sorry.

7           So agree with the recommendation No. 3 for sure,  
8 but really appreciate Amy's point about expecting  
9 communities to contribute and would ask us to take another  
10 look at that.

11           All three, actually, I was agreeing with until  
12 this discussion, and I think some of the unintended  
13 consequences that have been brought up are worth another  
14 look.

15           The one point, additional point, I was going to  
16 make that I don't think has been talked about is I was  
17 thinking about this issue of the physician payment at the  
18 off-campus versus the on-campus and sort of in my mind  
19 tying it to the discussion we're going to have tomorrow  
20 about telehealth, because this question comes up all the  
21 time about, gee, are we going to create access problems if  
22 we pay physicians differently in different settings, and

1 really, what we want to be doing is promoting the use of  
2 services that are most convenient and still in a site of  
3 care that has what the patient will need for care to be  
4 appropriate, which to me almost says that you want to  
5 motivate by giving higher payment rates for the care that's  
6 more accessible and not tied to a facility.

7           The downside of that, of course, is we move even  
8 farther than we are today from a real cost-based approach  
9 to what folks get charged.

10           So I wanted to put on the table that tie it to  
11 telehealth and that we should be thinking of these as a  
12 continuum as we think about what providers are being paid  
13 for the services they deliver and really keeping access in  
14 our mind as we do that.

15           DR. CROSSON: Paul.

16           DR. GINSBURG: Yeah. I'm very much in accord  
17 with supporting the first one and trying to make the second  
18 one more stringent. I don't know the exact best way to do  
19 it, but we've got the time to work on it.

20           I want to share my enthusiasm for the rural  
21 approach, and part of that is influenced by some work I did  
22 in a situation where there was a hospital in a rural part

1 of a metropolitan area that had been acquired by a system.  
2 And they had this convert. They closed the inpatients and  
3 expanded their outpatients and kept their emergency  
4 department open, and what was striking is how the quality  
5 of care before the inpatient was closed had become so  
6 problematic and how data showed that the community was  
7 bypassing the hospital beforehand. They were going to  
8 other hospitals, and that it just seems to be such a good  
9 solution that I'm just very enthusiastic.

10 As far as whether the community should be called  
11 on to support, to the degree that there are hospital  
12 districts in counties that can do that, I think it's fairly  
13 feasible to do that, but it may be that the idea is so  
14 compelling we want to do it everywhere where there's a  
15 hospital that can close.

16 DR. CROSSON: Pat.

17 MS. WANG: I agree with the rural proposal. I  
18 think it's great. I also agree with the first one for  
19 physician fees.

20 For the second one, I would encourage us to stay  
21 away from any approach that seeks to differentiate payment  
22 types within one facility, because I think it encourages



1 upcoding, and it's already happening, and I think, you  
2 know, we shouldn't go down that path.

3 I would like to ask whether there could be  
4 further exploration on the second bullet, for urban  
5 situations where an OCED is stood up as part of a closure  
6 of an inpatient facility, similar to the rural treatment.  
7 You know, to me -- because, you know, there's an example of  
8 that that's fairly fresh in my mind, from New York City,  
9 and, you know, 20 minutes, if you told the residents of  
10 that community which is densely populated, like there's an  
11 emergency room 20 minutes away. You know, like that  
12 hospital would never have closed, and the only reason that  
13 it did, which was a good thing, was that another operator  
14 came in and stood up a freestanding emergency department.  
15 Did have to meet, you know, state licensure requirements  
16 for ED.

17 So the overhead costs actually are higher than an  
18 urgent care center. I really respect the research that you  
19 did and it's not right to pay ED rates for urgent care, but  
20 there may be a particular situation that is worth paying a  
21 little bit more if, in the process, you can get a community  
22 to let go of their local hospital. That is a better

1 outcome all the way around.

2           And given the trend right now for the way that,  
3 you know, health care is going and medicine is being  
4 practices, I do think that it's going to be an issue that  
5 comes up more frequently, of people needing to sort of say,  
6 okay, I'm going to let my local hospital go, because it's  
7 just not needed anymore. The beds aren't needed, they're  
8 not getting filled, and you have all of this capital  
9 infrastructure that is just sucking up money and not  
10 providing the highest quality of care.

11           So if part of that can be to persuade operators  
12 to go and stand up a freestanding ED, with higher overhead  
13 costs, albeit not handling the, you know, serious trauma, I  
14 think if we can kind of take a closer look at that in urban  
15 areas it would be a good thing to do.

16           DR. CROSSON: Warner.

17           MR. THOMAS: So I would agree with the third  
18 recommendation. I think the one comment I would make is  
19 you may want to think about -- and this may help get better  
20 acceptance -- creating some sort of period, three- or five-  
21 year period where they could revert back. I think the  
22 likelihood of reverting back is very low, but it may give

1 comfort to the community that, hey, if we make this  
2 decision and it ends up being the wrong decision we've got  
3 a chance to revert back.

4           On the second bullet on the freestanding EDs --  
5 and I think there are examples which you have gone through  
6 where there's been a proliferation of EDs, which is  
7 unnecessary -- we also have to understand that there's a  
8 lot of our EDs, especially in urban areas, that have, you  
9 know, 10-, 12-, 14-hour waits, frankly, which isn't great  
10 either. Now you could argue that that's, you know -- they  
11 need to have better service, but there's also just -- and  
12 maybe a bunch of the folks that are there shouldn't be  
13 there, but there is a level of care that is not appropriate  
14 for an urgent care but probably doesn't need to be in a  
15 trauma center, and there's something in the middle. And  
16 perhaps your reimbursement or Type B rates, you know, kind  
17 of get there.

18           I mean, for example, we were going to open up an  
19 ED, a freestanding ED. It was going to be two, three miles  
20 away from one of the -- from the trauma center. We ended  
21 up not opening it because the Department of Health and  
22 Hospitals asked us not to. But the wait at the trauma

1 center is 10 and 12 hours. So I don't think that's a great  
2 solution either.

3 So I'm not -- you know, so I don't think having,  
4 you know, 50, 60, 70 EDs in an urban area, close to each  
5 other, makes sense, but I think maybe something in the  
6 middle is a good alternative, understanding that if you  
7 look at the ratings of access to many of the large urban  
8 EDs, they are not very good.

9 So I don't know if that's helpful to you, but I  
10 do think having an alternative between urgent care and  
11 between a trauma center or even a level 2 is an important  
12 alternative, even though you don't need to have a  
13 freestanding ED on every corner, like a drugstore. We can  
14 talk about that later, but anyway.

15 [Laughter.]

16 DR. CROSSON: Rita.

17 DR. REDBERG: So I support the recommendations.  
18 I think you did a great job of identifying a lot of the  
19 issues, and, you know, addressing sort of the ED needs but  
20 not the inappropriate payments and certainly trying to stem  
21 the growth of off-campus EDs.

22 I just wanted to add a comment. You know, I also

1 have a lot of concerns and it was addressed, I guess, with  
2 some of the imaging being paid so high. But there's also  
3 just been -- I'm sure you know -- a huge proliferation of  
4 use of imaging in EDs. You know, multiple CT scanners, and  
5 everyone getting multiple CT scans that are often not  
6 appropriate and not good, because it's a lot of radiation  
7 risk and a lot of increased cancer. And often even before  
8 they are seen now. You know, I know that it's routine.  
9 They'll say, oh, you know, abdominal pain, they need a CT,  
10 which is not -- you know, it's nice to see the patient  
11 first and then decide what you're going to need and what  
12 you're going to evaluate.

13           And so if we could address those inappropriate --  
14 the incentives for inappropriate CT imaging, I think it  
15 would be good for the program and good for the  
16 beneficiaries.

17           DR. HOADLEY: So I support these recommendations,  
18 broadly speaking. The first one, I think, you know, fixing  
19 the loophole makes a whole lot of sense. You know, we're  
20 obviously on record with a stronger call for site-neutral  
21 rates than what Congress did, even, so, you know, I think  
22 that's important context here.

1           For the urban, you know, I'm finding some of what  
2 Craig said and some other have said to be sensible,  
3 thinking that maybe this even needs to go further. I do  
4 like some of what Pat was talking about in terms of maybe  
5 their circumstances but circumstances where a sort of rural  
6 style situation could be appropriate. I think it would be  
7 interesting to at least think about whether either those  
8 elements could be modified from what we have on this bullet  
9 two.

10           And bullet three, I'm really strongly in favor  
11 of. You know, I've probably made these comments before but  
12 I've seen, you know, both in much earlier settings, site  
13 visits that I once went on with some of you, you know, some  
14 of these kinds of settings. I think that the notion that  
15 communities, if they had an option, could really benefit  
16 from them, it really makes a lot of sense.

17           I think the question of whether there needs to be  
18 a community involvement, I think it's a good concept and  
19 maybe we need to think about whether some basis to create  
20 an exception to that, if we want to go with that route. I  
21 mean, as people have pointed out, there are a number of  
22 places where these hospital taxing districts have already

1 done that, and this is a natural extension and it does show  
2 that sort of community commitment. But I think Amy's and  
3 others' points, you know, make a lot of sense. There are  
4 clearly going to be some communities where financial  
5 situations just aren't -- you know, it's not taxable in the  
6 same way. So we may want to think about putting some  
7 language in there that says there could be an exception to  
8 this.

9 Thank you.

10 DR. CROSSON: Okay. Thank you, Jack. Thank you,  
11 everybody. This is a good discussion. I think it's going  
12 to be helpful. Jeff, Sydney, Zach, thank you for the  
13 presentation. We look forward to hearing more from you  
14 later this year.

15 We now have an opportunity for public comment  
16 period. If there are any members of the audience who would  
17 like to make a comment, please come up to the microphone  
18 and line up so we can see who you are.

19 MS. McDERMOTT: Hi. Mara McDermott, CAPG.

20 DR. CROSSON: Mara, just let me -- I have a  
21 little prologue I go through.

22 MS. McDERMOTT: Okay. Prologue away.

1 DR. CROSSON: This is an opportunity, Mara, I  
2 think as you know very well, there are other opportunities  
3 to provide input to MedPAC, and sometimes those are more  
4 effective, and I know you take advantage of that so I'm not  
5 telling you anything you don't know. But I do want to  
6 point that out to others in the audience who might think  
7 this is the only way to have input to MedPAC and the staff,  
8 which can be done through meetings and through e-mail, and  
9 through correspondence.

10 That said, we are delighted to hear from you. We  
11 will ask you to keep your comments to two minutes, and when  
12 this little red light here goes back on, that's 2 minutes.

13 MS. McDERMOTT: Okay. Thank you. Mara McDermott  
14 with CAPG. I just wanted to share a couple of comments on  
15 the MIPS portion of the discussion.

16 First, our members are very concerned that it's a  
17 little bit premature to declare defeat on MIPS. We've seen  
18 -- anecdotally, I'll share -- many of our members, about  
19 two years ago, looked at MIPS and saw a great opportunity  
20 to make a lot of money, scaling factors and exceptional  
21 performers and other bonuses. And I think as MIPS has  
22 evolved, many of them have sized it up and have said, you



1 know, that's not certain enough, and that's not an  
2 opportunity, and as a result they've moved into next-  
3 generation ACOs and Track 1+ and other things, and I think  
4 that's exactly what we, as stakeholders, have wanted to see  
5 out of MIPS.

6           So to some degree we think it is working, maybe  
7 not perfectly and there is certainly room for improvement,  
8 but we have concerns about throwing it out at the moment.

9           We also wanted to just offer a couple of comments  
10 on the VVP proposal. One is that we think that there is  
11 great value in having some reporting. So what we've seen  
12 with our membership is that there are organizational skills  
13 that come into play when you're doing some amount of  
14 quality reporting, and we would encourage you to consider  
15 that as you make a recommendation that would have no  
16 reporting at all.

17           We had a question about the MIPS APMs, so if  
18 you're in a Track 1 ACO in MIPS now, in VVP would that mean  
19 that you are reporting the 32 measures and earning back the  
20 same 2 percent withhold as a group that's reporting  
21 nothing? Sort of how would that work? So I guess that's  
22 just a question for the record.

1           And then the final thing that I'll say is our  
2 members have been reporting on quality for a long time,  
3 some of them back to when PQRS was voluntary over 10 years  
4 ago. They've made investments to be successful PQRS  
5 reporters, value-based payment modifier reporters. Some of  
6 them are receiving substantial bonuses in that program.  
7 And we worry a little bit that that investment that they've  
8 made, to be successful in MIPS, hasn't come up at all  
9 today. We've focused a lot on people who can't do it but  
10 not at all on people who can, and have, and have made  
11 substantial organizational and time investments to bring  
12 their organizations up to speed with what CMS has announced  
13 as existing rules.

14           So I offer those comments and I see my time is  
15 up.

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

17           So we have come to the end of the morning  
18 session. We are adjourned until 1:00. 1:00 we will be  
19 back. Thanks.

20           [Whereupon, at 12:06 p.m., the meeting was  
21 recessed, to reconvene at 1:00 p.m. this same day.]

22

## 1 AFTERNOON SESSION

2 [1:01 p.m.]

3 DR. CROSSON: Okay. Welcome, everybody, back  
4 after lunch and welcome to the guests we have. We're going  
5 to start the afternoon session with a discussion again --  
6 and I'm not sure I can remember how many years we've been  
7 talking about this issue -- of potentially rebalancing the  
8 physician fee schedule to deal with what may be a looming  
9 shortage of primary care physicians or physicians  
10 practicing and delivering primary care services to Medicare  
11 beneficiaries.

12 We welcome Kevin Hayes back and Ariel. It looks  
13 like, Ariel, you're going to start.

14 MR. WINTER: Yes. Thank you.

15 Good afternoon. Today, as Jay said, I'll be  
16 talking about rebalancing Medicare's physician fee schedule  
17 towards primary care services. And before we begin, we  
18 want to thank Kate for her help with this presentation.

19 Here's the outline for today. I'll start with  
20 talking about the context and some background information.  
21 Next I'll discuss problems with how the fee schedule pays  
22 for primary care services. And then I'll describe two

1 approaches to rebalance the fee schedule towards primary  
2 care.

3           Our work on primary care is part of a broader  
4 agenda on clinician payment policy. This morning, and at  
5 prior meetings, we've talked about MIPS. Beginning next  
6 month, we'll start presenting information for our annual  
7 assessment of payment adequacy for physician and other  
8 health professional services. And next spring, we'll  
9 provide an update on advanced alternative payment models  
10 and ACOs.

11           The Commission has been working on this issue for  
12 several years, as Jay pointed out, and this slide lists  
13 several of our key recommendations in this area. In 2008,  
14 for example, we recommended that Congress create a budget-  
15 neutral bonus for primary care services, which eventually  
16 became the Primary Care Incentive Payment program, or the  
17 PCIP. In 2015, we recommended that Congress establish a  
18 per beneficiary payment for primary care clinicians to  
19 replace the expiring PCIP.

20           We've also made recommendations to improve the  
21 accuracy of fee schedule payment rates for all services.  
22 We recommended that Congress set an annual numeric goal for

1 CMS to reduce the prices of overpriced services for each of  
2 five years. And we recommended that CMS regularly collect  
3 data on clinician volume and work time to set more accurate  
4 relative values for clinician work and practice expense.

5 High-quality primary care is essential for a  
6 well-functioning health care system, and primary care has  
7 five core elements: accessibility, which includes the ease  
8 of getting an appointment and after-hours care; continuity  
9 with the same practitioner or practice over time;  
10 comprehensiveness, which involves meeting the majority of  
11 each patient's physical and mental health care needs;  
12 coordination of care for a patient among multiple providers  
13 and settings; and accountability for the whole person,  
14 meaning that the clinician is knowledgeable about the  
15 patient's medical history and preferences.

16 According to the literature, primary care that  
17 includes at least one of these five core elements is  
18 associated with fewer emergency room visits, lower rates of  
19 hospitalization for ambulatory care-sensitive conditions,  
20 lower costs per capita, and higher patient satisfaction.

21 Physicians who focus on primary care are  
22 generally trained in family medicine, internal medicine,

1 geriatric medicine, and pediatrics. About 185,000 primary  
2 care physicians billed Medicare in 2016, accounting for 19  
3 percent of all health professionals who billed the program.

4 Other primary care practitioners include advanced  
5 practice registered nurses -- such as nurse practitioners -  
6 - and physician assistants. About 203,000 APRNs and  
7 physician assistants billed Medicare in 2016, accounting  
8 for 21 percent of all health professionals.

9 This slide summarizes the key problems with how  
10 the fee schedule pays for primary care, and there is more  
11 detail about this in your paper.

12 The first issue is that the fee schedule  
13 underprices primary care relative to other services.  
14 Payment rates are based on relative value units, or RVUs,  
15 and the RVUs for clinician work are based on estimates of  
16 the relative amount of time and intensity required for each  
17 service.

18 Eventually, the time needed to perform procedures  
19 often declines due to productivity gains and changes in  
20 clinical practice, technology, and technique. But the  
21 payment rates are not updated frequently enough to reflect  
22 these reductions in time.

1           On the other hand, primary care services, which  
2 include office visits, tend to be labor-intensive and so do  
3 not lend themselves to similar reductions in time.  
4 Therefore, over time, procedures tend to become overpriced  
5 relative to primary care services.

6           The second issue is that the nature of fee-for-  
7 service allows specialties that focus on procedures to more  
8 easily increase the volume of services they provide than  
9 primary care clinicians. This is because it's easier to  
10 achieve productivity improvements for procedures than for  
11 primary care services.

12           The third issue is that the fee schedule is not  
13 well designed to support primary care because it is  
14 oriented towards discrete services with a clear beginning  
15 and end. A major component of primary care, however, is  
16 ongoing, non-face-to-face care coordination.

17           Since 2009, CMS has reviewed many potentially  
18 mispriced codes, but the fee schedule is still unbalanced.  
19 Although the review process has been going on for eight  
20 years, many services have not yet been reviewed. These  
21 unreviewed services account for 29 percent of fee schedule  
22 spending.

1           Even among the services that were reviewed and  
2 received lower RVUs for clinician work, the RVUs did not  
3 decline as much as the estimated amount of time that it  
4 takes to provide a services.

5           Recall that work RVUs are based on the relative  
6 amount of time spent providing a service and the intensity,  
7 or effort, involved in the service. From 2008 to 2016, CMS  
8 decreased the work RVUs, the time estimates, or both for  
9 about 600 services. The time estimates for these services  
10 decreased by an average of 18 percent, but the work RVUs  
11 decreased by an average of 9 percent. A potential  
12 explanation for this disparity is that decreases in time  
13 were partially offset by increases in intensity.

14           Another indicator that the fee schedule is  
15 unbalanced is the substantial disparities in compensation  
16 between primary care clinicians and several other  
17 specialties, as shown on this slide.

18           Average annual compensation for primary care --  
19 the second bar from the left -- was about \$264,000 in 2015.  
20 By contrast, average compensation for radiology was more  
21 than twice as high -- \$560,000 -- and for nonsurgical  
22 procedural specialties it was \$545,000. There are concerns



1 that these compensation disparities could discourage  
2 medical school graduates and residents from choosing to  
3 practice primary care.

4           Prior incremental efforts to address the  
5 underpricing of primary care services have not succeeded in  
6 rebalancing the fee schedule towards primary care.  
7 Therefore, the Commission may wish to consider more  
8 significant changes. In doing so, there are some important  
9 policy questions to think about.

10           First, should Medicare increase payment rates for  
11 primary care services provided by all specialties or just  
12 primary care clinicians?

13           Should payments also be increased for psychiatric  
14 services? Many of the issues that affect primary care  
15 clinicians also affect psychiatrists. A large share of  
16 psychiatrists' fee schedule revenue for ambulatory services  
17 comes from E&M office visits, psychiatrists' average  
18 compensation is much lower than many other specialties, and  
19 psychiatrists are more likely than other specialties to opt  
20 out of Medicare.

21           Third, by how much should payments be increased?

22           And, fourth, should higher payments be

1 distributed on a per service basis or a per beneficiary  
2 basis?

3           We have developed two approaches that illustrate  
4 different ways to answer these questions.

5           The first approach would increase fee schedule  
6 payments for primary care and psychiatric services provided  
7 by all specialties and clinicians. This would be a budget-  
8 neutral change. Higher payments for primary care and  
9 psychiatric services would be offset by lower payments for  
10 other services.

11           The payment increase would be distributed on a  
12 per service basis because the goal of this approach is to  
13 spread the increased dollars among many clinicians.

14           The list of eligible primary care services  
15 includes: evaluation and management codes for office  
16 visits, home visits, and visits to patients in long-term-  
17 care settings; chronic care management and transitional  
18 care management codes; and Welcome to Medicare visits and  
19 annual wellness visits.

20           These are considered primary care services by CMS  
21 for the purpose of assigning beneficiaries to ACOs in the  
22 Medicare Shared Savings Program.

1           Psychiatric services include the E&M codes listed  
2 on this slide, as well as psychiatric diagnostic evaluation  
3 and psychotherapy.

4           One rationale for this approach is that some  
5 specialties other than primary care receive a high share of  
6 their fee schedule revenue from primary care services. As  
7 shown on this slide, for example, endocrinology received 76  
8 percent of their fee schedule payments from primary care in  
9 2016, and rheumatology received 68 percent from primary  
10 care.

11           The average share for all primary care  
12 practitioners was 54 percent, but there is variation among  
13 primary care specialties. For example, family medicine  
14 physicians received 70 percent of their payments from  
15 primary care services; whereas, internal medicine  
16 physicians derived 45 percent of their payments from  
17 primary care.

18           We modeled payment increases of 10, 20, and 30  
19 percent to primary care and psychiatric services, using  
20 2016 claims data. We assumed that the increases would be  
21 offset by an across-the-board reduction to all other  
22 services. Your mailing paper describes other budget

1 neutrality options, such as an annual numeric target for  
2 CMS to reduce prices of overpriced services.

3           So if we start by looking at the first column,  
4 which shows a 10 percent increase, this translates to an  
5 additional \$2.7 billion for primary care and psychiatric  
6 services. This would be offset by a payment reduction of  
7 4.5 percent for all other fee schedule services.

8           To show the specialty impact, we grouped  
9 individual specialties into larger groups. The net effect  
10 on each group varies based on the group's mix of primary  
11 care, psychiatric, and other services.

12           So staying in the first column, you can see that  
13 primary care practitioners would receive a net increase in  
14 payments of 3.4 percent, which reflects the net effect of a  
15 10 percent increase for the primary care services they  
16 provide, and a 4.5 percent decrease for the non-primary  
17 care services they provide. Psychiatry would increase by  
18 4.8 percent. Radiology would experience the largest net  
19 decrease of 4.4 percent.

20           And if we turn now to the last column, the 30  
21 percent increase in payments, this translates to about an  
22 \$8 billion increase, which would be offset by 13.4 percent

1 reduction to all other services. And primary care  
2 practitioners in this example would receive a net increase  
3 in payments of about 10 percent.

4           The second approach would increase fee schedule  
5 payments for primary care and psychiatric services provided  
6 only by certain specialties and certain clinicians within  
7 those specialties. Clinicians would be eligible based on  
8 their specialty designation of primary care or psychiatry  
9 and their share of fee schedule payments that are from  
10 primary care and psychiatric services.

11           As with first approach, this would be a budget-  
12 neutral change: higher payments for these services would be  
13 offset by a reduction for other services.

14           The rationale for targeting the increase to  
15 primary care is that PCPs, primary care practitioners, play  
16 a unique and important role in the delivery system. This  
17 approach uses the same definition of primary care and  
18 psychiatric services as the first approach and includes the  
19 primary care specialties that are listed on this slide.

20           So here are the modeling results for the second  
21 approach. As with the first approach, we modeled payment  
22 increases of 10, 20, and 30 percent to primary care and

1 psychiatric services. And on the slide, we've included the  
2 10 percent and 30 percent increases to show you the range.

3           We modeled various alternatives for the share of  
4 total payments that come from primary care and psychiatric  
5 services that would qualify clinicians for the payment  
6 increase. These alternatives range from 40 percent to 75  
7 percent, as shown in far left column. Your paper includes  
8 additional thresholds.

9           Where we set this threshold determines how many  
10 clinicians qualify for the increase and the size of the  
11 total payment increase. For example, at the 40 percent  
12 qualifying threshold, which is the first column of numbers,  
13 about 263,000 primary care practitioners and psychiatrists  
14 would qualify for the payment increase, and the total  
15 amount of the increase would range from \$1.2 billion  
16 (corresponding to a 10 percent increase) to \$3.6 billion  
17 (corresponding to a 30 percent increase).

18           To offset these increased payments, payments for  
19 services other than primary care and psychiatric services  
20 would decline between 2 percent and 5.9 percent. At the 75  
21 percent qualifying threshold, fewer practitioners would  
22 qualify for the payment increase, and the total amount of

1 the increase would be a little lower, ranging from \$1  
2 billion to about \$3 billion. And payments for other  
3 services would decline between 1.7 percent and 5 percent.

4 An important question is how to distribute the  
5 payment increase under the second approach. One option is  
6 to distribute it on a service-by-service basis. This would  
7 be easier for CMS to administer, but it would reward  
8 clinicians who provide more discrete primary care visits.

9 Another option is to distribute it on a per  
10 beneficiary basis, which is consistent with our  
11 recommendation from 2015. Paying clinicians based on the  
12 size of their patient panel rather than their number of  
13 visits could encourage non-face-to-face care coordination.

14 A per beneficiary payment would also provide  
15 funds to support investments in infrastructure and staff to  
16 facilitate care management. However, as the size of a per  
17 beneficiary payment increases, there are questions about  
18 how to attribute patients and whether to risk-adjust the  
19 payments.

20 Another idea is to consider a mix of both  
21 options. For example, you could begin by paying the  
22 increase on a per service basis and then move over time to

1 a per beneficiary payment.

2 To conclude, here are some key decision points to  
3 start your discussion:

4 Should Medicare increase payment rates for  
5 primary care services provided by all specialties or just  
6 primary care clinicians?

7 Should payments also be increased for psychiatric  
8 services?

9 By how much should payments be increased?

10 And should higher payments be distributed on a  
11 per service basis or a per beneficiary basis?

12 This concludes our presentation, and we'd be  
13 happy to take any questions.

14 DR. CROSSON: Thank you, Ariel.

15 So we're now open to clarifying questions. We'll  
16 start with Jack.

17 DR. HOADLEY: So thank you. This was a very  
18 helpful presentation. On Slide 12, where you break out  
19 some of the different specialties, I guess I had two  
20 questions. One is, you know, where you pulled out some of  
21 the non-primary care specialties and had some pretty high  
22 numbers there, were there any other specialties -- was this



1 all of the specialties that came in like at 50 percent or  
2 above, and were there others that are sort of close to that  
3 that sort of just missed that kind of a cutoff?

4 MR. WINTER: Right. So these are the major ones  
5 in terms of spending that came above 50 percent.

6 DR. HOADLEY: Okay.

7 MR. WINTER: There are some other variations of  
8 hematology and oncology that are also in that range, like  
9 oncology alone, hematology alone.

10 DR. HOADLEY: Okay.

11 MR. WINTER: There are some specialties that  
12 accounted for a very small amount of dollars that are above  
13 50 percent, like preventive medicine, addiction medicine,  
14 certified nurse midwife, which is really small in Medicare  
15 in terms of dollars. We picked out the big ones that are  
16 above 50 percent.

17 DR. HOADLEY: Okay.

18 DR. GINSBURG: If I could follow up on --

19 DR. HOADLEY: And with hematology and oncology,  
20 are the drug costs counted in the denominator on this?

21 MR. WINTER: The costs of the Part B drugs are  
22 not part of the denominator, but the cost of drug

1 administration services, which are paid out of the fee  
2 schedule, would be in the denominator.

3 DR. HOADLEY: Okay.

4 DR. GINSBURG: If I can follow up on Jack's  
5 question, you know, we also -- within specialties, you  
6 know, a lot of specialties are very subspecialized today,  
7 so sometimes you have enormous variation within a specialty  
8 as to how much of their care is evaluation and management  
9 services. Brian and I were talking at lunch about his  
10 brother, who is in a subspecialty of ophthalmology called  
11 neuro-ophthalmology, and this subspecialty is almost no  
12 procedures. It is all evaluation and management services.  
13 We wouldn't call that primary care because these are very  
14 specialized services. But the issue is that subspecialty  
15 is not viable today and it is dying I think because of our  
16 payment distortions.

17 DR. HOADLEY: So I had one other one. You had  
18 mentioned -- I guess it was on the previous slide -- the  
19 chronic care management and transitional care management  
20 codes. I recall the last time we talked about those, there  
21 was very little take-up of those codes. Is that still the  
22 case?

1           MR. WINTER: So when we talked last time about  
2 this, we had data from 2015, and the total dollars were  
3 about \$180 million for both. But take-up was increasing.

4           DR. HOADLEY: Okay.

5           MR. WINTER: Month by month it's growing. We  
6 don't have data yet for 2016. I hope to bring that to you  
7 for a future presentation. So it's still small, but I  
8 would say the take-up is growing.

9           DR. HOADLEY: It is growing. And the last  
10 question, if you were to do a per bene payment, I think  
11 this is -- I may have asked this question in a previous  
12 session. Is there a co-pay associated with that for the  
13 beneficiary, or how does that work?

14           MR. WINTER: Kevin and I were just talking about  
15 this right before the presentation. Under our  
16 recommendation from 2015, we said that the per beneficiary  
17 payment should be program dollars only. There should not  
18 be beneficiary cost sharing associated with it. And I  
19 think one rationale for that is that beneficiaries might be  
20 surprised to get a bill for cost sharing when they didn't  
21 receive the face-to-face service.

22           So in our modeling, you know, we thought more

1 about the per beneficiary payment for the second approach,  
2 and just for the sake of convenience, we assumed that  
3 however -- the dollars that would be distributed include  
4 both the program payment and the beneficiary cost sharing.  
5 If you distribute the increase on a per service basis, it  
6 probably makes sense to do that. If you do it on a per  
7 beneficiary basis, then there are pros and cons you have to  
8 think about whether or not to include the beneficiary cost  
9 sharing.

10 DR. HOADLEY: It becomes a policy option.

11 MR. WINTER: Yeah.

12 DR. HOADLEY: Thank you.

13 DR. CROSSON: Clarifying questions?

14 Pat.

15 MS. WANG: I am curious if you could say a little  
16 bit more about psychiatry in this. I don't remember in  
17 past conversations if we had explicit conversations about  
18 the psychiatry fee schedule. I think that some of the work  
19 here is meant to address perceived inequity, inaccuracy in  
20 the fee schedule, and some of it is to ensure that Medicare  
21 beneficiaries have access to the services that they need by  
22 making those specialties more attractive for physicians to

1 practice in.

2           Psychiatry is a little bit different, definitely  
3 much lower participation in all forms of insurance, that I  
4 think may have some reasons associated that go beyond just  
5 how much gets paid. It has to do with the hassle and just  
6 the way that people practice and the kind of scrutiny that  
7 insurance companies, whether they're private or public,  
8 place on high no-show rates, whatever it might be.

9           Is there -- can you talk more about why we  
10 included psychiatry and what we think an adjustment to the  
11 fee schedule is going to cure?

12           MR. WINTER: Right. So on -- just to clarify,  
13 the psychiatry -- psychiatric services are paid under same  
14 fee schedule as the other services we have been talking  
15 about, procedures, E&M office visits. So the reason we  
16 thought to include it or give you the option of including  
17 it, because it is a question we've raised for your  
18 discussion, is for a couple of reasons. One is they derive  
19 a lot of their fee schedule revenue for ambulatory services  
20 from the E&M office visits that are the main source of  
21 revenue for primary care physicians. So to the extent  
22 those codes are undervalued, it would affect both primary

1 care and psychiatry, so that's one reason.

2 Another reason is when you look at compensation  
3 by specialty, psychiatry tends to be at the lower end of  
4 that range. They're above primary care. Primary care  
5 averages 264,000; psychiatrists, 289,000. But if you look  
6 at the chart I put up over here, you can see that many  
7 other specialty groups are well above that. So there is a  
8 concern there about what could these disparities do to --  
9 potentially do to access in the future.

10 When we've done our focus groups with  
11 beneficiaries and physicians, an issue that's been raised  
12 is that primary care physicians say they have a difficult  
13 time getting access for their patients to psychiatric and  
14 behavioral health services, and last year, Kate and Dana  
15 did a whole presentation about this topic more generally.

16 So those are some of the things we were thinking  
17 about. As you point out, it is certainly correct that  
18 there is an issue on psychiatrists participating in all  
19 forms of insurance, not just Medicare, and this could be --  
20 so, therefore, Medicare's payment rates are not the only  
21 factor affecting participation in Medicare for  
22 psychiatrists. There are certainly other factors that

1 influence that as well.

2           So there are issues to think about, and that's  
3 why we thought to include it, but it's up to you to decide  
4 whether we should keep it in or leave it out.

5           DR. CROSSON: Yeah. I'd just make a couple  
6 points. I can't remember exactly when, but I think in one  
7 of our previous iterations of this discussion about the fee  
8 schedule, there were a number of Commissioners who said,  
9 you know, don't we want to take into consideration mental  
10 health providers, particularly psychiatrists. So that's  
11 one thing.

12           The second point I think is worthwhile making is  
13 I think in doing this work, we fully recognize that income  
14 is not the only issue impacting the decisions made by  
15 senior medical students, for example, in terms of what  
16 field they want to go into. Some specialties have come  
17 easier over time with the advent of technology. Some  
18 specialties, including some primary care specialties, have  
19 become much more arduous, longer days, harder, more complex  
20 patients.

21           There are aspects of that we can't solve. The  
22 one piece that we can attempt to solve is the income piece.

1 Brian.

2 DR. DeBUSK: On Chart 13, I really like the  
3 analysis you've done where you break that down by sort of  
4 who's affected when you use the E&M code-based thing. Do  
5 you have some of the underlying data that you could share  
6 with us or speak to on, for example, neurologists? Again,  
7 to Paul's earlier points, neuro-ophthalmologists, which is  
8 sort of an unfair question. I think there's about 500 of  
9 them in the whole country. So I'm pretty sure you don't  
10 have that one.

11 But I think sort of the classic neurologist who's  
12 probably making their income from E&M codes, could we get  
13 maybe just some points of reference? And the reason that I  
14 ask that question is if I look at nonsurgical  
15 nonprocedural, I'm guessing that's where a lot of these  
16 people fall, and that category, net, actually it's a slight  
17 decrease.

18 But what I'd like to see is what's going on under  
19 the waterline. If you could speak to that, that would be  
20 helpful because I would think there's probably a handful of  
21 canaries in the coal mine that we could look for.

22 MR. WINTER: Right. So on -- I'm just looking



1 for my notes. So we did look at -- within the nonsurgical  
2 and nonprocedural category, you're correct. Neurology is  
3 in there, and about 42 percent of their revenue is from  
4 primary care services. So presumably, my guess is they  
5 would get a small increase, but I have not modeled that.  
6 So I can come back to you with that information.

7           Also in that category is rheumatology and  
8 endocrinology, and both of them would receive increases.  
9 So the 10 percent level, for example, endocrinology would  
10 receive an increase of 6.5 percent, and rheumatology would  
11 increase by 5.4 percent. And in the future, we can come  
12 back to you with more disaggregated breakdown of  
13 specialties. For the purposes of this, we wanted to  
14 aggregate to show you the broader effects, but we can give  
15 you more detailed information.

16           DR. CROSSON: Paul.

17           DR. GINSBURG: If you could turn to slide 9, this  
18 is the bar chart, the income data from MGMA. I just wanted  
19 to make the point that multispecialty groups have a long  
20 history of having a smaller difference in relative incomes  
21 between proceduralists and primary care physicians and the  
22 like. So in a sense, it may be that MGMA -- the

1 disparities in MGMA are probably smaller than they would be  
2 in a more general data source.

3 DR. CROSSON: David.

4 DR. GRABOWSKI: Could you go back to slide 13? I  
5 wanted to follow up on Brian's questions.

6 I just want to see how you modeled this. You  
7 didn't assume a behavioral response here. This is just  
8 mechanical, right?

9 MR. WINTER: Correct.

10 DR. GRABOWSKI: I think it could be really  
11 important of how you pay more for primary care, you're  
12 going to get more primary care, and I think that's what we  
13 want here.

14 And to Jay's point, we want people shifting and  
15 entering this profession. I don't know if there's a  
16 literature out there, but I guess I'd encourage you to  
17 think about that and not just doing this mechanically  
18 because this may way underestimate the actual effect here.

19 Thanks.

20 DR. CROSSON: Amy.

21 MS. BRICKER: On the salary data that was  
22 provided, is that purely physician, or are mid-levels in

1 that number?

2 MR. WINTER: These are only physicians. I  
3 believe the survey only covers physicians.

4 MS. BRICKER: Okay.

5 MR. WINTER: That's correct. Yeah.

6 MS. BRICKER: So why -- I want to make sure I'm  
7 understanding. Are we suggesting that mid-levels would  
8 also get the increase?

9 MR. WINTER: Yes, we are. Under option 1 --  
10 sorry -- the approach 1, any mid-level that billed for  
11 primary care and psychiatric services would get the  
12 increase, so that includes MPs, PAs, LCSWs, and clinical  
13 psychologists because they billed for a lot of the  
14 psychiatric -- behavioral health codes, so they would  
15 receive an increase.

16 Under the second approach, it would be limited to  
17 those -- it would be limited to PAs and MPs that focus on  
18 primary care.

19 MS. BRICKER: So just wanted to push on that a  
20 moment. So if the concern is we're worried about  
21 physicians choosing primary care, do we see in our data  
22 that mid-levels are -- I understood them to be increasing

1 in number and in primary care. So if we consider not  
2 adjusting their reimbursement at the mid-level, how does  
3 that change the economics of what you recommended? How  
4 much of that weighting is associated with a mid-level  
5 increase versus physician?

6 The other thing to know on this slide 13, I read  
7 the footnote that was available in the reading material,  
8 and other practitioners noted -- included social workers  
9 and psychologists.

10 MR. WINTER: Yeah.

11 MS. BRICKER: And I understood that to be what we  
12 were hoping to preserve in part two, so --

13 MR. WINTER: Right.

14 MS. BRICKER: Maybe if we go this route, we don't  
15 further harm them in the reduction that's outlined here.

16 MR. WINTER: Right. So other practitioners  
17 include a broad range of practitioners, and the LCSWs and  
18 clinical psychologists which are in this category actually  
19 would receive a fairly significant increase, around 8 to 10  
20 percent under the 10 percent increase, because they billed  
21 so heavily. They so heavily bill on behavioral health  
22 codes.

1           The other practitioners in that category include  
2 chiropractors, podiatrists, other specialists that would  
3 not -- that bill very few of these services.

4           MS. BRICKER: So what is it then -- sorry. I  
5 misread it, then. So it says other practitioners include,  
6 and it lists social workers and psychologists in the  
7 footnote.

8           MS. BUTO: [Speaking off microphone.]

9           MR. WINTER: So what page are you looking at?

10          MS. BRICKER: Sorry, 32 in the footnote.

11          MR. WINTER: Right. It does include those, but  
12 the footnote also says includes chiropractors --

13          MS. BRICKER: Yeah, yeah.

14          MR. WINTER: -- physical therapists, podiatrists.

15          MS. BRICKER: I was just wanting to make sure  
16 that we weren't --

17          MR. WINTER: Yeah.

18          MS. BRICKER: -- hurting them in this when we're  
19 also trying to help them as part two. So if we need --

20          MR. WINTER: Yeah.

21          MS. BRICKER: -- to ensure that social workers  
22 and psychologists aren't negatively impacted by the

1 adjustment, that's all.

2 MR. WINTER: I'm sorry. This represents the  
3 average effect across all the specialties in that category,  
4 so some go up, like clinical psychologists. Others go  
5 down, like chiropractors and physical therapists.

6 MS. BRICKER: I see.

7 MR. WINTER: This is just showing the average.

8 MS. BRICKER: I see.

9 MR. WINTER: So I think for next time, we should  
10 give you more detail about the specialties within these  
11 categories.

12 MS. BRICKER: I gotcha.

13 MR. WINTER: They might be helpful.

14 MS. BRICKER: Thanks.

15 DR. CROSSON: Bruce.

16 MR. PYENSON: Thank you.

17 I've got three clarifying questions. On page 7,  
18 on the changes in productivity, do you have a sense of  
19 whether productivity improvements are more for recent  
20 procedures or existing procedures? Do they all improve?  
21 What do we know about that?

22 MR. WINTER: I would have to go back and look at

1 the literature, and maybe Kevin has come across this in his  
2 review of the literature. My sense is that for newer  
3 procedures, productivity tends to improve faster as through  
4 the process of learning by doing and as clinicians get more  
5 acquainted with the procedure.

6 I don't know whether this research on the change  
7 in productivity over time for a given type of service.

8 Kevin, do you know anything about that?

9 DR. HAYES: Yeah. Most of the work in this area  
10 has involved surgical procedures, and so to the extent  
11 there's anything on the service specific, it's going to be  
12 that. And so from there, you just would infer, well, okay,  
13 now, where else, you know, among the range of services that  
14 are provided -- where else have we seen the things that  
15 drive productivity improvements, like technological  
16 advances and so forth? And then you can just sort of  
17 extrapolate from that idea to what might be happening  
18 elsewhere in the fee schedule.

19 MR. PYENSON: Great. Thank you.

20 A related question, but on page 8, the time  
21 estimates and perhaps productivity, does productivity  
22 include things like a surgeon running two or three

1 operating rooms when they do those tabulations? Is that  
2 figured into the productivity?

3 DR. HAYES: When you say a surgeon running two or  
4 three operating rooms, maybe you could just sort of say a  
5 little bit more about what you mean by that.

6 MR. PYENSON: Concurrent surgeries. Concurrent.

7 DR. MILLER: You didn't know about this, Brian?

8 [Laughter.]

9 DR. DeBUSK: [Speaking off microphone.]

10 DR. HAYES: Well, if we -- so productivity is  
11 going to be outputs over inputs, and so the outputs are  
12 going to be going up if more services are billed relative  
13 to inputs, and so it's just a question of -- so yes. It  
14 would include whatever increases the outputs.

15 MR. PYENSON: But from a time standpoint.

16 DR. HAYES: Oh.

17 MR. PYENSON: So when you think of the time it  
18 takes to perform a surgery, if there's -- if it's a two-  
19 hour surgery, but you have three patients --

20 DR. HAYES: Right.

21 MR. PYENSON: -- does that count as a two-hour  
22 surgery? Does that count as a 40-minute surgery?



1 DR. HAYES: When we have asked contractors to  
2 look at time and how that time spent delivering services  
3 varies relative to the time that's assumed in the fee  
4 schedule, it's been the time for all the services billed  
5 under the fee schedule as assumed by the fee schedule  
6 relative to the actual hours worked.

7 MR. PYENSON: So it sounds like it's a patient --

8 DR. HAYES: Yes, it is.

9 MR. PYENSON: Okay.

10 DR. HAYES: The output, the productivity is  
11 measured at the patient level, at the level -- at the  
12 amount, the quantity of services that have been billed and  
13 the time assumed in the fee schedule for each one of those  
14 services, and if they're done concurrently, however they're  
15 doing, however they're billed, that's what's counted.

16 DR. MILLER: Right. But let's be clear so that  
17 there's not a misunderstanding here. You're talking about  
18 what we did in the contractor report.

19 MR. PYENSON: Yes.

20 DR. MILLER: Okay. I'm not sure what you're  
21 asking. If whatever was going on, legal or otherwise, they  
22 would bill for three surgeries, and the time that would be

1 assumed in paying them would be the time assigned to those  
2 three surgeries in the fee schedule.

3 MR. PYENSON: But it wouldn't be the actual -- so  
4 that's the time assigned.

5 DR. MILLER: It would not be the time they  
6 actually spent.

7 MR. PYENSON: So it's per patient. So it sounds  
8 like we're not dividing -- if there were three patients,  
9 we're not dividing the surgeon's time --

10 DR. MILLER: It really depends on what your  
11 question is, and this is what I can't get a handle on.

12 What Kevin was describing to you was an attempt  
13 where we went through and we were trying to see whether the  
14 time assumed in the fee schedule was concordant with the  
15 time that physicians were doing their stuff, and we were  
16 saying there is a difference. And Kevin was explaining to  
17 you how we asked them to measure that, which would say if  
18 you spent less than is assumed in the fee schedule, we  
19 were trying to capture that.

20 I'm not sure what you're asking, whether you're  
21 saying in the actual fee schedule, is the actual time  
22 reflected. I would say no. There's an assumption about

1 time.

2 MR. PYENSON: Well, but very particularly, I  
3 think, Brian, were you volunteering to help?

4 DR. DeBUSK: If you look at the RMRVS and the  
5 RVUs for any given CPT code, you can unwind that and  
6 actually look at the pre-service time, the inter-service,  
7 and the post. So what you -- I think the thing -- because  
8 I've talked to you about this before. You basically just  
9 unwind the RVUs and look at how many hours or minutes,  
10 technically, the surgeon earned by performing those CPT  
11 codes, and then you simply look at basically a time card,  
12 how many hours did they work, and you look at that ratio,  
13 that discrepancy.

14 DR. MILLER: But that's what we did.

15 DR. DeBUSK: That's what you did.

16 DR. MILLER: Right, which I'm still not sure --

17 DR. DeBUSK: That's your top-down approach.

18 MR. PYENSON: That clarifies it because the time  
19 card would show 8 hours and not 24 hours. The time card  
20 would clock in and clock out.

21 DR. MILLER: Yeah. And we're using that in a  
22 stylized way, but yes. But the thing is that that data is

1 not available. We have a small micro study that did that,  
2 and just one more time -- and I just want you to nod when I  
3 do this to make sure we're communicating to each other. In  
4 his example, he said there was the time assumed in the fee  
5 schedule, and then there's the time card over here. No  
6 matter how much time I spent with that patient, the bill is  
7 implying that I have a fixed time, no matter how much time  
8 I spent.

9 MR. PYENSON: Correct.

10 DR. MILLER: We're good on that, right?

11 MR. PYENSON: Yeah.

12 DR. MILLER: Okay. sorry.

13 MR. PYENSON: Last clarification. Are there  
14 enough palliative care physicians to have palliative care  
15 listed as primary care?

16 MR. WINTER: I think we'd have to check if --  
17 that is, if palliative care is a distinct specialty code in  
18 the claims data -- I think it is. I think it's hospice and  
19 palliative care together.

20 Kevin is looking right now.

21 DR. HAYES: We're not sure.

22 MR. WINTER: We're not sure. So we'll have to

1 get back to you on that.

2           And if it's not, I think it would be hard to  
3 identify with the claims data, but we'll look into it.

4           MR. PYENSON: Thank you.

5           DR. CROSSON: Kathy.

6           MS. BUTO: Yeah. So, I'm trying to understand,  
7 because I liked your analysis of, you know, actual time  
8 versus time assumed and the different fee schedule  
9 services. But I'm trying to understand how much of a role  
10 time plays in the payment rate. And I'm assuming that time  
11 plays a greater role in things like E&M services, at least  
12 it used to, I think, and that skill and whatever the other  
13 characteristics of the work are, play a greater role in  
14 other services.

15           So I'm trying to understand how you did -- you  
16 did just a straight comparison of time, actual time, versus  
17 assumed time in each of the services. Right? But does  
18 time play a significant role in the payment rate? So if we  
19 corrected for that, it would make a big different across  
20 the board, or just in the time-heavy codes?

21           DR. HAYES: If you look in your mailing materials  
22 -- do you have your paper from -- that we sent you?

1 MS. BUTO: Yep, I do.

2 DR. HAYES: If you look at page nine, Figure 1,  
3 you will see there the result of an analysis where we tried  
4 to show how important time is relative to intensity. All  
5 right? And so one way to think about those figures in  
6 there, you can see how time, as a factor, you know, ranges  
7 from 79 percent to 77 percent, and that's pretty uniform  
8 across services. You know, so the office visits, for  
9 example, are in that E&M category --

10 MS. BUTO: Yeah.

11 DR. HAYES: -- and then we've got some -- and all  
12 that's telling you is that if you know how long a service  
13 takes to perform, you've got quite a bit of confidence that  
14 you know what the relative value unit is going to be for  
15 that service, and that finding holds pretty much across the  
16 board for all categories.

17 Now what that's not saying is that all services  
18 are assumed to take the same amount of time. It's just  
19 that, right --

20 MS. BUTO: You're saying as a proportion of the  
21 total work value.

22 DR. HAYES: Right.

1 MS. BUTO: That's a percentage --

2 DR. HAYES: Exactly.

3 MS. BUTO: -- assigned to time.

4 DR. HAYES: That's right.

5 MS. BUTO: Okay. So --

6 DR. HAYES: And so if you -- so time -- if you

7 get the time right --

8 MS. BUTO: Yeah.

9 DR. HAYES: -- then you have a good shot at  
10 getting the RVU right.

11 MS. BUTO: The overall RVU right.

12 DR. HAYES: Yeah.

13 MS. BUTO: Okay. Then on -- so I have a couple  
14 of questions from the mailing materials. Page 11, I think  
15 this related to someone else's question about productivity  
16 earlier. We talk about it's harder to increase the  
17 productivity, if you will, of primary care versus  
18 procedural services, and I have to say I'm not completely  
19 sure -- I know from the early experience with the fee  
20 schedule that E&M services grew much faster than procedural  
21 services, and that may have just been a function of they  
22 were underpaid even more, and so an increase in payment

1 then generated some utilization.

2           But I think the thing that troubled me about this  
3 comparison was we compared the growth in E&M service volume  
4 to the volume of tests in imaging, so the growth in those  
5 services. And yet I know that primary care physicians  
6 order tests and imaging. They either order it or sometimes  
7 they even provide it in the office. So it felt a little  
8 bit like a strange comparison, because we seem to want to  
9 use that to make the argument that, see, E&M is really --  
10 has a harder time generating income. And I'm wondering if  
11 we've thought about that relationship in making that  
12 comparison, between the E&M -- the primary care doc  
13 actually ordering tests and imaging and so on.

14           MR. WINTER: Okay. I hear what you're saying.  
15 So our main point there was that because E&M are labor-  
16 intensive codes that involve the clinician's time, in terms  
17 of getting the patient's history, performing an  
18 examination, making medical decisions, it is harder to do  
19 more per day than it is for procedures, or tests or  
20 imaging, which rely more on technology on non-physician  
21 clinicians to operate the equipment, for example, and where  
22 there are more opportunities to improve productivity.



1           And then your other point was -- I think your  
2 main point was if primary care practitioners are also  
3 providing these other services, why would we be -- why do  
4 we think that the valuation of primary care is related to  
5 their income? And I think my answer would be primary care  
6 practitioners, they perform -- they get more of their  
7 revenue from primary care services, like E&M services, on  
8 average, than other specialty, or than all specialties put  
9 together, on average.

10           So primary care physicians, if you look at the  
11 prior slide, 54 percent of their revenue is from primary  
12 care services, most of which are E&M, which is on Figure 3  
13 on page 11 --

14           MS. BUTO: Mm-hmm.

15           MR. WINTER: -- that you were talking about. And  
16 across all specialties, that share is 29 percent. So  
17 because they're getting more of their revenue from services  
18 that do not lend themselves to productivity improvements,  
19 volume increases, we think that plays a role in lower  
20 compensation.

21           MS. BUTO: Right. And I think -- I guess, to my  
22 mind, the best point that's made by that comparison is that

1 it's important to capture the time and productivity  
2 improvements around procedures and tests and so on. That  
3 point is well made, and I think that example helps that.

4           What it doesn't help me, you know, get my mind  
5 around is, and, therefore, we need to figure out how to  
6 increase the incomes of primary care physicians in some way  
7 to compensate. I mean, to me, those are two different  
8 kinds of things.

9           But, anyway, that's just a Round 2 conclusion.

10           On page 17, back to Jay's point, do we have any  
11 data on what entered -- what factors medical students  
12 consider are important in choosing primary care versus a  
13 specialty or a procedural specialty, I guess? Do we have  
14 any information on that, because I think that would help  
15 with the analysis.

16           DR. HAYES: Yeah. This has come up before, and  
17 we will want to get back to you on the details of it. But  
18 certainly some aspects of medical practice influence  
19 specialty choice, outside of just the issue of  
20 compensation. So compensation is up near the top of the  
21 list in terms of factors, but it's also issues having to do  
22 with, you know, the satisfaction of doing a certain kind of

1 job, of performing a function that's interaction with  
2 peers. There's a number of factors like that and we will  
3 bring that back to you next time.

4 MS. BUTO: Okay.

5 DR. HAYES: But there's been some good research  
6 on that.

7 MS. BUTO: Good, and if you could also, just a  
8 sense of proportionality for the different factors --

9 DR. HAYES: Sure. Sure.

10 MS. BUTO: -- that would be helpful.

11 And then my last comment is about Slides 13 and  
12 15. So I thought that your Slide 13, which did the -- for  
13 instance, net impact by specialty group, 10.2 percent at  
14 the 30 percent increase level, positive impact on primary  
15 care payments, and then 14.4 percent for psychiatry. But  
16 on 15, I don't think we did -- and I wondered if you had --  
17 the same kind of breakdown as to impact by some of the key  
18 specialties.

19 MR. WINTER: We have not done that. We can do  
20 that for the future.

21 MS. BUTO: It should be -- isn't it higher, or is  
22 it not higher?

1 MR. WINTER: For primary care?

2 MS. BUTO: My first -- yeah -- my first glance at  
3 this, it says 3.6 billion, but at the, say, at the 30  
4 percent increase level, when 40 percent of physicians, I  
5 guess, are included. Is that right?

6 MR. WINTER: Yeah, so --

7 MS. BUTO: Or is it 40 percent of services?

8 MR. WINTER: It's clinicians who receive at least  
9 40 percent of their revenue --

10 MS. BUTO: Right.

11 MR. WINTER: -- from -- fee schedule revenue from  
12 primary care services. So it's not all clinicians. It's  
13 not all primary care clinicians. It's a subset. And --

14 MS. BUTO: Do you have the percentages in terms  
15 of what level of increase this represents for those --

16 MR. WINTER: I think it would be very similar, if  
17 not identical, to what you see here on the 10 percent  
18 level. So taking the 10 percent column, look at primary  
19 care, on -- their revenue goes up by 3.4 percent, because  
20 in this case they're all getting the 10 percent increase  
21 for their primary care services. And if you go to Slide  
22 15, those clinicians that qualify for the increase --

1 MS. BUTO: Mm-hmm.

2 MR. WINTER: -- are probably getting in the range  
3 of that same 3-point -- what did I say? -- 3.4 percent.  
4 Now there's going to be some differences probably the  
5 distribution of clinicians -- these clinicians here are  
6 getting more of their revenue from primary care. So I  
7 would say 3.4 percent is the floor. It's probably going to  
8 be higher than that, and we can come back to you with that  
9 information.

10 MS. BUTO: Could you? That would be helpful.

11 MR. WINTER: Yes.

12 MS. BUTO: Thank you.

13 DR. CROSSON: David.

14 DR. NERENZ: Just two clarifying questions on  
15 terminology. If we can go to Slide 11, it's on the  
16 definition of primary care, I just want to be sure. If a  
17 patient sees a surgeon, a pre-surgical consult, and that's  
18 billed as E&M, that's called primary care here?

19 MR. WINTER: Assuming it's an office visit --

20 DR. NERENZ: Yes.

21 MR. WINTER: -- which it probably would be, yes.

22 DR. NERENZ: Primary care. And a follow-up

1 visit, outside the global window, same surgeon, same  
2 office, that's called primary care.

3 MR. WINTER: Yes.

4 DR. NERENZ: Any specialist, one-time consult,  
5 that's called primary care.

6 MR. WINTER: Yes, if it's billed as an E&M.

7 DR. NERENZ: Billed as E&M.

8 MR. WINTER: Yes.

9 DR. NERENZ: Is there any distinction, then, in  
10 terminology between primary care and E&M, for this  
11 discussion?

12 MR. WINTER: Yes, because we are including a  
13 certain set of E&M codes as primary care. We are excluding  
14 inpatient E&M visits --

15 DR. NERENZ: Okay.

16 MR. WINTER: -- and ED, emergency E&M visits.

17 DR. NERENZ: Thank you.

18 MR. WINTER: Those are outside the definition.

19 DR. NERENZ: That was not clear, but if it's an  
20 office visit, no matter -- all those examples I gave, those  
21 are called primary care.

22 MR. WINTER: Yes. We'll clarify that.

1 DR. NERENZ: All right. Slide 16, distributed.  
2 I don't understand this. The options in front of us are  
3 about enhancements to the fee schedule, which basically  
4 suggests you perform a visit, you bill the E&M code, you  
5 get an enhanced payment. Not seemed to me that was pretty  
6 simple. Then you get a check, eventually.

7 So distributed suggests that there's a second  
8 step in this, somehow separate, that -- and I don't  
9 understand what -- how that would work. So if I'm a  
10 physician and let's say in a month I do a whole bunch of  
11 E&M visits and now in this model I get an enhanced -- well,  
12 that the question. Do I get an enhanced payment from that  
13 billing or is it held in some kind of pool or something and  
14 then distributed separately? I just don't know what  
15 "distributed" means.

16 MR. WINTER: Okay. So service-by-service basis  
17 would mean -- it's essentially what you said. If you bill  
18 for an E&M visit and you meet the criteria, you qualify for  
19 the bonus or the enhanced payment, you just get a higher  
20 E&M payment. Okay? That's the simplest example.

21 The other way of doing it is to take that money,  
22 pool it together, and distribute it to the same clinician

1 based on the number of beneficiaries that are attributed to  
2 them. So if they're attributed 10 beneficiaries and you  
3 figure out the average amount per beneficiary, that's what  
4 they get on a monthly basis. And you could do that either  
5 prospectively, based on estimate of the beneficiaries they  
6 treated in a prior year, or you could do it  
7 retrospectively, or a combination of the two, and settle  
8 up.

9 DR. NERENZ: Okay. So then to generate the money  
10 to be distributed, I need to do office visits, but then I  
11 may get the money, supposedly to do something else, but I'm  
12 not billing E&M codes for those other things, like the back  
13 room care coordination.

14 DR. MILLER: Okay. So we've talked about this in  
15 a past discussion of primary care, and I can't remember. I  
16 think -- I thought you were here but maybe you weren't.

17 So there's -- whether we use the word -- let's  
18 just use the word "pay," okay? So either it's a model  
19 where you say, I'm going to do an add-on based on some  
20 criteria. So let's just say we've come to some agreement,  
21 you know, some set of -- some amount, some set of services,  
22 E&M, primary care, and some set of providers. And one way



1 you get the money to them is every time you bill a service  
2 you get a bump up. Okay? That's the conversation you just  
3 had.

4 In other conversations, particularly when they  
5 were focused on primary care, many Commissioners said,  
6 well, I don't want it to be service-specific because I want  
7 the primary care physician to have more resources, but not  
8 necessarily to have all that time booked up in visits, so  
9 that they can do coordination. So then what you would say  
10 is, calculate the add-on that would have occurred on each  
11 check and just sum it up and say, I'll give it to you on a  
12 per-person basis, either at the beginning or the end of the  
13 year, or as Ariel said, some combination of the two, and  
14 you deliver it on patient count instead of service count.

15 DR. NERENZ: Yeah, except -- well, I mean, I'm  
16 probably slipping into Round 2. I still don't understand  
17 it because the only way I generate any money to be  
18 distributed is by doing more visits. It has nothing to do  
19 with how many people I see.

20 MR. WINTER: So I think the pool of dollars --  
21 the total pool of dollars available for this per  
22 beneficiary payment would be based on, I think, the number

1 of -- the total dollars billed for E&M primary care  
2 services, let's say, in a prior year. Right? And then you  
3 distribute that money -- you divided that total pool of  
4 dollars by the number of beneficiaries who are receiving  
5 those services, and then you attribute those beneficiaries  
6 to primary care clinicians, and based on that attribution  
7 determines how many -- how much of that pool they get, each  
8 of those clinicians gets.

9           And as long as there's still some E&M services  
10 being generated -- and I would assume there would be,  
11 because we do not expect -- we do not anticipate that this  
12 per beneficiary payment would replace all E&M office  
13 visits. Right? We expect it would supplement what -- it  
14 would -- pay for service is that either they are already  
15 providing or hopefully provide, now that they have this per  
16 beneficiary payment, but they would still be providing  
17 office visits, so they will still be generating revenue  
18 that could be then distributed in the following year to  
19 clinicians who are providing primary care services.

20           DR. NERENZ: Okay. Well, that was something I  
21 guess I didn't pick up, this idea of a lag year, and I  
22 think you implied maybe something about grouping, or is

1 this still purely at the level of the individual physician?

2 MR. WINTER: I was going back to our 2015  
3 recommendation on per beneficiary payment, and, Kevin,  
4 correct me if I'm wrong but my understanding was we  
5 determined a pool of dollars, which at that point was about  
6 \$700 million as a starting point, and the way we distribute  
7 it -- I'm sorry, the way we paid it out to clinicians was  
8 based on clinicians who met the criteria for participating  
9 in the PCIP. That is, they had a designated specialty  
10 within primary care, and they provided at least -- they  
11 derived at least 60 percent of their fee schedule revenue  
12 from primary care services in a prior year. And then we  
13 had a mechanism for attributing patients, beneficiaries, to  
14 those clinicians.

15 MS. BUTO: But Ariel --

16 MR. WINTER: And that determined how the dollars  
17 were allocated.

18 MS. BUTO: I think just to be clear, if I'm  
19 hearing you correctly, that pool of dollars, the \$700  
20 million --

21 MR. WINTER: Yes.

22 MS. BUTO: -- wasn't just the -- obviously not

1 just the individual physicians' pool of dollars, but you  
2 pooled all the physicians who met that -- those criteria  
3 and then you did a per beneficiary amount, which then got  
4 paid out.

5 I think -- what you've just pointed out raises a  
6 question of maybe some duplicate payment, but I guess we  
7 can get into that later.

8 MR. WINTER: Yeah, and there are probably other  
9 ways of thinking about it, but I was thinking about the  
10 model -- I was talking about the model that was part of our  
11 -- that was discussed as part of our recommendation.

12 DR. CROSSON: Okay. We've got -- Dana, do you  
13 have a point on this point?

14 DR. SAFRAN: Just a really quick clarification.  
15 So that last bit of conversation raised this question for  
16 me, but I think it might have also answered it. How do you  
17 differentiate internal medicine doctors who have a  
18 subspecialty but mostly they're functioning as primary care  
19 versus mostly they're functioning in that specialty? If we  
20 want to go with your Approach 2, and we really wanted this,  
21 is the answer to that your attribution model, is how you  
22 differentiate the cardiologists who are really functioning

1 as a cardiologist versus a cardiologist who is functioning  
2 most of the time as primary care but they happen to have a  
3 cardiology subspecialty?

4 MR. WINTER: So, in the second approach they  
5 would have to meet two criteria. One is they would have to  
6 be -- their designated specialty would have to be a primary  
7 care specialty, so it could not be cardiology, right? Plus  
8 they would have to meet this threshold of sharable allowed  
9 charges related to primary care.

10 And so if you had an internal medicine -- a  
11 physician who had enrolled with Medicare as internal  
12 medicine, right, and they met this threshold for sharable  
13 allowed charges related to primary care, which indicated  
14 they were truly focused on primary care services, they  
15 would be in. They would be eligible for this bonus. But  
16 if they were subspecializing in cardiology, and most of  
17 their revenue is derived from cardiac testing, let's say,  
18 then they would not be eligible. Does that help?

19 DR. SAFRAN: Yes. Thank you.

20 DR. CROSSON: Alice.

21 DR. COOMBS: Two questions. I'll be brief. So  
22 someone who is a family practice doc who follows their

1 patient in the hospital, does an E&M code, that's not  
2 considered part of the primary care.

3 MR. WINTER: No. So, I mean, that E&M code was  
4 billed --

5 DR. COOMBS: Even though they are --

6 MR. WINTER: -- for an inpatient setting.

7 DR. COOMBS: So even though they are primary  
8 care. And then on page 12, you have internal medicine at -  
9 - share of a fee schedule at -- I'm sorry, Slide 12 -- as  
10 45 percent. What are they doing in the other time? I  
11 mean, is it just that -- is that -- what do we say the  
12 proportion of other things is that are being done?

13 MR. WINTER: Right, so what other kinds of  
14 services are they doing -- is that the question.

15 DR. COOMBS: Mm-hmm.

16 MR. WINTER: So my guess is they're doing E&M  
17 visits in the ED setting, inpatient setting. I think they  
18 could be -- even though their specialty is internal  
19 medicine, they could be functioning as hospitalists, so it  
20 could be most of the revenue is from inpatient E&M visits.

21 DR. COOMBS: Mm-hmm.

22 MR. WINTER: They could be performing minor

1 procedures, imaging and tests, and we can drill down into  
2 this and get you more information --

3 DR. COOMBS: Okay.

4 MR. WINTER: -- from the claims data.

5 DR. COOMBS: Thank you.

6 DR. CROSSON: Craig.

7 DR. SAMITT: One suggestion and one question. I  
8 got intertwined in the whole descriptor of primary care  
9 services versus primary care clinicians, so I wonder if we  
10 want to use the term "non-acute E&M services" because  
11 that's essentially what we're talking about. The term  
12 "primary care" confuses things from my point of view.

13 My question is: Is it possible to get a  
14 comparative grid that is a combination of Slide 9 and Slide  
15 13? In particular, what I'm interested in is the  
16 comparator of the differential incomes by specialty versus  
17 the impact -- you don't have to pick all these columns --  
18 the impact of the model on that specialty. And, in  
19 essence, the reason I'm asking is I kind of want to see are  
20 there some higher-income disciplines that are actually  
21 going up as a result of this model. I think we lose stuff  
22 when we bundle it under non-surgical, non-procedural, and

1 so on and so forth. I think we need a level of granularity  
2 that says where are there high-income physicians that are  
3 also seeing a rise with this methodology, because that may  
4 drive to whether we like Approach 1 or Approach 2 better --  
5 unless we have that somewhere that I didn't see.

6 MR. WINTER: Yes. So we can do it on sort of by  
7 -- we tried to do it by specialty but not the individual  
8 clinician level, because we don't have their income data --

9 DR. SAMITT: No, no. I mean by specialty.

10 MR. WINTER: Okay.

11 DR. CROSSON: Okay. We're going to have a  
12 discussion now. Bring up the last slide if we don't have  
13 it already, Slide 17.

14 As I mentioned earlier, we have been at this for  
15 a long time. This is still an ongoing piece of work here.  
16 We're not going to come to conclusions in the short run,  
17 but we do need to continue to provide input to the staff in  
18 terms of preferential directions.

19 So what I'd ask folks to do -- and we do have to  
20 be rather direct and efficient here -- is to focus on these  
21 four bullet points, yes, no, and the like, and we've got  
22 three individuals who have asked to begin, Paul, Kathy, and



1 Alice. We'll start in that order with Paul.

2 DR. GINSBURG: Thanks. Ariel and Kevin, you did  
3 a really good job at documenting the distortions in the  
4 Medicare physician fee schedule and also the longevity, the  
5 whole history of MedPAC recommendations to fix it. But I  
6 spent a lot of time organizing a conference on the Medicare  
7 fee schedule. Very consistent with what you're talking  
8 about, you know, it has not been -- you know, the fee  
9 schedule is distorted. The problem is the updating  
10 process. There has been a slight degree of movement, but  
11 not a lot. So it brings up two main points I want to make  
12 about this.

13 One is that every time you used the word "primary  
14 care" and in the Commission's discussion we use "primary  
15 care," I was wincing because all of the evidence about the  
16 distortion of the fee schedule, it's not about primary  
17 care, whatever that means. It's about evaluation and  
18 management services. So that's what's being distorted.  
19 And, you know, I don't know which one -- I don't  
20 necessarily agree or disagree -- or maybe I don't agree too  
21 much with how you've -- which evaluation and management  
22 services are in primary care. But I think we should be

1 talking in terms of evaluation and management services.  
2 There are problems -- you know, there are real problems in  
3 the primary care workforce, problems which probably would  
4 have been much more severe if not for the recent growth of  
5 nurse practitioners and physician assistants, a fair amount  
6 of whose time goes into primary care. But I'm concerned  
7 about some of these specialties that do not have a lot of  
8 income from procedures, that they're being hurt as much. I  
9 think we can have problems with supply in those  
10 specialties, and that we should rebrand this from -- I  
11 mean, primary care is a politically hot topic, but I think  
12 we should be thinking in terms of evaluation and management  
13 services and those physicians who perform them.

14           What I could see doing is -- you know, this  
15 doesn't come up in Option 1, but in Option 2, I would want  
16 to include specialties which have a low proportion of  
17 income from procedures along with the primary care  
18 specialties because I think the case is sufficiently  
19 compelling.

20           The other point I want to make is that, you know,  
21 this 25-year experience with the Medicare fee schedule,  
22 somewhat unique among countries in the world, as I

1 understand it, is an attempt to use science and measurement  
2 to set relative values -- relative payments for physician  
3 services. And that's the way I would like it to be, but  
4 I'm really concerned about the results so far and the  
5 magnitude of the distortions and thinking that we may have  
6 to make some decisions not supported by measurement, just  
7 supported by judgments.

8           This is what the Congress did in the Affordable  
9 Care Act when they had the unfortunately temporary increase  
10 in payment rates for primary care services provided by  
11 primary care clinicians. I would have rather them do it  
12 permanently, would rather they had done it for evaluation  
13 and management services period. But in the sense I'm  
14 comfortable with diverging from the science-based approach  
15 to make ad hoc adjustments based on our judgments about  
16 access to care, supply physicians in different specialties.  
17 So I'm really very comfortable with these options of going  
18 outside the measurement.

19           DR. CROSSON: Thank you. Kathy.

20           MS. BUTO: So I'm not so comfortable with the  
21 approach. I think the chapter highlights the issues of  
22 income disparity and concern about attracting physicians to

1 -- wince, wince -- primary care. I don't think at its best  
2 that the solution of raising fees is really -- again, this  
3 is my judgment -- at the core of the problem with the  
4 disparity, that, yes, I think fees should be adjusted to  
5 take into account overpriced procedures and looking to  
6 value those more appropriately, including those that have  
7 time built into them that productivity has since, you know,  
8 overcome.

9           But that to me is just a baby step because I  
10 think the issue is bigger and goes to the fact that primary  
11 care or -- it's really primary care, or management of  
12 patients by some physician, be they endocrinologists or  
13 family practice physicians, that that is kind of at the  
14 core and at the hub of what the Medicare program does or  
15 supports, and that the spokes are things like  
16 hospitalization, post-acute care, specialty care, and so  
17 on.

18           I think the fundamental problem is that Medicare  
19 has never fully recognized that critical role and signaled  
20 that it's an important role and ought to be rewarded  
21 justly. I think you can get to that reward through more of  
22 a per beneficiary payment. I don't think, having thought

1 about this a lot recently, that you can do it for all  
2 primary care physicians or even those other specialties who  
3 do a lot of E&M services. I think you would need to start  
4 more in a more targeted way looking at can we improve the  
5 management of the most difficult patients, maybe modeled  
6 after the monthly capitation payment for ESRD, so maybe a  
7 monthly capitation payment for endocrinologists or for  
8 rheumatologists or for some of the other specialties like  
9 that.

10 I don't think the paper makes a compelling case  
11 that E&M services are actually per service underpaid. I  
12 think there is some good arguments in there, and I think we  
13 should be about the business of trying to make those fees  
14 and that fee schedule better. But I really don't -- I  
15 guess I can't yet get to the point where Paul is where I'm  
16 willing to just make a judgment call about how much higher  
17 payments should be, because I don't know where the ceiling  
18 is for that. I don't know where we decide primary care  
19 physicians are being paid salaries or their income is high  
20 enough in comparison to proceduralists. I just don't know  
21 where that is, and I'm not convinced that proceduralists  
22 shouldn't be paid more for some things.

1           So I'm struggling with that idea, and so,  
2 consequently, I'm queasy about assigning an arbitrary  
3 percentage increase, 10, 20, or 30 percent, and then taking  
4 reductions in fees from every other service or every other  
5 physician. So, really, that's my major concern.

6           What I would like to support is that  
7 directionally I think we all feel that these services, E&M  
8 services, and primary care physicians, that we ought to  
9 address some of the inequities in the way fees have been  
10 computed and not updated, et cetera.

11           What I'd like to see us do potentially in the  
12 next phase is something that looks a little bit more like  
13 partial capitation, as I've already alluded to, with the  
14 goal of increasing and highlighting the central role of  
15 management and of primary care. And so, again, I think we  
16 could start with some of those really difficult chronic  
17 diseases, and I think that helps to address concerns about  
18 risk adjustment. If you take individuals who have certain  
19 characteristics, diabetics that, you know, meet certain  
20 criteria, or people with severe autoimmune disease or  
21 something like that, you have less of an issue of having to  
22 risk-adjust -- develop an adjustment mechanism across all

1 patients. And then, secondly, I think it also will help  
2 focus not just risk adjustment but help us focus better on  
3 what that payment should be so it's more uniform across  
4 patients.

5           You can also then be pretty specific about what's  
6 in that bundle and what's not in that bundle. When we were  
7 talking at the last round, the issue of, yes, you could go  
8 with a per beneficiary kind of primary care distribution of  
9 payments, but then what's outside of that gets to be pretty  
10 murky. I think it's really hard to navigate that, and I  
11 would just imagine, you know, opportunities for abuse are  
12 there.

13           So I'll just finish by saying that I do think we  
14 can go quite a way -- and you've done a lot of good work in  
15 this area -- to address some of the real inequities in the  
16 fee schedule itself. But I would hope that we could go  
17 beyond that and look at, you know, a much more  
18 comprehensive approach that will raise both the position  
19 and the funding for managing patients to a higher level.  
20 And I think you could get there step-wise. You wouldn't  
21 have to do everybody at once.

22           DR. GINSBURG: Excuse me. Can I answer one of

1 Kathy's points?

2 DR. CROSSON: Please, but let's not have  
3 arguments back and forth.

4 DR. GINSBURG: Sure. I just want to say, Kathy,  
5 I think that we could come up with or the staff could come  
6 up with an estimate of the magnitude of the distortions  
7 that we have now. There's a lot of evidence that could be  
8 used so we're not flying blind in saying -- I mean, it  
9 could be -- my first choice would be to get the update  
10 process fixed up, use better data to recalibrate the fee  
11 schedule, and continue to do it science-based. But in a  
12 sense, if that doesn't happen, I could see using our best  
13 analysis of the magnitude of the distortions and saying,  
14 well, there's this distortion, Congress has shown  
15 willingness to make judgments and, you know, it's our  
16 second choice but let's do that.

17 MS. BUTO: Yeah, and I agree with you, Paul. I  
18 think, you know, we do coding creep adjustments. With MA  
19 plans, we've looked at creep and I think the risk  
20 adjustment mechanism. So I think that is a possible route,  
21 and I would feel very comfortable with that.

22 The one thing I forgot to mention that you



1 reminded me of is this whole issue of how do you enroll  
2 patients in a model where somebody is managing their care.  
3 And if you start with the most difficult cases and they're  
4 fairly uniform, I think the way I imagine it possibly could  
5 be done is to offer those beneficiaries with those  
6 difficult chronic conditions sort of an extra benefit. So  
7 you'll have the additional benefit, and we'll allow you to  
8 do this. You know, we'll ask you to elect among these  
9 physicians or among the physicians that meet these criteria  
10 to be that person, your go-to person for a variety of  
11 things. And I think we'd be surprised at how many  
12 beneficiaries would like that kind of option, particularly  
13 if they have multiple chronic conditions and can't figure  
14 out how to navigate.

15           So I don't think you have to start big. I think  
16 you could start fairly small.

17           DR. CROSSON: Alice.

18           DR. COOMBS: So the title of this presentation  
19 was "Rebalancing the Fee Schedule for Primary Care." I  
20 want to drive us back home. But we've had a discussion  
21 around the table that has varied from everything to  
22 increasing primary care physicians, increasing primary care

1 services, and I think we'd like to have all of those things  
2 together. But for the number one bullet that's up there, I  
3 think that I would vote in favor of that for services. And  
4 I just wanted to read a couple of recent data points.

5           So for M.D. to A.P., advanced practice nursing,  
6 the ratio is expected to go from 3.6:1 to half of that by  
7 2030. So there is rapidly increasing mid-levels. I think,  
8 Amy, you asked that question. For M.D. to P.A., in 2015 it  
9 was 7:2, and it's going to go to 3.5 to -- half of that.  
10 So rapidly increasing mid-level primary care influence is  
11 going to make a difference, I think, with some of the  
12 workforce issues. However, the AAMC has indicated that we  
13 are somewhere in the vicinity of 7,000 to 43,000 deficit in  
14 primary care.

15           So the question is: Do we want to do something  
16 to incentivize primary care workforce? And today in the  
17 New England Journal of Medicine, November 2nd, comes out in  
18 answer to our problem, but I don't know if we're going to  
19 be that cagey to deal with it, and that is, looking at  
20 primary care spending rate, which is a very different  
21 notion, and they've actually done this in the National  
22 Health Service in the U.K., and they looked at the absolute

1 percentage of all your dollars and how much is put forth  
2 toward primary care.

3           With that being said, they've shown in Rhode  
4 Island that they've gone from 34 to 74 million poured into  
5 primary care, which gives them a primary care spending rate  
6 of about 10 percent, that their overall capital spending  
7 has gone down tremendously to a fraction, 0.6, compared to  
8 other New England areas.

9           So I'm wondering how we decide to look at the  
10 bucket of cash that's necessary to distribute amongst  
11 primary care services can be determined by doing a  
12 calculation looking at how much money is poured into  
13 primary care. You could do that. I think that's not a  
14 hard thing to do. If you look at all the services and you  
15 say, okay, you know, the Medicare program is 570, 600  
16 billion, what percentage of that is actually put toward  
17 primary care?

18           Now, the innovative things that they did with the  
19 study is they actually looked at how they poured the money  
20 into primary care. It wasn't in fee-for-service and  
21 volume. It was in things like, you know, medical home. It  
22 was in loan repayment. And the very thing that would drive

1 primary care doctors to say, "I want to be a part of this  
2 whole process," it's a very different way of thinking, but  
3 it's definitely something that actually has proven in the  
4 National Health, in Oregon, in Rhode Island, and I think  
5 that it's a plausible thing. So I'd refer you to that.

6 In terms of Bullet 2, absolutely, and I think,  
7 you know, if you talk to psychiatrists, they have a  
8 reaction not just to Medicare but to Medicaid as well. How  
9 should payments be increased? And should higher payments  
10 be distributed on a per service per beneficiary basis? I  
11 agree with Kathy with the per member per month  
12 incentivizing overall more global care.

13 How much should it be increased by? I would take  
14 the benchmark of once you've figured out the primary care  
15 spending rate, look at the dollars and say how much needs  
16 to be poured back to reach these benchmarks. The U.K. is  
17 12 percent. We may not get to that. Rhode Island was 10  
18 percent. It's a number that actually lets you know that  
19 when you're pouring this amount of resources into the  
20 primary care world, maybe you'll get to a better place with  
21 the overall capital spending. And that's what our goal is.  
22 I mean, rebalancing the fee schedule is one piece of this,

1 but the big picture is how can we get to more cost  
2 efficiency in addition to taking care of the patient and  
3 getting better quality outcomes.

4 DR. CROSSON: Okay. We now are short of time.  
5 So we're going to have continued discussion, but I would  
6 ask people to be fairly direct in what you say. Otherwise,  
7 we risk running well over on this very busy day.

8 And let's start this end now. Craig.

9 DR. SAMITT: So just a quick sense of context, I  
10 thought of this again through the lens of the problem we're  
11 trying to solve, which is to stabilize primary care and  
12 address where we think there is a shortage of supply, and  
13 from my vantage point, that very much is in the primary  
14 care and mental health-related fields, especially if we  
15 believe that those are crucial services as we advance to  
16 population health and value.

17 So through that context, I would say that I am  
18 more inclined to support the targeted focus on primary care  
19 clinicians. I'd want to see the list that I asked for  
20 because, again, we're not trying to solve all of the  
21 inequities from specialty to specialty to specialty. If  
22 this is about population health transformation, it seems

1 like that's where the greatest need is, so I'm more  
2 inclined to say targeted. But it may be more than just  
3 primary care clinicians. I'd like to see if there are  
4 others, not all specialties.

5           Psychiatric services, yes. Payment increases, I  
6 think we'd start with your lower threshold, 10 percent. I  
7 mean, it seems like it's probably too aggressive and  
8 perhaps untenable to go higher, and then similar to Kathy,  
9 I would say per beneficiary.

10           I don't think I'd wait with any changes until we  
11 move to a more direct capitation model. I see this as a  
12 stop-gap measure. Hopefully, our ACO efforts and other  
13 strategies will move us more to population health. The  
14 reality is in certain population health settings, some  
15 high-performing systems pay their primary care physicians  
16 today more than they pay their specialists. So a movement  
17 to value may accomplish that, anyway. In the meanwhile, I  
18 think we have to correct some of the short-term imbalances.  
19 We bridge the gap through a PMPM focus as opposed to a per-  
20 service focus.

21           DR. CROSSON: Which I would remind people is the  
22 current standing policy of the Commission.

1 David.

2 DR. NERENZ: I'll be brief.

3 I do share many of Kathy's concerns about  
4 features of this, but let me just emphasize a couple  
5 things. As laid out for us, this strikes me as a very,  
6 very blunt instrument for trying to address the problem we  
7 have in front of us, particularly option 1. It basically  
8 says we're going to pay more for all the non-acute E&M  
9 services, and I absolutely agree with Paul's point. I  
10 don't think primary care is the right label for what we're  
11 talking about. I was trying to hint at that politely in my  
12 Round 1 question. And we're talking about a lot of things  
13 I'd never call primary care.

14 But we're basically saying we're going to pay  
15 more for all of that without differentiation, and then by  
16 rebound, we're going to pay less for everything else  
17 without differentiation.

18 I'm not convinced that everything under E&M is  
19 valuable or worth more money. Two examples, follow-up  
20 visits, whether it's following a procedure, following a  
21 medication change. I sit in these discussions all the  
22 time. There's no consensus usually about what the

1 appropriate follow-up interval is. There's on evidence-  
2 based guidelines, but here, we're saying more is better and  
3 we'll pay more, we want more. I worry about that, and I  
4 know others may feel differently. But I've seen two, three  
5 independent studies and analysis finding no value in the  
6 annual physical, so we'll pay more for that. Well, why?

7           So I'd certainly encourage us to be much more  
8 nuances and a lot more attention to where's the value  
9 within these categories, not just one big one up, one big  
10 one down.

11           And then second thing is I know we try to be  
12 behavioral economists here, but I worry a little bit about  
13 what happens sort of on the downside of this among the  
14 procedural specialists, when pay gets caught on a unit-of-  
15 service basis. A lot of places have fixed monthly practice  
16 budgets to hit or other kind of financial goals to hit.  
17 You take down the payment in each service; you're going to  
18 do more services. What else can -- and we've just said  
19 that it's relatively easy for proceduralists to do that.

20           So I'd have to put that in the mix as a concern.  
21 There's got to be some answer to that.

22           DR. CROSSON: And there's some evidence



1 historically that that's exactly what takes place.

2           Okay. Bruce.

3           MR. PYENSON: Thank you very much.

4           On a stop-gap measure, I would support items 1  
5 and 2 up there and the broader E&M approach. I recognize  
6 David does have a very good point on the -- many of the E&M  
7 services probably have no value.

8           However, on a broader issue, we're not going to  
9 reach the goals of reducing cost and improving value  
10 without having an expectation of productivity improvements  
11 reducing cost, and I think we have an opportunity here to  
12 institutionalize an expectation in the Medicare fee  
13 schedule for procedures, for virtually all procedures that  
14 productivity will increase.

15           The default assumption is that productivity  
16 doesn't increase. That's just wrong. So I think we should  
17 institutionalize in the recommendation an expectation that  
18 procedural productivity increases.

19           DR. CROSSON: Amy.

20           MS. BRICKER: Based on what Alice shared, I'm in  
21 support of, one, focused on the second primary care  
22 clinicians, not all, and two, do want to understand, again,

1 based on, again, using the data that Alice shared. If we  
2 don't have a mid-level problem, let's focus the resources  
3 on the physicians and what that would mean to pull mid-  
4 levels out of this from a financial perspective.

5 I don't have a sense of what the payment increase  
6 should be. It does feel a bit arbitrary. I think 10  
7 percent is a good start, and understanding what we think  
8 through that increase the outcomes would be, sort of what  
9 David said, behavioral economics.

10 I'm generally, though, in support of a shift, at  
11 least as a step one in a longer-term plan.

12 DR. MILLER: Can I get you just to say whether  
13 you have anything -- any feeling about service or per bene?  
14 I don't mean to put you on the spot, just in case you did.

15 MS. BRICKER: No, I don't -- if it's easy to do  
16 per bene, I think that's cleaner. I get the sense that  
17 it's everything that we construct is very difficult.

18 And the notion to just try to get funds allocated  
19 and out, it feels easier and cleaner on it per service, but  
20 then you could say, well, then things are just going to be  
21 abused. So I can see both sides of that, but --

22 DR. MILLER: So you would be fine with 5.

1 MS. BRICKER: Yeah, there you go.

2 DR. MILLER: Thank you.

3 DR. CROSSON: In case you haven't noticed, this  
4 Medicare business is pretty complicated.

5 [Laughter.]

6 DR. CROSSON: Virtually everything here --

7 David.

8 DR. GRABOWSKI: Similar to Craig, I want to think  
9 about what's the distortion we're trying to correct here.  
10 Is it that we underpay for E&M services, as Paul suggested,  
11 or is it that we have too few primary care physicians?  
12 Maybe both.

13 But I think the chapter and the problem we're  
14 trying to address here is really the latter. We have too  
15 few primary care physicians, and so I would definitely  
16 favor kind of targeting the second approach there going  
17 through the primary care docs.

18 I also would favor increasing payments for  
19 psychiatric services. I also wondered a little bit about  
20 geriatrics. I don't know if that's been discussed at prior  
21 meetings, but that's another area of shortage here that  
22 could potentially be addressed. And then the interaction

1 of the two, obviously geriatrics could be an area for  
2 targeting at well.

3 For the 32 issue, how much should payments be  
4 increased? I really think this comes back to my earlier  
5 comment. We want to know the response here. If you put  
6 more dollars into the system, what effect does that have in  
7 terms of entry, in terms of movement into primary care?

8 And then to David's point, what happens on kind  
9 of the other side there for non-primary care physicians and  
10 their shift in payments? I do think you want to look at  
11 this at a system level, but I would hope we could do some  
12 more sophisticated modeling around that behavioral response  
13 for a 10 percent increase. What's the corresponding change  
14 in the supply?

15 And finally, I would favor a per-beneficiary  
16 approach on that fourth question.

17 Thanks.

18 MR. WINTER: And, David, just to note that  
19 geriatric medicine is included in our definition of primary  
20 care clinicians.

21 DR. GRABOWSKI: And I just wanted to say whether  
22 there was something worth targeting in addition to that, if

1 that was above and beyond, but perhaps not.

2 Thanks.

3 DR. CROSSON: And just one note, I mean, you talk  
4 about modeling. It is a modeling question because in  
5 dealing with it experientially, given the timeline we're  
6 talking about of going through residency and training  
7 program or even before that, the expectations set in  
8 medical school and then training programs and fellowship  
9 and potentially -- we've got a pipeline length that's  
10 considerable. To get feedback from actually experience  
11 would be probably well beyond all of our times on this  
12 Commission, so it is a modeling issue. Yeah.

13 Dana.

14 DR. SAFRAN: Yeah. Thanks.

15 So I, too, find it most constructive to think  
16 about this through the lens of we're trying to solve access  
17 issues as opposed to we're trying to deal with payment  
18 distortions because I don't think we could deal with the  
19 latter without basically getting rid of the whole RVU  
20 system and trying something else, so that's probably a  
21 conversation for another day.

22 But in terms of solving the access problems, I

1 found what Paul said really interesting, but I don't know  
2 the data -- and I'd love to know it -- on whether we have  
3 evidence that other nonprocedural specialties are really  
4 struggling, dying off, having a hard time attracting folks,  
5 but we know that's been a problem for primary care.

6 I can say in our market where there's so much  
7 move towards population-based payment that that's been  
8 mitigated, that we see movement into primary care and some  
9 positive signs, so that's a good thing.

10 But I think primary care and psychiatric care,  
11 for sure we know that we have access issues, so I'm really  
12 in support. So that means on bullet 1, I like the more  
13 targeted approach.

14 It means I am a "yes" on No. 2, though I will  
15 mention that I'm not confident that we can get greater  
16 participation of psychiatrists in Medicare just by the  
17 moves that we're talking about making here because I think  
18 there's quite reasonable payments offered through  
19 commercial for psychiatrists in the market that I'm in, and  
20 still, it's not enough to keep up with what they can earn  
21 by just private pay. So I'm a little concerned that upping  
22 payment on No. 2 isn't going to help us with the

1 psychiatric access problem.

2           I don't know how much payment should be  
3 increased. I agree 10 percent sounds reasonable, but I  
4 think we shouldn't try to answer that question without  
5 trying to tie our thinking to MIP, to the whole MIPS and A-  
6 APM conversation because, you know, it does strike me as  
7 kind of ironic that we're sitting here talking about sort  
8 of doubling down on like the volume part of the incentives,  
9 and so that probably tells you my answer to the fourth,  
10 which his I would rather not put it in the fee schedule and  
11 rather have it be a PMPM.

12           But I also feel a little queasy about that PMPM  
13 having no performance basis to it. It's just for being in  
14 a particular specialty. So as a starting point, maybe it's  
15 just a PMPM, but I would like us to sort of have our eye on  
16 having that have some performance component to it.

17           DR. CROSSON: Great. Thank you.

18           Brian.

19           DR. DeBUSK: Well, I know we've talked about it a  
20 little bit in the past and touched on it today. I do think  
21 the situation with primary care is dire, dire.

22           To begin with, any solution that gets them more

1 money, whether it's approach 1 or approach 2, I'm on board  
2 with.

3           Having said that, Paul made a really good point  
4 in his opening remarks about trying to address the  
5 distortion in the fee schedule, and I do think if you don't  
6 address it using -- looking at the chronic care codes,  
7 TCMS, E&Ms -- well, primarily E&Ms, you're going to create  
8 these cliffs, where you're going to have, for example, an  
9 endocrinologist who acts a lot like a primary care  
10 physician based on his billing patterns and how he treats  
11 his patients, but he's not going to qualify under the  
12 targeted approach.

13           So I would caution you. I like the solution 1,  
14 is a little bit more "hit it over the head." It does  
15 address the distortion issue. I personally think it could  
16 be implemented more quickly because imagine if you work  
17 with solution 2, you're starting to think about, well, how  
18 do you pay the money out? Is it per member per month?  
19 Well, now you've bought all the attribution issues. What  
20 defines a patient on the panel?

21           To me, it just seems it would be like it would be  
22 much more technically simple to implement the approach 1,



1 considering that time is of the essence here. I mean, we  
2 are on a ticking clock.

3 And that's it. Thank you.

4 DR. CROSSON: Pat.

5 MS. WANG: Okay. If it were possible to solve  
6 this issue by fixing undervalued E&M codes, it would be  
7 great. If that's not going to happen, though, I don't  
8 think that we should let the perfect be the enemy of the  
9 good here.

10 My personal priority is very primary care  
11 practitioner physician-focused, and I think that I have --  
12 I'm a little bit more of a purist in what I consider to be  
13 primary care, so certainly approach 2.

14 A technical question, which I should have asked,  
15 which is whether the identification of this threshold of  
16 charges or fee schedule includes MA because docs who do --  
17 see, that to me, we should think about a little bit because  
18 I think that the goal there would be to identify, first  
19 identify what we consider to be potential primary care  
20 specialties, and I think it's general internists,  
21 geriatricians, primary care geriatricians, family practice,  
22 and then within that, this sort of threshold of primary

1 care practice. MA, I think is an issue about how you  
2 include that.

3 I think that the issue that people have raised  
4 here about sort of protecting what I consider to be  
5 specialties that practice or that delivery E&M services  
6 that people consider to be primary care, whether they're  
7 psychologists or endocrinologists or rheumatologists or  
8 whatever is a very slippery slope. And I think it's  
9 important instead of just getting everybody's favorite like  
10 whatever that they think of, it's whether there is  
11 something that we can look to in research that says this is  
12 the commonly defined universe of what's considered to be  
13 primary care.

14 And maybe these are the other specialties that  
15 have a very low volume of procedural services that we would  
16 want to exclude or treat differently from any payment  
17 reduction to fund the primary care bump.

18 Within the identification of what I would  
19 consider to be a real primary care doctor who -- that's  
20 what they do -- I would give differential treatment even  
21 within that to primary care geriatricians. I really every  
22 day believe that my Medicare members would be a lot better

1 off if we could have more geriatricians taking care of  
2 them.

3           A lot of what family docs and internists and  
4 specialist who provide a lot of E&M services struggle to  
5 do, I think is what primary care geriatricians do. It's  
6 what they're trained to do. It takes an enormous amount of  
7 time for them to do what they do, but I really believe that  
8 the Medicare program has a direct interest in trying to  
9 invest in that particular specialty, so I would actually --  
10 if anybody were to give a bigger bump, I would try to do  
11 that to encourage more people to go in. There aren't very  
12 many geriatricians in the country, frankly.

13           For psychiatry, you know, I have to say unless we  
14 really think that increasing the fee schedule is going to  
15 increase participation in Medicare, I wouldn't do it. I  
16 think that the issues that people have talked about that it  
17 is much more complex, I'm sure the fee schedule is part of  
18 it, but that there are other compelling reasons that  
19 psychiatrists do not participate in insurance including  
20 Medicare. And I think that I'd want to know that doing a  
21 fee schedule bump would actually increase that level of  
22 participation so that it's more intentional.

1           And finally, in terms of how should the payment  
2 be distributed, I'm honestly kind of indifferent. I think  
3 whatever is easiest to implement is the way it should go.

4           DR. CROSSON: Thank you, Pat.  
5           Warner.

6           MR. THOMAS: I'll be brief. I would agree with  
7 approach No. 2. I think anything that gets more funds into  
8 primary care is going to be favorable.

9           I do think having some of those funds going to  
10 psychiatric care is important. I hear Dana and Pat's point  
11 on is that really going to make a difference, but I do  
12 think it will -- we need to try to attract more folks into  
13 this area, and I think there are a lot of reasons behind  
14 it. But I do think compensation is part of that.

15           As far as the level, just looking at the 10  
16 percent versus 20 -- actually, if you went 15 percent, it  
17 would actually put the impact of primary care to about 5  
18 percent, which may be an interesting middle ground to  
19 something to consider and think about.

20           I would agree with Pat. I think whether it's on  
21 a per beneficiary or per service, I would encourage to just  
22 go the most simplistic route.

1           I would agree with Alice that mid-levels are  
2 usually not an issue from a supply perspective. So I think  
3 if you could exclude them, if that can be done in a  
4 simplistic fashion, I think that would be fine. I really  
5 think we need these dollars targeted to physicians.

6           DR. CROSSON: Rita.

7           DR. REDBERG: I will also be brief because I  
8 agree with a lot of what's already been said.

9           I really support the shift in payment to primary  
10 care. I like approach 2.

11           I do prefer the per-beneficiary basis because I  
12 think it will encourage more innovation. Like we'll be  
13 talking later about telehealth and non-face-to-face issues.

14           With the payment rates for all specialties versus  
15 just primary care, I will say, as a cardiologist, I do  
16 primary care, and currently, I can spend an hour talking to  
17 a patient with new onset angina about medications,  
18 lifestyle changes, lots of things, but if I went to the  
19 cath lab and put a stent in, I would get paid a whole lot  
20 more, and I don't think we want to have that kind of  
21 imbalance, though it's not just primary care where we see  
22 the imbalance. I think you want to recognize that a lot of

1 specialties can provide really important E&M.

2 DR. CROSSON: Thank you, Rita.

3 Jack.

4 DR. HOADLEY: So I like the way Paul originally  
5 sort of framed some of this. I think a lot of this, what  
6 we're really -- what I think I'm trying to do here is look  
7 at the imbalance in the fee schedule, which is why I would  
8 apply it more. I would take approach -- the approach -- I  
9 guess it's No. 1 -- the primary care services provided by  
10 all specialties, including the PAs and MPs and so forth, in  
11 this.

12 I think maybe one way to add some measurement or  
13 another way to sort of present some data that might help us  
14 -- you have given us sort of averages for some of these  
15 other specialties like endocrinology. We might also look  
16 at what's the share of the physicians in those specialties  
17 who are over some threshold like 50 percent or 75 percent  
18 or whatever is a logical number, they're doing primary  
19 care, because I think as somebody said before, maybe the  
20 cardiologists are divided between the ones who mostly only  
21 go do procedures, and then maybe it's only a subset who do  
22 a lot of this. And I realize that the breakout you're

1 proposing would use that, but this would give us a sense  
2 of, well, it's a tiny subset of this specialty that's going  
3 to qualify under these rules. I think that just would be a  
4 helpful way to think of it.

5           And whether there's any data we have on who  
6 beneficiaries see or who they regard as their -- we used to  
7 use the term their "primary doctor," not their primary care  
8 doctor, but the one they mostly go to for just general  
9 things, and whether there's any way in the data to sort of  
10 pull out is there one doctor they see the most or from some  
11 other survey kinds of things, just the other ways to get a  
12 sense of where others are playing that sort of primary care  
13 role.

14           To the other bullet questions, I'd say yes on the  
15 psychiatric services. Like many of us, I'm not sure where  
16 to go on the amount of the increase.

17           I would side with the per service partly for the  
18 ease of doing it, but I also think the attribution issues  
19 could get pretty complicated, partly because of some of  
20 those things I was just talking about. Are you going to  
21 pick up a beneficiary who just saw that primary care doctor  
22 once, but that's not really who they spend most of their

1 time with or go to for sort of general things? And I think  
2 it's just going to get complicated to try to think about  
3 attribution.

4 DR. CROSSON: Okay. Thank you, Jack.

5 In summary --

6 [Laughter.]

7 DR. MILLER: Well, this, I got to see. Go ahead.

8 DR. CROSSON: I'm sorry. Alice, you have one  
9 last point?

10 DR. COOMBS: Yeah, just real quick, three  
11 seconds.

12 What he just said, it makes a lot of sense in  
13 terms of if you were a neurologist and you reached a  
14 certain benchmark, maybe not the 40, maybe the 70, but I  
15 think that's an important point. I agree with you.

16 DR. CROSSON: I do think that we have a pretty  
17 rough agreement that there is an issue that needs to be  
18 addressed. I heard some variances of that. I do.

19 And I think this discussion, although we have had  
20 a lot of different perspectives here at least, it will be  
21 helpful to the staff in terms of prioritizing the next set  
22 of discussions.



1           As I said when we began this, this has taken us a  
2 long time. We've been at this. We have a standing  
3 recommendation that calls for a per-beneficiary payment for  
4 primary care physicians providing primary care services.  
5 This has not been taken up by the Congress so far. So the  
6 recommendation we made some years ago, which provided a 10  
7 percent increase for primary care physicians, has not been  
8 replaced.

9           On the other hand, I think this discussion has  
10 been very helpful in pointing out the complexity of the  
11 situation, and quite simply, I think we are going to have  
12 to spend more time on this to try to come to a point where  
13 we can come back and either just simply reaffirm our  
14 current position or augment that with some more detailed  
15 thoughts that might be helpful to the Congress.

16           I anticipate us discussing this off and on  
17 throughout this cycle and perhaps well into the next cycle.

18           So thank you for your points. They will all be  
19 taken into consideration, and the next time we come back,  
20 maybe we can get to a little bit of a sharper focus.

21           So, Ariel, Kevin, thank you very much for that  
22 presentation, and we'll move on to the next discussion.

1 [Pause.]

2 DR. CROSSON: Okay. I think we can move on to  
3 the next presentation, try to catch up a little time here.

4 Carol Carter is here with us in the dedicated  
5 Carol Carter seat to bring us back to the post-acute care  
6 issue, and we're going to talk a little bit about a topic  
7 that I think Kathy has brought up over time here, which is  
8 given the importance and the potential impact of our  
9 broader recommendation with respect to unified post-acute-  
10 care service payment system, are there things that we  
11 should be doing in the shorter run to deal with some  
12 distortions in the provision of services and, therefore,  
13 Medicare costs within specific post-acute-care settings?  
14 So if I haven't given your presentation, take it from the  
15 top.

16 DR. CARTER: Okay. As Jay said, today we are  
17 going to be talking about a way to use the post-acute-care  
18 Prospective Payment System design as a way to increase the  
19 equity of payments within each post-acute-care setting.  
20 I'll outline the approach and then ask if we should include  
21 it in our evaluation of the adequacy of Medicare's payments  
22 at next month's meeting. In this work, post-acute care

1 includes care furnished by home health agencies, skilled  
2 nursing facilities, inpatient rehabilitation facilities,  
3 and long-term care.

4 I'll start with a review of the goals of the  
5 Commission's payment recommendations and outline our  
6 concerns about the current payment systems for post-acute  
7 care. Then I'll briefly summarize our work on a unified  
8 PAC PPS and describe how one element of the design could be  
9 integrated into each setting's payments as a way to  
10 increase the equity of payments within each setting.

11 You may ask why we would want to do this before  
12 implementing the unified payment system, and there are  
13 several good reasons to do it. First, it would begin to  
14 correct the known biases of the current payment systems and  
15 redistribute and increase the equity of payments within  
16 each setting. Providers would have less reason to prefer  
17 to treat certain types of patients and avoid others, like  
18 medically complex patients. It would also encourage  
19 providers to begin to make the changes that they will want  
20 to make to be successful under a unified PAC PPS. And,  
21 last, it would support recommendations that would better  
22 align payments to costs without undesirable impacts. Some

1 of you will recall that in past years, the Commission has  
2 at times been constrained in its update recommendations  
3 because of the wide disparities in financial performance  
4 across providers.

5           By law, each year the Commission has two goals in  
6 mind when it reports on Medicare's fee-for-service payment  
7 systems. First, it considers the level of payments and  
8 evaluates whether total payments to a setting are adequate  
9 to ensure beneficiary access while protecting taxpayers and  
10 the long-run sustainability of the program. Second, the  
11 Commission considers changes to the payment systems to  
12 improve payment accuracy and equity. Payments need to be  
13 aligned with the costs of care for all types of conditions  
14 so that providers have minimal financial incentive to  
15 prefer to treat some beneficiaries over others. Making  
16 recommendations to correct the known biases and distortions  
17 in the payment systems is another dimension of the work we  
18 do on payment adequacy and their accuracy. The accuracy of  
19 fee-for-service payments carries over to MA plans and  
20 alternative payment models, such as ACOs and bundled  
21 payments, since fee-for-service costs and service use form  
22 the basis of MA benchmarks and APM payments.

1           For many years, the Commission has raised  
2 concerns about Medicare's current Prospective Payment  
3 Systems for PAC. First, the level of program spending is  
4 high relative to the cost of care, with Medicare margins in  
5 the double digits for three of the settings.

6           Second, the current payment systems have one or  
7 more of the following shortcomings. They encourage  
8 providers to: furnish therapy unrelated to patient care  
9 needs; prefer to treat some types of patients and avoid  
10 medically complex patients; extend lengths of stay to avoid  
11 short-stay payments or, in the case of SNFs, to extent  
12 their stays; and, last, to code clinical conditions and  
13 frailty to raise their payments.

14           Partly reflecting differences in providers'  
15 practices, the financial performance of providers differs  
16 widely. For example, there is more than a 10-percentage-  
17 point difference in the Medicare margins for nonprofit and  
18 for-profit SNFs and more than a 20-point difference between  
19 nonprofit and for-profit IRFs. The Commission has made  
20 recommendations to correct all of these shortcomings in the  
21 past.

22           Other concerns about post-acute care have framed

1 the Commission's discussions of the need to reform the way  
2 Medicare pays for these services. First, similar  
3 beneficiaries can be treated in each of the four settings,  
4 but Medicare uses separate payment systems for each that  
5 can result in quite different payments. Further, there are  
6 few evidence-based guidelines for post-acute care, so it's  
7 not always clear when this care is needed, where the care  
8 would be best provided, how much care is required, or when  
9 more care is results in better outcomes. PAC placement  
10 decisions often reflect clinical factors such as local  
11 practice patterns, financial arrangements, and the  
12 availability of PAC in a market. Given these factors, it  
13 is not surprising that per capita Medicare spending varies  
14 more for post-acute care than for any other service, and it  
15 has led the Congress to include mandated studies of a  
16 unified payment system in the IMPACT Act.

17           As mandated, in June 2016, the Commission  
18 recommended a design and the design features of a unified  
19 payment system and estimated its impacts. To complete this  
20 work, the Commission used 8.9 million PAC stays in 2013 and  
21 other readily available data and focused on over 30  
22 different patient groups defined by their clinical and

1 other characteristics.

2           We found that a unified payment system would  
3 redistribute payments across conditions, increasing  
4 payments for medically complex patients and decreasing  
5 payments for rehabilitation care that's unrelated to a  
6 patient's characteristics. The redistribution would narrow  
7 the relative profitability across conditions, and as a  
8 result, providers would have less incentive to admit  
9 certain types of patients over others.

10           We concluded that a unified PAC PPS was feasible,  
11 could be implemented sooner than contemplated, and would  
12 result in more equitable payments.

13           The broad outline of a PAC PPS is consistent with  
14 the design of any prospective payment system, which I've  
15 outlined in green. I'm going to take a minute to go over  
16 this because the mechanics are key to the approach we're  
17 going to consider to increase the equity of payments.

18           In the first green box, you see there is a base  
19 rate that reflects the average cost of a stay. This base  
20 rate gets adjusted up or down, based on the patient's  
21 characteristics using a case mix adjuster to reflect the  
22 stay's relative costliness. That's the second green box.

1 The adjusters include characteristics about the patient,  
2 including the primary reason for their treatment, their  
3 age, co-morbidities, severity, cognitive status, and  
4 impairments -- information that is readily available from  
5 claims and from an enrollment database. Other adjusters,  
6 in the third box, vary payments to reflect things like  
7 differences in wages across markets. The base rate  
8 multiplied by the case mix and the other adjusters computes  
9 the payment.

10 I want you to notice the relative weights in the  
11 second box because it is this part of the design that we're  
12 going to propose integrating into each setting's payments  
13 to make them more equitable.

14 The basic approach to increase the equity in  
15 payments across each setting is to take the relative  
16 weights of the PAC PPS and use them in setting payments  
17 within each setting.

18 Within each setting, payments would be calculated  
19 based on a blend of the current setting-specific relative  
20 weights and the relative weights from the unified PAC PPS.  
21 This would begin to redistribute payments across  
22 conditions. Total payments to the setting would remain at



1 the recommended level of spending. So this approach  
2 doesn't affect the level of payments. It's all about  
3 redistributing payments within a setting.

4           This chart illustrates the redistribution of  
5 payments within and across settings. I'm sorry that's so  
6 dark. This should have been in white. I don't know why.  
7 Sorry. We have the wrong version loaded here. So the  
8 implementation begins in 2021, and that's at the bottom.  
9 And that arrow shows the redistribution that would occur  
10 across the settings.

11           That's not what we're talking about today. Today  
12 we're talking about the green arrows, and that's about  
13 redistributing payments within each setting. Payments to  
14 each setting would remain at the recommended levels, and,  
15 again, what we're focusing on is just redistributing  
16 payments within a setting. By blending the relative  
17 weights that are in current use with the relative weights  
18 from the PAC PPS, the resulting payments would shift across  
19 conditions. Payments would be more closely aligned with  
20 the costs of care, so the equity of payments within each  
21 setting would increase.

22           So then going back to the mechanics, what we're

1 talking about is that second adjuster. We'd make changes  
2 to the relative weights, and those would affect the  
3 payments.

4 I want to walk through a simple illustration to  
5 see how this blending of the relative weights works and  
6 changes payments.

7 Okay. I can see we can't read the second line on  
8 there. All right. Imagine a provider that treats two  
9 patients. One patient has an orthopedic condition and the  
10 other is medically complex, and that's the one that's  
11 really hard to read. The top two rows show the relative  
12 weights, and the bottom two rows show the resulting  
13 payments using those relative weights.

14 Starting at the top, under the unified PAC PPS,  
15 the relative weight for the orthopedic condition decreases  
16 from 1.2 to 0.9. And if we blended that rate 50:50, the  
17 relative weight would be 1.05. In the second row, we show  
18 the medically complex case, and that relative weight  
19 increases from 0.8 to 1.1, and when blended, the relative  
20 weight is in the middle.

21 In the payment rows, you see the impacts of the  
22 changes to the relative weights on payments. For the

1 orthopedic case in this example, the payment decreases from  
2 \$7,200 to \$5,400 under a PAC PPS, and when blended, it  
3 would be \$6,300.

4           In the next row, payments for the medically  
5 complex case increases from \$4,800 to \$6,600, with a  
6 blended payment of \$5,700. The blending begins to shift  
7 payments across conditions in the direction the Commission  
8 has called for, while keeping total payments the same at  
9 \$12,000, and you see that at the bottom. In the approach  
10 we're outlining, we've assumed the same volume and mix of  
11 patients, so aggregate payments to a setting would remain  
12 the same, but the payments would be redistributed across  
13 the conditions.

14           As outlined in the paper, we estimated the  
15 changes in payments within each setting if total payments  
16 remained the same, but payments were based on a 50:50 blend  
17 of the relative weights established by the PAC PPS and the  
18 current setting-specific PPSs. We focus on the impacts on  
19 providers since that's the most relevant for the update  
20 discussion.

21           Within a setting, payments to providers would be  
22 redistributed based on the mix of conditions they treat,

1 how their costs compare to the average, and their current  
2 therapy practices. Within each setting, payments would  
3 increase for nonprofit providers and hospital-based  
4 providers and decrease for for-profit facilities and  
5 freestanding providers. These shifts reflect the mixes of  
6 patients they treat and their practices, not their  
7 ownership or provider type per se.

8           Our work on SNFs, for example, has shown that  
9 hospital-based SNFs treat a disproportionate share of  
10 medically complex patients. Under this approach payments  
11 based on the blending of the weights would increase to  
12 them. The redistributions would have the effect of raising  
13 payments to low-margin providers and lowering payments to  
14 high-margin providers. And I want to remind everyone that  
15 at current levels, aggregate payments to a setting remain  
16 well above the cost of care.

17           In conclusion, it is possible to increase the  
18 equity of payments within each setting before implementing  
19 a unified PAC PPS. The redistribution would correct the  
20 biases of the current PPSs, increase the equity of payments  
21 across conditions so providers would have less incentive to  
22 favor treating certain types of patients over others, and

1 encourage providers to begin to make the kinds of changes  
2 they would want to make to be successful under the unified  
3 payment system. It would also support update  
4 recommendations that would better align payments to the  
5 cost of care without undesirable impacts.

6           Next month, the Commission will discuss the  
7 adequacy of payments for each PAC setting and make a  
8 judgment about what, if any, update is needed, just as it  
9 does every year. The Commission could also consider a  
10 policy option that would increase the equity in payments  
11 within each setting by using a blend of setting-specific  
12 and PAC PPS relative weights to establish payments.

13           Some of you have asked how to integrate the  
14 Commission's recommendation regarding the unified PAC PPS  
15 and its update discussions, and here is one way to do that.  
16 We would like to get your reactions to this option and  
17 whether we should include it in the December update  
18 chapters.

19           DR. CROSSON: Thank you, Carol. Very clear.

20           Clarifying questions? We'll start with David.

21           DR. NERENZ: [off microphone] -- sorry. Slide  
22 14, the word "before," should we take that to mean we're

1 really talking about a transitional temporary approach  
2 before something more permanent kicks in? Is that what  
3 "before" means here?

4 DR. CARTER: What I meant here was the Commission  
5 has a recommendation to start implementing and beginning  
6 the transition to the PAC PPS in 2021, and so the "before"  
7 here refers to '19 and '20.

8 DR. NERENZ: Thank you. Okay. And then so as we  
9 think about sort of the full implementation of this, if we  
10 can jump back to Slide 12, the center column there, unified  
11 PAC PPS, those are the weights that then would be applied  
12 under full implementation? And the illustration here, I  
13 understand it's a hypothetical, just those two patients.

14 DR. CARTER: Yes.

15 DR. NERENZ: But what would happen for an  
16 individual provider, in fact, even during the temporary  
17 part, is if two different providers had different mixes of  
18 these two types of people, there would be money going up  
19 and down within, between providers but within --

20 DR. CARTER: Between providers but within a  
21 setting, yes.

22 DR. NERENZ: Thank you. Okay.

1 DR. CARTER: That's right.

2 DR. CROSSON: Clarifying questions? Alice.

3 DR. COOMBS: So I noticed there's a little bit of  
4 -- because this is the transition, so there's that gradient  
5 between the joint versus the non-joint. Are we looking at  
6 three hours of rehab and saying that it's going to be  
7 equivalent to the medically complex patient after this  
8 transition period? Is that the ultimate disposition for us  
9 to be...

10 DR. CARTER: I'm not quite sure. So we haven't  
11 talked about -- so is your question asking are we thinking  
12 about waiving regulatory requirements during the  
13 transition?

14 DR. COOMBS: Well, we talked about that already.

15 DR. CARTER: Yeah, okay. So you're not --

16 DR. COOMBS: We talked about that, so the next  
17 question is: There's still an incentive to go with the  
18 joints in the PAC --

19 DR. CARTER: There would be less incentive, but  
20 you're right.

21 DR. COOMBS: Okay. So is that --

22 DR. CARTER: Because we're still just blending

1 current incentives with future incentives, right.

2 DR. COOMBS: So the blend is -- do you think the  
3 blend is narrow enough in terms of the calculation? I  
4 mean, this is a transition, but are we going to go to a  
5 different type of blend, a little bit narrower bandwidth  
6 for the permanent?

7 DR. CARTER: So we could talk about -- and I  
8 don't know if the Commission would want to get specific  
9 about what the blend should be kind of before you begin the  
10 implementation. Once you start implementing, we talked  
11 about a three-year -- our recommendation was for a three-  
12 year transition. That's full PAC PPS rates -- right? --  
13 folded in over three years, but you're allowing the money  
14 to get distributed across settings.

15 DR. COOMBS: Okay.

16 DR. CROSSON: Kathy, questions.

17 MS. BUTO: I may be missing this because I know  
18 we're doing this within settings. But let's take SNFs, for  
19 example. If SNFs have a disproportionate number of  
20 patients whose care is being overpaid because of rehab  
21 services, for example, when you go to a blend with a  
22 unified PAC, won't the total money involved, even at a



1 50:50 blend, won't that potentially go down for the whole  
2 category of SNFs?

3 DR. CARTER: No, because we've actually made --  
4 you could adjust the relative weights in a way that --

5 MS. BUTO: So we're deliberately keeping it  
6 budget neutral, is what you're saying.

7 DR. CARTER: Yes.

8 DR. MILLER: Exactly. You're out of model  
9 holding it neutral to each [off microphone].

10 DR. CARTER: Yeah.

11 MS. BUTO: Got it. Okay. I know that's more  
12 acceptable, but I think --

13 DR. CARTER: Yeah.

14 MS. BUTO: -- my preference would be to take the  
15 next step.

16 DR. MILLER: Your preferences have been clear  
17 throughout this process.

18 [Laughter.]

19 DR. MILLER: But you see what we're trying to do  
20 here. We're trying to accommodate those preferences and  
21 then also stay within the silos for the short term until we  
22 get to the bigger -- right.

1 DR. CROSSON: Questions, questions, questions,  
2 question. Pat.

3 MS. WANG: This is going to be very imprecise.  
4 When you did the first set of work you showed some of the  
5 changes that would result from implementation of the full  
6 PPS across sectors and shifts based on the condition of the  
7 patient. Do you feel like doing this for a couple of  
8 years, where within the sector payments would shift,  
9 changes the, in some instance, kind of makes the transition  
10 to the full PPS more traumatic rather than less? So in the  
11 example of SNF, if certain services get a payment increase  
12 because of this interim, and then the full thing happens, a  
13 SNF has been living with increased payments for its  
14 medically complex patients, but then, when the full thing  
15 comes in, it drops even more precipitously than it would  
16 have because money is shifting out of the sector.

17 Is that a concern that we should have about the  
18 transitions, because I think, you know, one of the things  
19 that all of the providers are going to have to sort of  
20 adjust to is sort of managing their businesses with  
21 different levels of resources. So if there's a temporary  
22 boom because the sector is overpaid, and since it's budget

1 neutral within the sector it's like wow, you know, this is  
2 great, you know, is there a potential that the cliff will  
3 be even steeper, when the whole thing --

4 DR. CARTER: I don't think so. I think what this  
5 is really going to get providers thinking about is  
6 decreasing the amount of therapy that's not related to  
7 patient characteristics. That's the biggest change that's  
8 going to need to go on under a unified PAC PPS. This puts  
9 their toe in that water, because it is a baby step towards  
10 doing that.

11 So I think the kinds of changes in practices that  
12 a provider is going to need to take on are -- would be the  
13 incentives here. So they are moving -- what you were  
14 suggesting is sort of, oh, these things take us in one  
15 direction and then we're going to be going here, so the  
16 drop is going to be even larger, and all of these  
17 incentives, actually, are parallel.

18 DR. CROSSON: Warner.

19 MR. THOMAS: So on Slide 12, and I may have  
20 missed this, and if I did I apologize, explain to me  
21 exactly how you're getting what the -- are there different  
22 categories than the two? I mean, do you see having more or

1 would it just be the two categories?

2 DR. CARTER: Oh, no. So we would be using all of  
3 the patient characteristics that we've been using. I just  
4 showed two here.

5 MR. THOMAS: That's what I thought, so it would  
6 be -- you know, so, I guess, how do you see setting that  
7 weighting? I mean, what exact process would you use to --

8 DR. CARTER: Well, you could do something fairly  
9 simply like calculate what the current payment would be,  
10 which is how, when a claim comes in, CMS processes that  
11 claim, and then you could take that same claim and run it  
12 through the alternative, that is the new unified payment  
13 system, get that payment, and then do a blend.

14 MR. THOMAS: But in the new payment system you're  
15 coming up with a weighting.

16 DR. CARTER: Well, that would just be a weighting  
17 of the two different payments, yeah.

18 DR. MILLER: Warner, are you asking like where do  
19 those unified PPS weights come from?

20 MR. THOMAS: Correct.

21 DR. MILLER: Okay. So one place they could come  
22 from, Carol, is --

1 DR. CARTER: Well, I mean, our design has --

2 MR. THOMAS: It sounds like you have an idea.

3 DR. CARTER: Well, we have a payment system that  
4 would be calculating payments.

5 DR. MILLER: She produced these weights as part  
6 of the report that we did on this.

7 DR. CARTER: Yeah.

8 DR. MILLER: We wouldn't insist and say, CMS has  
9 to use those weights, but that's a place they could go to.  
10 We could turn that research over to them and the weights  
11 over to them, or they could replicate them in some way.

12 MR. THOMAS: Okay.

13 DR. MILLER: But there is a set inside Carol's  
14 office right now.

15 [Laughter.]

16 DR. CARTER: Yes, there is.

17 DR. MILLER: And, Warner, if you want me to take  
18 you over there, I'll show you.

19 DR. CROSSON: Okay.

20 MR. THOMAS: I'm sure I don't have clearance, so,  
21 you know.

22 [Laughter.]

1 DR. CROSSON: I've got Paul and Alice.

2 DR. GINSBURG: Just one clarifying thing. I was  
3 wondering if one of the advantages of doing this is that it  
4 opens up another pathway to reform. I mean, there's the  
5 ultimate reform, which is the unified PPS system, but if  
6 there should be resistance to that it's possible that there  
7 could be less resistance to this and at least you start  
8 making these changes that are part of the big system. And  
9 I like the fact that it's phased because we're -- this is  
10 for '19 and '20, and the full system isn't scheduled to be  
11 implemented until '21.

12 DR. CROSSON: Alice and then Dana. Alice.

13 DR. COOMBS: So, Carol, your last trip at the  
14 rodeo we talked about home health, and this is really huge  
15 because there is such a trend now for same-day joint  
16 surgery and discharge home. So I was wondering if we were  
17 going to model that juxtaposed to the other options.

18 DR. CARTER: So in this scenario we have just  
19 assumed constant volume. But what you're suggesting is  
20 payments to a setting might not remain the same if there  
21 are fewer patients going to SNF, and that's --

22 DR. COOMBS: I am telling you the train has so

1 left the station with people going home after same-day  
2 joint surgery --

3 DR. CARTER: Right.

4 DR. COOMBS: -- and we've got to upscale it to  
5 say that, oh, they have to go to the ERFs or the SNFs or  
6 whatever. But that -- we talk about the advent of a new  
7 intervention and how the cost of something post-PAC will  
8 change.

9 DR. CARTER: Mm-hmm.

10 DR. COOMBS: I think this is an area that we  
11 could be ahead of the curve and kind of simulating that.

12 DR. CARTER: Right. And, of course, the  
13 redistribution would still happen for the cases that still  
14 remain in the setting. But I think what you are suggesting  
15 also points out the importance of recalibration and  
16 revising the weights over time, because we know the  
17 practice patterns are shifting already, and they're going  
18 to continue to shift. And I know Anne and Kathy really  
19 pushed for us to have, in our recommendation and that whole  
20 discussion, how important it is to revise and rebase and  
21 recalibrate. And so you're sort of making that point and I  
22 think it's a good one.

1 DR. CROSSON: Dana.

2 DR. SAFRAN: So this is a new topic for me. I  
3 wasn't here for your last rodeo, so I'm just trying to get  
4 caught up.

5 So my question is with respect to the changes  
6 that are scheduled to take effect in 2021. It sounds like  
7 there's some question around the table about whether that  
8 will really happen, and so that prompts my question about  
9 whether doing this makes it more or less likely that the  
10 2021 changes will actually come to pass. And if it makes  
11 it less likely, kind of how far down the field does it take  
12 us that we're doing this first?

13 DR. CARTER: So in 2021, is our recommendation,  
14 but CMS is not required to do that. In fact, the Impact  
15 Act required studies of a unified payment system but didn't  
16 actually require one to be implemented. So that's sort of  
17 our timeframe. But there's -- you know, there's been no  
18 action, shall I say, at least so far, about something  
19 actually being implemented in 2021.

20 I do think that this kind of redistribution is  
21 something that would be desirable anyway.

22 DR. CROSSON: Okay. So we're going to proceed



1 with the discussion now. I'm thinking that we haven't  
2 heard a lot of opposition to this proposal, but the  
3 proposal is that if we have significant amount of support  
4 here then as we take on the post-acute care discussions in  
5 December and January that, in addition, as Carol has  
6 pointed out, and to just doing the update recommendation,  
7 that this be included as a policy option within that.

8           So if there's significant disagreement with that  
9 idea, I'd like to hear that, and if you want to augment  
10 support that's fine as well.

11           David's going to start.

12           DR. GRABOWSKI: Great. Thanks. First, Carol,  
13 great job, as always. That was really super. I'll start  
14 by saying, Jay, that I'm very supportive of this kind of  
15 incremental step towards implementing the unified PAC, so  
16 count me as supportive.

17           I just wanted to provide a little bit of context,  
18 because I think there's distortions at two levels in post-  
19 acute care. There is within-sector distortions and then  
20 there's across-sector distortions, in terms of how we pay  
21 and deliver services. So the within post-acute care  
22 sector, for example, SNFs, we tend to value and pay for

1 therapy at the expense of medically complex patients, and  
2 so that's the sort of within-sector type of distortion.

3           Then we have this across-sector distortion as  
4 well, where, you know, you think about skilled nursing  
5 facilities and inpatient rehab facilities. The same  
6 patient may be paid very different across those two sectors  
7 with unclear impact on their outcomes. So, ultimately, the  
8 unified PAC system will correct both of those distortions.  
9 By 2021, Kathy, you'll have your full correction there.

10           But in the meantime, I like this step, and I  
11 think there's actually some experience in implementing  
12 post-acute care payment reforms incrementally, going back  
13 to the skilled nursing facility prospective payment system.  
14 That was implemented when we moved from cost-based to  
15 prospective payment in 1998. We did it in 25 percent  
16 increments, so we had this one --

17           DR. CARTER: Then we jumped very fast.

18           DR. GRABOWSKI: Then we jumped very fast. That's  
19 right. But it went, you know, kind of in -- and my sense  
20 is that was a positive, and I think going here, in that  
21 same incremental fashion, could also be a positive, whether  
22 that's kind of one-third in 2019 and then two-thirds in

1 2020 and then the full step in 2021. I like that approach.

2 My final comment, and I think it's a really  
3 important one and timely, is around budget neutrality, and  
4 it goes back to Kathy's point. I do think we need to hold  
5 this budget neutral within each of the sectors. We just  
6 saw yesterday that CMS announced they're not going to go  
7 forward with home health -- new home health payment model.  
8 That payment model is different than what we're proposing  
9 here but it shares some similarities in that it was going  
10 to pay higher rates for medically complex patients and sort  
11 of less for therapy. It also was going to take about \$1  
12 billion annually out of the home health payment system.

13 So I think there's obviously going to be winners  
14 and losers, as Carol described, but I don't think we want  
15 to pull dollars out of -- we don't want to shrink the pie.  
16 We may want to reallocate. But I think that's very  
17 important that we keep this budget neutral.

18 So, once again, I am very supportive of this and  
19 I'll stop there. Thanks.

20 DR. CROSSON: Thank you.

21 DR. MILLER: Can I add just one clarification?

22 So the way we've been talking about budget neutrality

1 throughout this presentation is that you come in like you  
2 do as a regular order, you evaluate the sector, and you  
3 say, you know, this sector, no update, or this sector, an  
4 actual reduction. Then this distribution is budget neutral  
5 to that decision.

6 DR. GRABOWSKI: We're on the same page, yes.

7 DR. MILLER: That's what I wanted to know. Thank  
8 you.

9 DR. CROSSON: Okay. So the question on the table  
10 is, is there enough support for bringing this policy option  
11 forward in December and January? Discussion? Kathy and  
12 then Alice. I saw thumbs up from Craig.

13 MS. BUTO: Yes, I would definitely support that.  
14 I think this is great work. The only thing I'd ask us to  
15 leave open is, you know, as whoever the Commissioners are  
16 in 2019 and '20, if it looks like we're not going to get  
17 the full PAC PPS, then I think it is time to look at the  
18 issue of budget neutrality across sectors, that broader  
19 issue, or even within sectors. I guess you'd start there  
20 first. So looking at not just keeping everybody -- every  
21 sector or setting whole.

22 But I do very much support the idea of

1 introducing this in January with the updates.

2 DR. CROSSON: Okay, Kathy. Alice, Paul.

3 DR. CARTER: But I just wanted to make one point.

4 Of course, some of your level conversation with the update  
5 will get at that issue. Right?

6 DR. COOMBS: Well, I just want to go on record to  
7 say I support it.

8 DR. CROSSON: Okay. Paul.

9 DR. GINSBURG: Yes, I'm very enthusiastic about  
10 this and I've been reflecting about the question Dana  
11 posed, about whether this will make it easier to do the  
12 whole thing later. I think it will, because I think this  
13 is going to get some of the adjustment out of the way, so,  
14 in a sense, the full system will be less daunting if we've  
15 already done this.

16 DR. CROSSON: Further points? I've got some  
17 thumbs up and then we've got Jack first and then Warner.

18 DR. HOADLEY: Some very brief. I mean, I am very  
19 enthusiastic about this approach, and like Paul, I think  
20 the answer to Dana's question is, yes, it moves us in the  
21 right direction. Now I suppose politically, at some point  
22 you could say if we get close somebody may say, well, we're

1 close enough. But I think that's, you know -- that will  
2 still be judged on its merits, and it just means it's less  
3 disruptive, so hopefully less reason for stakeholders to  
4 push back if, you know, if some of the changes have already  
5 been made.

6 I do think -- I'm just thinking about Pat's  
7 question, and I wonder if it's worth checking to see if  
8 there are any cases -- I think they would be rare -- where  
9 this step would push somebody upwards where they would  
10 eventually come down under the unified, just because that  
11 sector is coming down, but they might fall just on the  
12 positive side within the sector. Just to be aware of that.  
13 I suppose you could even say if that was the case then we  
14 won't do it, or something. But mostly it would be just a  
15 reassurance that that's quite rare.

16 DR. CROSSON: Okay. Warner.

17 MR. THOMAS: I think directionally I'm in favor.  
18 I would like a little more clarity and transparency around  
19 the weighting and how that is -- at least how the proposal  
20 is put together, or what the methodology or the thinking is  
21 behind how that weighting would come forward. I'm not sure  
22 if we're going to make a recommendation around how the

1 weighting ought to occur or the fact that it would just be  
2 essentially budget neutral within that discipline and then  
3 CMS is going to, you know, going to generate the whatever  
4 weighting they determine.

5           So I just would like to understand more about  
6 that. But directionally, you know, I agree.

7           I would just like to comment on Alice's point  
8 that I think it's important that, you know, as we see, you  
9 know, more and more components -- you know, more and more  
10 care in the hospital that's really being done on more of an  
11 outpatient basis with follow-up home care versus going to a  
12 post-acute facility, that I think we need to make sure that  
13 we are funding that appropriately. Because, once again, I  
14 think it's probably a more intensive home care process for  
15 the beginning components of that post-outpatient, you know,  
16 if you're thinking of some sort of joint replacement. So I  
17 think we want to make sure that that's funded appropriately  
18 so that we continue to see folks get discharged to home and  
19 have the appropriate home care that's funded right, versus  
20 going to another inpatient setting, even though it's a  
21 post-acute.

22           DR. CROSSON: Okay. Thank you. A good

1 discussion, Carol. Thank you again for a good policy  
2 option clearly presented, and I think you have the support  
3 you were looking for. So we will be looking forward to  
4 your presentations in December and January.

5           And we will move on to the last presentation of  
6 the day.

7           [Pause.]

8           DR. CROSSON: Okay. We're going to move on to  
9 the final presentation today, and that's a relatively new  
10 issue for the Commission. We're going to be looking at  
11 durable medical equipment, specifically the issue of non-  
12 competitively bid medical equipment, prosthetics,  
13 orthotics, and supplies. That's easy for me to day.

14           [Laughter.]

15           DR. CROSSON: Brian is going to start off.

16           MR. O'DONNELL: Good afternoon. This  
17 presentation continues the Commission's work on medical  
18 devices. The Commission's June 2017 report to Congress and  
19 the presentation at last month's public meeting focused on  
20 providing a broad overview of the medical device market and  
21 policy issues surrounding implantable medical devices.

22           Today I'll discuss another segment of the device



1 market: the market for durable medical equipment,  
2 prosthetics, orthotics, and supplies, referred to  
3 collectively as DMEPOS. DMEPOS comprises a large number of  
4 products that vary in cost and complexity, ranging from  
5 complex power wheelchairs to diabetes testing supplies to  
6 knee braces.

7           For background, I'll first review the two main  
8 ways in which Medicare sets payment rates for DMEPOS  
9 products -- through a fee schedule and through the  
10 Competitive Bidding Program, or CBP -- and also provide an  
11 overview of Medicare spending trends for those two broad  
12 categories of DMEPOS.

13           I'll then present some analyses suggesting that  
14 Medicare's payment rates for DMEPOS products paid on a fee  
15 schedule basis are likely excessive.

16           Finally, I'll discuss and seek the Commission's  
17 feedback on potential policy options to address those  
18 excessive payment rates and protect beneficiaries.

19           I'll begin with a discussion of how Medicare sets  
20 fee schedule payment rates.

21           Medicare's current fee schedule is largely based  
22 on average reasonable supplier charges from 1986 and 1987.

1 The fee schedule payment rates are not routinely evaluated  
2 for accuracy and instead have been mostly updated for  
3 inflation over the past 30 years.

4 DMEPOS fee schedule rates have often been  
5 excessive. OIG and GAO have issued numerous reports over  
6 many years demonstrating that Medicare's DMEPOS fee  
7 schedule rates have often been far higher than rates set by  
8 many other purchasers, suppliers' costs, and the direct  
9 purchase price -- that is, the price at which beneficiaries  
10 could purchase the device outside of insurance coverage.

11 Excessive payment rates resulted in rapid growth  
12 in expenditures and high rates of inappropriate utilization  
13 and potential fraud and abuse. In response to these  
14 trends, Congress required CMS to implement the Competitive  
15 Bidding Program, or CBP.

16 CMS has the authority to phase in CBP starting  
17 with the highest-cost products or those products with the  
18 highest potential for savings. However, CMS is prohibited  
19 from including certain DMEPOS products in CBP. I've listed  
20 several of those products on the slide.

21 And just a little bit of foreshadowing here.  
22 Some of the products that I'll be talking about in a few

1 slides were not among highest-cost products when CMS first  
2 developed CBP, while others are statutorily excluded from  
3 CBP or CMS has faced industry pressure not to include them  
4 in competitive bidding.

5 CMS was also required to phase in CBP in terms of  
6 the area covered. So in 2011 the agency implemented the  
7 first round of CBP in nine large urban areas. Since then,  
8 CMS has expanded the number of areas included in CBP so  
9 that, as of 2017, the 99 largest urban areas are included  
10 in CBP.

11 CMS is also required by statute to use the  
12 information from competitive bidding to adjust fee schedule  
13 rates for products covered by CBP but for beneficiaries who  
14 live outside the 99 largest urban areas.

15 The next slide summarizes the impacts CBP has had  
16 on prices, volume, and beneficiary outcomes. I've included  
17 more details on these topics and the structure and  
18 criticisms of CBP in your mailing materials.

19 Since CBP was first implemented in 2011, payment  
20 rates have fallen substantially. Among the 25 highest-  
21 expenditure items, rates have declined by a median of  
22 around 50 percent from 2010 to the most current round of

1 CBP.

2 CBP has also resulted in substantial utilization  
3 declines. For example, after studying a CBP round that was  
4 implemented in July 2013, GAO found that the reduction in  
5 volume was higher for the same products in competitive  
6 bidding areas versus non-competitive bidding areas.

7 CMS has routinely stated that no negative changes  
8 in beneficiary health outcomes have resulted from CBP. CMS  
9 bases this finding on its monitoring of secondary outcomes,  
10 such as emergency department use, for beneficiaries who use  
11 CBP products, beneficiaries who might need to use CBP  
12 products, and all fee-for-service beneficiaries.

13 Moving on from the background, this slide  
14 provides an overview of the spending trends of those two  
15 broad categories of products I just reviewed -- those  
16 included in CBP and non-CBP products.

17 As you can see in the second row of the chart,  
18 Medicare expenditures for products included in CBP decrease  
19 by 42 percent from 2010 to 2015. The decrease in  
20 expenditures has been particularly dramatic for certain  
21 product categories. For example, expenditures for diabetes  
22 testing supplies fell by 79 percent over the same time

1 period.

2           In contrast to these large declines, expenditures  
3 for non-CBP products have increased steadily over time,  
4 growing a total of 24 percent from 2010 to 2015. Given  
5 these divergent trends and the history of abuses among  
6 products paid on a fee schedule basis, the next three  
7 slides examine non-CBP products for evidence of excessive  
8 payment rates. If products have excessive fee schedule  
9 payment rates and are supplied by multiple companies, they  
10 could be good candidates for competitive bidding.

11           To evaluate whether products had excessive  
12 payment rates, we mainly focused on the highest-expenditure  
13 non-CBP products, as Medicare spending is concentrated in  
14 these products. For example, roughly half of Medicare  
15 spending on non-CBP products was concentrated in the top 25  
16 products in 2015.

17           To evaluate the pricing accuracy of those top  
18 products, we conducted two analyses. First, we compared  
19 Medicare's payment rates to private payer rates; and,  
20 second, we looked for rapid growth in utilization and  
21 spending, which are classic signs of excessive rates, as  
22 suppliers are encouraged to bill for highly profitable

1 items.

2           So for our first analysis, we compared Medicare's  
3 fee schedule payment rates for the top ten DMEPOS products  
4 in 2015 to the median private payer rate for the same  
5 products in the MarketScan database, which is a database of  
6 private payer claims. We found that Medicare's payment  
7 rates were higher than private payer rates for nine of the  
8 ten products we examined.

9           For those nine products, Medicare's payment rates  
10 were anywhere from 18 percent to 57 percent higher than  
11 private payer rates. For example, Medicare's payment rate  
12 was 35 percent higher than the median private payer rate  
13 for bone growth stimulators. For the products we examined,  
14 we estimate that Medicare would have saved roughly \$192  
15 million in 2015 if Medicare's payment rates were equal to  
16 private payer rates. Additional savings beyond this  
17 estimate are likely position for a few reasons.

18           First, Medicare payment rates for products  
19 outside the top ten are also likely excessive. For  
20 example, Medicare would have saved an additional \$47  
21 million in 2015 if Medicare rates were equal to the median  
22 private payer rate for off-the-shelf orthotics outside the

1 top ten. And, second, private payer might more  
2 appropriately represent an upper bound on Medicare rates  
3 rather than an ideal rate.

4 Our second analysis examined the growth in volume  
5 and expenditures of non-CBP DMEPOS products because rapid  
6 growth in volume and expenditures can be a sign of  
7 excessive payment rates. Among the ten highest-expenditure  
8 non-CBP products, the average growth rate in expenditures  
9 was 21 percent from 2014 to 2015.

10 For several products, the rapid growth was part  
11 of a longer-term trend and continued into 2016. For  
12 example, Medicare expenditures for an off-the-self back  
13 brace grew from \$46 million to \$190 million, or more than  
14 300 percent, from 2014 to 2016.

15 Before moving on to the discussion of policy  
16 options, I'd like to note that three or more suppliers  
17 billed for all but one of the top 25 non-CBP products in  
18 2015, suggesting that including these products in CBP could  
19 lower payment rates as suppliers would be expected to  
20 compete with one another based on price.

21 So given the seemingly excessive payment rates we  
22 found, the rapid growth rate for many products, and the

1 abundance of suppliers for most non-CBP products, the first  
2 option for the Commission to consider is encouraging CMS to  
3 use its current authority to include more products in CBP  
4 and expand the agency's statutory authority to include  
5 other products in CBP.

6           As I discussed in your mailing materials, it  
7 would likely take CMS several years to include many new  
8 products in CBP because, for instance, the agency would  
9 need to develop special rules for certain products. So  
10 including many more items in CBP could be thought of as a  
11 medium- or long-term option.

12           To address excessive payment rates in the short  
13 term, the Commission could consider an option of  
14 immediately reducing payment rates for those products that  
15 will eventually be included in CBP. The payment rate  
16 reductions could continue on an annual basis until  
17 Medicare's payment rates are roughly similar to private  
18 payer rates or the items are included in CBP.

19           This next policy option for the Commission to  
20 consider is not directly related to reducing excessive  
21 payment rates. Rather, the option is designed to better  
22 align balance billing and participation rules for the



1 DMEPOS sector with the rest of Medicare and to add a  
2 protection for beneficiaries who use DMEPOS products in  
3 situations where assignment is not mandatory. But before I  
4 review the option, I'll give some background on the issue.

5           Participation and assignment rules are different  
6 for DMEPOS compared to many other Medicare services.

7           First, outside of CBP products used by  
8 beneficiaries from a competitive bidding area, assignment  
9 is not mandatory, meaning that suppliers do not have to  
10 accept the fee schedule rate as payment in full and can  
11 balance bill beneficiaries.

12           Second, there is no limit on balance billing.  
13 Other providers face limits on how much they can balance  
14 bill. For example, physicians are limited to balance  
15 billing 115 percent of the physician fee schedule.

16           And, third, DMEPOS suppliers do not face a  
17 penalty for enrolling as non-participating. In contrast,  
18 physicians who enroll as non-participating face a 5 percent  
19 reduction in the allowed amount under the physician fee  
20 schedule. Non-participating suppliers can accept or reject  
21 assignment on a claim-by-claim basis; whereas,  
22 participating suppliers accept assignment on all claims in

1 a given year.

2           So the option for the Commission to consider is  
3 to cap balance billing at a percentage of the fee schedule  
4 rate and to reduce the allowed amount by 5 percent for non-  
5 participating suppliers.

6           So this last slide just boils down some of the  
7 information I've talked about today. Roughly half of all  
8 Medicare spending on DMEPOS is for products that are not  
9 competitively bid, and our analyses indicate that many of  
10 those products appear to have excessive payment rates.

11           To address this, I discussed a policy option of  
12 shifting many products currently paid on a fee schedule  
13 basis to competitive bidding and to reduce the payment  
14 rates for those products while CMS works on incorporating  
15 them into CBP.

16           I also highlighted another policy option that is  
17 intended to align balance billing and participation rules  
18 for DMEPOS suppliers with the rest of Medicare and to  
19 further protect beneficiaries.

20           I am seeking the Commission's feedback on the  
21 policy options discussed today and the Commission's  
22 suggestions for any further context or analyses that should

1 be added to the current mailing materials should these  
2 findings be incorporated into a June chapter.

3 With that, I look forward to your comments, and I  
4 turn it back to Jay or Jon.

5 DR. CHRISTIANSON: Thanks, Brian.

6 Let's start with Jack and work our way around  
7 this way this time for clarifying questions.

8 DR. HOADLEY: So I have two. One, do you have a  
9 number of the share of overall Medicare expenditures that's  
10 represented by this category of spending?

11 MR. O'DONNELL: No, I don't, but you could take  
12 whatever, \$8 to \$10 billion divided by, you know, \$570  
13 billion, or whatever the number is.

14 DR. HOADLEY: It just always seems useful to have  
15 that as a context-setting thing. We sometimes talk about  
16 that in some of the other areas.

17 The other thing, I don't know that this was in  
18 your slides, but in the mailing material you talked about  
19 \$42 billion total savings over ten years that was \$25  
20 billion in program and \$17 billion for beneficiaries, which  
21 is about a 60/40 ratio, which surprised me given the  
22 general 80/20 thing. Does that reflect the balance billing

1 issue, or does that reflect some other things going on?

2 MR. O'DONNELL: So that number is a CMS estimate,  
3 but what I think it reflects is, you know, the 80/20,  
4 right? So part of that 80 percent being paid is  
5 beneficiary premiums, so I think it reflects that, that  
6 premium effect.

7 DR. HOADLEY: Okay. Thank you.

8 DR. CHRISTIANSON: Rita.

9 DR. REDBERG: Thanks. A very well done chapter.  
10 I was just curious. Maybe I missed it. Do we know what  
11 percentage are non-participating suppliers?

12 MR. O'DONNELL: Right, so I have the share of  
13 claims that were paid on a non-par basis, which is 60  
14 percent. I haven't calculated the share of providers. I  
15 could do that on a tax ID level or on an NPI level. But  
16 from conversations, I think it's right around that same  
17 level as the claim percentage. But that's just anecdotal.  
18 But I can calculate that for you.

19 DR. REDBERG: If it's not too much trouble.

20 MR. O'DONNELL: Yeah.

21 DR. REDBERG: And the other, do you know why in  
22 the MMA certain categories were excluded from competitive

1 bidding, like Class III devices?

2 MR. O'DONNELL: Right, so I've asked that  
3 question multiple times, and I've tried to read the  
4 Committee report, and I don't think it was, you know,  
5 particular to certain concerns. I mean, it has kind of a  
6 topical appeal, like Class III devices are serious maybe.  
7 So maybe they were just being overly cautious. But I  
8 haven't found a great answer for you, is what I found.

9 DR. REDBERG: Okay. We'll stay tuned.

10 DR. CHRISTIANSON: Warner, any clarifying  
11 questions? Pat?

12 [No response.]

13 DR. DeBUSK: And if this was in the reading, I  
14 apologize --

15 DR. CHRISTIANSON: Mic, please, Brian.

16 MS. BRICKER: If this was in the reading, I  
17 apologize, but I read through it a couple of times and  
18 couldn't find it. The off-the-shelf orthotics portion of  
19 the non-competitively bid items, what percentage does that  
20 make up?

21 MR. O'DONNELL: So if you look at the off-the-  
22 shelf orthotics the way CMS defines it, in 2015 it was

1 about \$400 million in total allowed charges. So total non-  
2 CBP is about \$4 billion, so, you know, 10 percent.

3 DR. DeBUSK: Okay. So about 10 percent of the \$4  
4 billion is -- I'm obviously very familiar with that  
5 industry. I just wondered what it was. Okay. Thanks.

6 MR. GRABOWSKI: I was really taken by the section  
7 of your report on critiques of the competitive bidding  
8 process. We didn't talk about this in the policy options,  
9 but is that something that we could think about in terms of  
10 recommending that they make some changes? I mean, the bids  
11 are non-binding, as you write. The prices are set -- they  
12 use a median price rather than the pivotal bid. Composite  
13 bids are used. The system lacks transparency, so there's a  
14 lot of issues. Maybe this is a Round 2 comment. I'm  
15 tucking it into Round 1. Or maybe it's politically not  
16 viable, but I'm curious as to why we can't think about  
17 making recommendations here.

18 DR. MILLER: It's going to start a fight between  
19 Jon and me, which I'm always happy to have.

20 [Laughter.]

21 DR. MILLER: But maybe it's better done in Round  
22 2?

1 DR. CHRISTIANSON: Yeah.

2 DR. MILLER: We'll talk about it in Round 2.

3 DR. DeBUSK: Let me ask you a question. What  
4 [off microphone]?

5 [Laughter.]

6 DR. CHRISTIANSON: David, do you have anything  
7 else for this round?

8 MR. GRABOWSKI: No, no.

9 DR. CHRISTIANSON: Okay. Amy.

10 MS. BRICKER: More on the question that Brian had  
11 around off-the-shelf. Is it just orthotics that have a  
12 cash price or other things have a cash price, direct-to-  
13 consider price?

14 MR. O'DONNELL: So in the paper, we highlighted  
15 orthotics as an example, but certainly, you know, you can  
16 look at direct purchase prices for other items. So in the  
17 past, I know people have looked at the direct purchase  
18 price for some diabetes testing supplies, for instance, but  
19 I didn't in my paper.

20 MS. BRICKER: But would you say the majority of  
21 the non-CBP products are available direct to consumer?  
22 You're not going to go out and buy an AED or defibrillator,

1 but, okay, aside from that, like most things -- can you do  
2 that?

3 DR. MILLER: Jim is.

4 MS. BRICKER: Can you do that?

5 [Laughter.]

6 MS. BRICKER: Does Amazon sell these?

7 [Comments off microphone.]

8 MS. BRICKER: Okay. Well, some other thing that  
9 I -- a ventilator? I mean, do you buy these things on  
10 Amazon. A ventilator.

11 DR. REDBERG: You can get almost anything you  
12 want [off microphone].

13 MS. BRICKER: Okay. Good to know. Okay.

14 [Laughter.]

15 DR. MILLER: Would you like us to get you one?  
16 We're going to get some [off microphone].

17 MR. PYENSON: I understand there's some drugs  
18 that are categorized as DME, and I'm curious what they are  
19 and whether there's a sort of -- how that's defined, if  
20 there's more drugs that could be considered DME and brought  
21 into competitive bidding.

22 MR. O'DONNELL: Right, so just for context, there



1 are drugs that are infused or inhaled with DME, and just as  
2 background, I think relatively recently -- so those used to  
3 be paid on AWP up until the last couple of years or year or  
4 two. It was one of the last vestiges of being paid at AWP.  
5 So they were recently switched or transitioned to paying  
6 106 percent of ASP now. So payment changes have occurred  
7 for those drugs, just as context. But CMS does have the  
8 ability to include infused drugs, DME infused drugs in  
9 competitive bidding. And I think there's a heart drug  
10 that's kind of top-billed as of a few years ago. But they  
11 haven't done it to this point, and I suspect at least part  
12 of it was because there were some changes going on in  
13 payment reductions for those drugs that happened in the  
14 last couple of years.

15 MR. PYENSON: So what's a DME-infused drug? What  
16 does that mean?

17 MR. O'DONNELL: So the DME would be like the pump  
18 that you purchase, and then the pump, you would kind of  
19 administer the drug through the pump.

20 MR. PYENSON: For example, insulin that's used in  
21 a pump would flow through the DME --

22 MR. O'DONNELL: That's right.

1 MR. PYENSON: -- or inhalers that come with a  
2 device, is that --

3 MR. O'DONNELL: So like a nebulizer?

4 MR. PYENSON: Yeah.

5 MR. O'DONNELL: You use drugs with a nebulizer  
6 would be an example of an inhaled drug.

7 MR. PYENSON: How about a handheld? Not the  
8 nebulizer, but --

9 MS. BRICKER: Inhaler.

10 MR. PYENSON: Inhaler.

11 MS. BRICKER: Yeah.

12 MR. O'DONNELL: Yeah. I don't think that's -- I  
13 don't think that's a DME. That's a --

14 DR. HOADLEY: It's a drug.

15 MR. O'DONNELL: Yeah.

16 DR. HOADLEY: The drug is the device.

17 DR. CHRISTIANSON: Kathy.

18 MS. BUTO: Brian, I just wonder how much  
19 authority CMS has to make some adjustments. I think you  
20 mentioned sort of phasing in to using the commercial price  
21 as at least the upper limit. Is that something they could  
22 do under current authority? I know there is inherent

1 reasonableness authority, but that's very cumbersome to  
2 actually do. Do they have authority under the DME  
3 competitive bidding to do something like that?

4 MR. O'DONNELL: So I think the answer is no. So  
5 sans the inherent reasonableness authority, which you  
6 already know about, I think that the fee schedule is the  
7 exclusive payment rule for DME not included in CBP. So I  
8 don't think they could do that without some kind of  
9 legislative authority.

10 MS. BUTO: Do you have an overall savings amount  
11 related to -- if they were to set, if Congress were to put  
12 a limit on payment for DME at the commercial -- widely  
13 available, I guess, commercial price, do we know if there  
14 is significant savings there?

15 MR. O'DONNELL: Right. So I've only done it for  
16 kind of a thimbleful of products.

17 MS. BUTO: Yeah.

18 MR. O'DONNELL: And that's all I could really  
19 speak to now.

20 DR. CROSSON: Questions? Alice.

21 DR. COOMBS: Brian, I was curious. Certain  
22 states have balanced billing rules and regulations, and

1 Massachusetts is one of them. There might be other states  
2 as well. Does this sector have the same -- does this  
3 follow the sector for a balanced billing for physician fee  
4 service? In other words, in Massachusetts, can you  
5 balance-bill for this kind of thing as well?

6 MR. O'DONNELL: Right. So that's a good  
7 clarification, and I was referring to kind of the federal  
8 policy. So if there are state-based things, I didn't  
9 highlight those.

10 DR. COOMBS: So I was just curious because if  
11 there are other states that have no balanced billing on  
12 this type of equipment, that might be important because  
13 that would be one of the limitations.

14 DR. CROSSON: Okay. Seeing no more questions,  
15 we're ready to proceed with the discussion. I'd point our  
16 attention to the center of the slide, which is the two or  
17 three policy options, depending on how you look at it.

18 And I would request CMS to add more products to  
19 the competitive bidding process and produce rates in the  
20 interim. You can divide that, if you wanted.

21 And then the issue of beneficiary protection  
22 related to balanced billing.

1           And I think we've got two requests to lead the  
2 discussion. Brian first and then Rita.

3           DR. DeBUSK: Well, thank you, and congratulations  
4 on a very well-written chapter.

5           I want to start off by making a couple of blanket  
6 statements about the noncompetitive-bid items. I think, in  
7 general, it is very good policy to expose those items to  
8 market forces. So I think the idea of moving forward with  
9 CBP is a good one.

10           Having said that, I would also take care because  
11 I think depending on the product segment, I think the  
12 tactics that we're going to have to use are going to differ  
13 a little bit, and I'd like to build on something that David  
14 said. I wouldn't advocate a complete overhaul of CBP, but  
15 I would advocate that we make it a little more clever, make  
16 it a little more effective.

17           And by means of example, you know, I work in two  
18 segments, one that has been through CBP, negative pressure  
19 wound therapy, and then for 45 years or so, basically  
20 virtually my whole life, I've been in prefabricated bracing  
21 and orthotics. And it's interesting to see because I think  
22 the application in negative pressure was very, very

1 effective, and I think what made it effective was at the  
2 end of the day, the machine does one thing. It creates  
3 pressure, negative pressure on a wound to remove exudate  
4 and encourage healing.

5           And poor choices made along the supply chain in  
6 that case, for example, if someone makes an economically  
7 poor decision -- they buy a machine that maybe is lower  
8 cost, higher maintenance -- the brunt of that is felt by  
9 the DME provider. They basically have to live with their  
10 choices.

11           Bracing -- and this is again only a 10 percent  
12 segment of the non-DME post-bid items. But I'd like to --  
13 hopefully, there will be some generalizations that we can  
14 take from this. Bracing is an area that has a tremendous  
15 number of degrees of freedom. For example, the L code  
16 descriptors vary very widely, and, you know, David, you  
17 really set the precedent of this when you brought a prop  
18 because I had to bring a prop. Okay? I'm inspired.

19           [Laughter.]

20           DR. DeBUSK: This is an L3908. It's a wrist and  
21 form splint. You can't really see it from here, but it's  
22 got a metal stay in it. This is for carpal tunnel. This

1 is for sprains. We've all had them.

2 Well, this is also an L3908. This is not going  
3 to get the job done. It's about a quarter of the price,  
4 but you'll see within that category, within the same  
5 billing code, literally, a 400 percent difference. And so  
6 it's always easy to say, well, if you look at this product,  
7 it's overpaid, and by the way, there's no question there  
8 are inductive effects created by overpayment in this  
9 sector. Hopefully, that didn't get taken too far out of  
10 context, but I will repeat it. There are inductive effects  
11 created by overpayments in this area.

12 The issue, though, is there's also latitude in  
13 how they even choose to bill for this brace. So for  
14 example, I can conservatively code it or I can aggressively  
15 code it, and the challenge here -- and again, I think this  
16 would apply broader to other CBP areas. The challenge is  
17 you've got so much latitude in how you want to manipulate  
18 the margin on any given billing code, and you've got a  
19 large number of very good actors in this industry. I mean,  
20 the physicians, the hospitals that are trying to put these  
21 braces on, and the vast majority of the DMEs are trying to  
22 do the right thing.

1           The problem is you get a small number of bad  
2 actors in a segment where the margins can be so easily  
3 manipulated. If we just take a "hit it over the head"  
4 approach and cut the rates across the board, which by the  
5 way will reduce program spending, one of the problems is  
6 you're going to penalize the good actors. Well, the bad  
7 actors are simply going to adjust their behavior.

8           I mean, Mark made a joke earlier about how  
9 quickly they can adapt. They can do that in 30 days. This  
10 industry will adapt.

11           And I'll give you another good example. For  
12 example, there are a lot of parallel codes between customs  
13 and off-the-shelf prefabricated. A great example is a back  
14 brace. Well, the industry has been preparing to make the  
15 leap from prefab to customs for years now. I mean, we've  
16 anticipated that coming.

17           If you take an off-the-shelf back brace and you  
18 pull the support out of the back of it, the vast majority  
19 of them are Kydex. They're already thermoformable. That  
20 brace, as it's shipping to you today, they're ready to flip  
21 that switch and turn that into a custom product.

22           So I just want to emphasize when you see



1 something with this many degrees of freedom -- one is a  
2 physician's office trying to conscientiously use a brace  
3 for conservative treatment as opposed to opioids. There's  
4 another segment that's just a mail order house that's  
5 advertising on late night TV about a brace that can be  
6 shipped at little or no cost to you. There's this huge  
7 delta of how these margins can be manipulated.

8           We've all seen them. Actually, one of our people  
9 in the negative wound pressure segment, she came from  
10 Liberty Medical, and she was telling me, she said, "The  
11 competitive bid people, all they need to do is watch  
12 'Jeopardy,' 'Wheel of Fortune,' and 'Matlock,' and they can  
13 get everybody they need to put out to bid. It will be  
14 right there."

15           [Laughter.]

16           DR. DeBUSK: But anyway, that's pretty much the  
17 technology that they use.

18           Anyway, back to my original point, I think in  
19 some of these situations -- and I think bracing would be  
20 one of those examples -- I think we need to get clever, and  
21 we need to figure out how to rein in some of those  
22 practices and to be specific like let's narrow the L code

1 descriptor so that this and this don't get the same code.  
2 Let's require PDAC letters on more products. Let's look at  
3 preauthorization for some products. Let's put some type of  
4 face-to-face or some type of visit-based encounter in  
5 before a brace and even be prescribed.

6 Let's also, for example, try to keep the  
7 prescribing and the dispensing closer together. For  
8 example, I don't lose a lot of sleep over hospitals or  
9 physicians prescribing a brace to their own patient on  
10 their own premises because when the patient opens up that  
11 bill, he's going to see the name of that physician's  
12 practice on the copay. There's almost a check-and-balance  
13 there. You can't dispense a low-quality product, charge --  
14 up-code it at a very high rate. You still have to deal  
15 with that patient. That's much easier to do when you're a  
16 mail order house a thousand miles away and you're never  
17 going to lay eyes on the patient.

18 So my one recommendation -- this is why I want to  
19 circle it back to CBP. I think it's a great program, and I  
20 think it's been very successful. There are some people who  
21 would feel like, well, it's a somewhat flawed program  
22 applied to a somewhat flawed industry. And I would want to

1 point out that two wrongs still don't make a right.

2 I mean, Medicare should adhere to a higher  
3 standard. It's been a very successful program. I hope to  
4 see it continue. I just would advocate that we make it  
5 smarter because I think there's a real opportunity there to  
6 make it smarter and ultimately more effective.

7 DR. CROSSON: Rita.

8 DR. REDBERG: Thanks.

9 I would also like to compliment you on a really  
10 excellent chapter.

11 Before talking -- which I support the  
12 recommendations to move towards more competitive bidding,  
13 but as always, I'm always interested in not just the price,  
14 but what are beneficiaries getting for this?

15 I looked at the list that's in Table 1 of the  
16 mailing materials, and a lot of these devices have no data  
17 actually showing patient benefit. For example, the bone  
18 growth stimulator, that was the Class III. So Class III  
19 means it went through a premarket approval of the FDA.

20 So I looked up the summary of safety and  
21 effectiveness that the FDA publishes, which is what they  
22 base the approval. So this bone growth stimulator, there

1 were 323 subjects randomized, 25 percent dropped out,  
2 including died, noncompliance, broken hardware, suicide,  
3 and they didn't follow -- they didn't include them. And  
4 they say the success or failure of those is not known,  
5 obviously, because the dead ones are not -- it's pretty  
6 clear.

7           These unavailable data could possibly or  
8 negatively affect the overall success of the study. Then  
9 the whole endpoint of the study was an x-ray done,  
10 profusion at 6 months which they said was different, but  
11 then at 12 months, there was no difference between the two  
12 groups in this x-ray. And they had a clinical endpoint,  
13 and at no time was there any difference between the two  
14 groups for this clinical endpoint. And that's just one  
15 example. I could go on and on.

16           But I will just tell -- I mean, the enteral  
17 formulas, there's no data that -- and we're trying to get  
18 away from all of this enteral and parenteral nutrition  
19 because there is no data that it improves outcomes, and it  
20 often just makes people miserable for all kinds of  
21 different reasons, the same with the oxygen.

22           So even before we look at payment, I think the

1 appropriateness and sort of the benefit is, unfortunately,  
2 we're talking billions of dollars here when you add all of  
3 these up, and then, of course, the prices -- I mean, I  
4 remember when I worked in the Senate in 2004, we had a  
5 hearing on power wheelchairs. Actually, Herb Kuhn, one of  
6 our former Commissioners, spoke because he was at CMS and  
7 at the hearing, and besides the fraud and abuse -- and  
8 again, the front-end abuse, I should say, as you put in the  
9 materials, is there for bone growth stimulators, but it's  
10 also this was about fraud and abuse. It's actually, in a  
11 sense, taking our taxpayers for a ride, the story of the  
12 power wheelchair.

13 [Laughter.]

14 DR. REDBERG: But at that time, it said Medicare  
15 was paying like \$1,200 for these wheelchairs, and you could  
16 get them online for \$300, I believe. That was 13 years  
17 ago.

18 So I think I don't see why Medicare is paying  
19 more for these prices than you can get online, by private  
20 payers, or anywhere else. It's clearly not a benefit to  
21 the program or beneficiaries. We're all concerned about  
22 solvency and value, and those are some clear examples.

1           So I support the options to add more products. I  
2 don't, as I said, understand why some things are excluded  
3 from the competitive bidding process, and to add the  
4 beneficiary protections and also to try to go to more sort  
5 of value-based payment because I think some of these are  
6 just not worth anything.

7           DR. CROSSON: Thank you, Rita.

8           Brian, if I could just return to you one second.  
9 I don't want to put words in your mouth, but I want to see  
10 if I understood what you were saying with respect to the  
11 policy options that we have in front of us. So I'm going  
12 to say what I think I heard, and then tell me if that's  
13 right.

14           That in terms of adding more products to the  
15 competitive bidding process, since you feel it's a pretty  
16 good process, you would be in support of that with some  
17 provisions.

18           In terms of reducing rates across the board, you  
19 would not be in favor of that at sort of a large, across-  
20 the-board, interim, not specific level. You might be in  
21 favor of it once some of the corrections in the coding that  
22 you described were put in place.

1           And in addition to that, you have some additional  
2 ideas about how Medicare expenditures could be improved in  
3 this area, which you would like to add.

4           And lastly, I didn't hear you say anything about  
5 the beneficiary protection piece.

6           DR. DeBUSK: I would support the beneficiary  
7 protection piece.

8           DR. CROSSON: Did I summarize it correctly or  
9 not?

10          DR. DeBUSK: You did.

11          I noticed the reading material spoke to this idea  
12 of doing a precut. I would like to achieve the same or  
13 better level of savings but do it through using that couple  
14 of years that we need to clean up the billing practices and  
15 the coding practices. I think you'll easily get -- I think  
16 the reading materials maybe was talking about an 8 to 9  
17 percent -- was it 9 percent? What?

18          MR. O'DONNELL: Ten.

19          DR. DeBUSK: Ten. Okay.

20          I think you'll do vastly better than 10 by  
21 applying that, by making the billing practices, by  
22 tightening those up, and getting rid of some bad actors.

1           Then I think what you would do is take the net  
2 result of that and then subject that to competitive bid,  
3 because then you won't have those same people who can adapt  
4 their practices so easily.

5           I think that an up-front cut is a great blunt  
6 hammer, but I think you're going to push the good guys out  
7 of the market and probably keep the bad guys, if not -- if  
8 anything, double them down.

9           DR. CROSSON: Right. So since you're  
10 knowledgeable in this area, as we evolve this policy -- and  
11 I assume that you would be helpful in providing some more  
12 specifics to the staff about your ideas.

13          DR. DeBUSK: I can get very, very specific.

14          DR. CROSSON: I know that.

15          [Laughter.]

16          DR. CROSSON: I know this would come very hard  
17 for you.

18          DR. DeBUSK: I'm not a details guy.

19          [Laughter.]

20          DR. DeBUSK: Thank you.

21          DR. CROSSON: Okay. Thank you.

22          So now we're open to a broader discussion. Let's



1 start over this way this time. Jack.

2 DR. HOADLEY: So I like the direction we're going  
3 here. I thought this was really helpful material. I  
4 certainly learned a lot from it.

5 I think the comparisons of how much the prices  
6 came down with the competitive bidding -- I remember when  
7 the competitive bidding was just cranking up, and there  
8 were all these issues about getting it started, but I  
9 hadn't really seen sort of these results. And it's  
10 impressive, and I think it's particularly impressive with  
11 the decline in utilization that came along with it. So  
12 often, we figure, well, you lower the price; there will be  
13 generated volume to make up the difference. And there's  
14 another logic. You've articulated why that may play out  
15 differently, but so often we lose on volume when we make  
16 progress on price.

17 And I'm certainly open to the kinds of  
18 suggestions Brian has to refine the short-term things.

19 I'm very much in favor of the beneficiary  
20 protections, and I think my default would be to go to the  
21 levels that the physician now in billing rules has. That's  
22 worked well on that side, and I think that's important.

1           It is an interesting question that Alice raised  
2 about what's going on in some of the states. Of course,  
3 there's balance -- I mean protections for commercial  
4 insurance in a number of areas. I think there's only a  
5 couple of states that have had their own sort of Medicare  
6 balanced billing rules, but as you pointed out,  
7 Massachusetts is one. But I have no idea either whether  
8 that was applied to this particular sector. So I think  
9 that's just a useful thing to have in the context.

10           But this is really helpful. I think we're moving  
11 in a good direction.

12           DR. CROSSON: Other comments?

13           David.

14           DR. GRABOWSKI: I wanted to pick up on my comment  
15 from earlier during the first round. Brian, you called  
16 this a flawed program for a flawed industry, and I think --  
17 is there a way to correct some of the flaws in the current  
18 CBP? I don't know if that's an additional policy option,  
19 so I'll put that out there.

20           I will say before kind of stopping that I am  
21 supportive of both adding more products and adding those  
22 beneficiary protections, but in adding more products to the

1    CBP, I would like to see it strengthened.  Some of the  
2    issues that Brian raised in the chapter and his critiques  
3    on page 15, could we think about recommending some  
4    corrections there?

5                Thanks.

6                DR. CROSSON:  Paul, I'm sorry.  I missed you,  
7    passed you buy.

8                DR. GINSBURG:  It's fine because I was going to  
9    raise the issue about the -- and have Jon and Mark discuss  
10   some of what they've said before about refining the option  
11   process as to whether that -- but otherwise, the program is  
12   very impressive, what it's accomplished in savings, and  
13   despite very strong political opposition.

14               DR. MILLER:  Hold that thought.

15               DR. GINSBURG:  Yes.

16               [Laughter.]

17               DR. GINSBURG:  Despite very strong political  
18   opposition.

19               I think especially as revised by Brian DeBusk, I  
20   think I'm very much in favor of the policy options.

21               DR. CROSSON:  Okay.  Amy.

22               MS. BRICKER:  I am in support of the

1 recommendations, also in support of where David was going  
2 around reform. I'm very interested in what Brian can teach  
3 us about the details that you referred to you, and this is  
4 your world. I'm interested in your perspective.

5           One of the things that struck me with respect to  
6 this comparison of what's available on Amazon or what have  
7 you is that in drug reimbursement, it's customary for when  
8 you're reimbursing pharmacy so you're paying for drugs, you  
9 do lower of logic, lower of the contracted rate or the cash  
10 price. Medicare should get the benefit of that.

11           So I don't know if what I'm missing is the  
12 providers that are billing Medicare are not the providers  
13 that are selling these direct, and if that's the case, then  
14 that won't fix it. But if it happens to be the same entity  
15 that will bill Medicare and also bill direct to a cash  
16 payer, we should be given the benefit of that and also  
17 encouraging beneficiaries in the interim that they don't  
18 have to use their benefit. I mean, can you just not be a  
19 Medicare beneficiary in that case and take advantage of the  
20 cash price that's considerably less than presumably what  
21 would be the exposure you would experience if you had gone  
22 through the plan?

1           So I don't know all that I have suggested there,  
2 if that's doable and possible, but I'm just drawing those  
3 parallels with respect to how we pay for drugs.

4           DR. CROSSON: Other comments?

5           [No response.]

6           DR. CROSSON: Okay. Seeing none, Brian, thank  
7 you for introducing us to this topic. There is more work  
8 to do. I think we'll spend probably a year or more working  
9 this through before we're done.

10           I'm sorry. Did I miss someone?

11           DR. MILLER: So you want to do that bidding  
12 thing? Go to David's question.

13           DR. CROSSON: I'm sorry.

14           DR. GRABOWSKI: I think you were out of the room.

15           DR. CROSSON: Oh, okay.

16           DR. GRABOWSKI: I raised this bidding issue in  
17 the first round, and they told me it was the second round.  
18 I tried to take advantage of Jon when you were out of the  
19 room.

20           DR. CROSSON: Oh, okay. I'm sorry. Go ahead.

21           But Jon didn't bite.

22           [Laughter.]

1 DR. GRABOWSKI: No, Jon didn't bite, and so Jon  
2 and Mark were going to go back and forth on this issue of  
3 bidding.

4 DR. CROSSON: And what did they conclude?

5 DR. GRABOWSKI: They didn't. They haven't.

6 DR. MILLER: Do you want to --

7 DR. CHRISTIANSON: Sure. I'll start.

8 So I have a little history on this. Way back  
9 when they started contemplating competitive bidding for  
10 this and also for the lab, they brought me together with a  
11 couple of more theoretical competitive bidding experts to  
12 advise them on how they should design the competitive  
13 bidding system for DMEPOS. And we came up with some very -  
14 - a set of very elegant, I thought, recommendations, none  
15 of which they really followed. And a lot of them were  
16 along the lines of what you saw there, with this letter,  
17 you know, in the chapter with the letter of how to do  
18 bidding better and so forth. And then I also was brought  
19 in later to go visit some suppliers and see what they were  
20 thinking about their strategies for competitive bidding for  
21 DMEPOS.

22 So my takeaway from this is that a lot of this

1 stuff that you would do in a competitive bidding system  
2 with a more standardized product to maximize the value of  
3 the system really weren't needed here. I mean, I'm amazed  
4 at the results that got -- with the competitive bidding  
5 system design that they used. And I guess -- and then we  
6 had a discussion about why they didn't do some of the stuff  
7 that we thought would be useful to do, and Mark was  
8 explaining somewhat the politics of it, from the standpoint  
9 of CMS, and why they couldn't go all the way down the road  
10 and do a competitive bidding system, like setting the price  
11 for government securities and other things like that.

12 DR. MILLER: Yeah, so the -- and I want to be  
13 clear that I think I understand enough of the economics  
14 that I agree that, in the abstract, it would be better to  
15 do it the more theoretically pure way. And as I understood  
16 the argument at the time it came to this, the way the  
17 auction, or bidding works is you have a series of binding  
18 bids. So each person steps up and says, "I will bid \$100  
19 per bed and I will provide 25 percent of the market for  
20 hospital beds in this MSA." And then you accumulate bids  
21 up until you've covered 100 percent of the market, and then  
22 you say, "That's my price and these are my people." Okay?

1 And if you bid was above that, you're out, and you've  
2 covered 100 percent of your market.

3           The theoretical point is it's a binding bid. I  
4 can't walk away. This market, I would be worried, and  
5 particularly early on, that people could walk away. You  
6 know, so if I say I'll do 25 percent of the market and then  
7 I'm gone, what is the government's recourse? And I could  
8 pursue you and, you know, try and put you -- fine you, and  
9 whatever the case. But meanwhile, if I were the  
10 administrator of CMS -- I know that's unnerving -- but if I  
11 were the administrator of CMS I have a 25 percent gap in my  
12 market.

13           And so the flexibility to take that price and  
14 say, okay, I can bring in another supplier, and then with  
15 the results that occurred -- I mean, Brian, the average  
16 kind of reductions that we were getting --

17           MR. O'DONNELL: Fifty-ish.

18           DR. MILLER: Fifty-ish, price reductions,  
19 clearing whole sets of providers who weren't good enough to  
20 qualify and get into the bid -- I saw that as a huge  
21 success, and given the political resistance, like go and  
22 stand and declare victory. Now maybe it's far enough along



1 that, you know, people could revisit it, but I do want to  
2 say, there is still considerable resistance out there, and  
3 lots of people who have complained about access for the  
4 beneficiary, and to me, that's the Achilles heel, and  
5 leaving some flexibility for that administrator to say,  
6 "No, I'm bringing in another bed supplier because I've got  
7 a gap," I felt like was evil worth entertaining.

8 DR. CHRISTIANSON: Yeah, you raise a good point,  
9 too, because to qualify to be a bidder you had to submit a  
10 lot of information about you, and I think CMS really didn't  
11 have that information before. And the folks that weren't  
12 able to do that were not able to bid, and, as you said, it  
13 kind of cleaned out a lot of that from the market. And  
14 that was a positive effect of the way they designed the  
15 system.

16 DR. DeBUSK: If I could build on that -- they  
17 have come a long way in making sure that qualified bidders  
18 -- they're not there yet but they're doing better. I can  
19 tell you, firsthand, the day they announced negative  
20 pressure wound therapy bid winners, there were companies  
21 calling us, saying, "We have no volume, no business. We've  
22 never done this before. We've never bought a unit. But we

1 won bid. Would you like to buy our company now?"

2 [Laughter.]

3 DR. DeBUSK: And there was an industry, a cottage  
4 industry that popped up around building these paper  
5 companies to participate in negative -- in the competitive  
6 bids, so that you could sell them off.

7 DR. CHRISTIANSON: The reason for that was they  
8 were so concerned that they wouldn't get bids in that  
9 initial round that they were welcoming a lot of bids from a  
10 lot of different folks, but over time they --

11 DR. DeBUSK: Well, now you can actually create  
12 somewhat of the opposite effect. Let's say that you're  
13 very well established in, say, wound care and negative  
14 pressure wound therapy, and now you want to take on  
15 bracing. Well, if you can't answer the question that you  
16 have bracing in that business, even though you've dealt  
17 with an even more difficult segment, now you're on the  
18 outside looking in. So you can -- you know, that door  
19 works both ways.

20 MS. BUTO: I'm just going to say, Mark, that I  
21 thought, in the original -- and maybe Jon knows -- design,  
22 they built in extra capacity. They didn't just go up to

1 100 percent but went beyond that, so they would have extra  
2 capacity in case somebody dropped out.

3 DR. MILLER: That is, but that was the complaint.  
4 The complaint was this isn't the true market clearing  
5 price. You could get a lower price. So there was a big  
6 push when this was being --

7 MS. BUTO: Right.

8 DR. MILLER: -- you know, implemented, and there  
9 was a set of economists, led by economists, I think from  
10 the University of Maryland, if I'm remembering properly,  
11 who were saying, this is not the pure model. You've done  
12 this little boost and you could get a more, you know,  
13 correct market clearing price.

14 MS. BUTO: Right. But, you're the government --

15 DR. MILLER: If 40 or 50 percent --

16 MS. BUTO: -- you've got to cover your bets.

17 DR. MILLER: Yeah, 40 or 50 percent reduction,  
18 and you had the latitude to cover the beneficiary, I  
19 thought was like a worthwhile tradeoff, was my view. But I  
20 also want to acknowledge, to any of the economists and  
21 purists out there, they are right. You can probably get a  
22 cleaner market-clearing price using a strict 100 percent.

1 DR. CROSSON: Paul.

2 DR. GINSBURG: Yeah, actually, from our  
3 perspective, this is probably a topic that's hard to get  
4 policymaker attention to, and that there seems to be a lot  
5 more upside in bringing more items into the competitive  
6 bidding than we find in the competitive bidding. So I'm  
7 comfortable just focusing there.

8 DR. CROSSON: Okay. Good discussion. Brian,  
9 thank you for bringing this to us. I think you've got some  
10 good input here, and we'll look forward to the next  
11 iteration of this topic.

12 We've come to the end of the sessions and so now  
13 we have time for public comment. If there are any of our  
14 guests who wish to make a public comment on the items  
15 discussed this afternoon, please come forward to the  
16 microphone so we can see who you are.

17 Seeing none, we are -- I'm sorry. Come, come,  
18 come. Let me give my little speech first. Just to point  
19 out, not necessarily to you but to the audience that this  
20 is an opportunity to provide input. It's not the only one  
21 and it's not necessarily the best one. The MedPAC staff is  
22 open both in person and through electronic communication to

1 input prior to the discussion that we have here. But we do  
2 offer this opportunity. I would ask you to say who you are  
3 and the organizational affiliation you have, and confine  
4 your remarks to about two minutes. When this light comes  
5 back on that will be the end of the two minutes. Thanks.

6 MS. NUSGART: Good afternoon. My name is Marcia  
7 Nusgart. I am the Executive Director of the Alliance of  
8 Wound Care Stakeholders. We represent all the clinical  
9 associations whose members treat patients with wounds.  
10 Wound care is multidisciplinary, so we have the vascular  
11 medicine, vascular surgeons, podiatrist, physical  
12 therapists, nutritionists, nurses all under one umbrella.

13 But we are also a member of the Alliance for  
14 HCPSC Coding Reform. So I would suggest that when MedPAC  
15 and its staff, and all of you, start thinking about other  
16 products to add -- and I didn't have the opportunity to see  
17 which products you're really thinking about because I  
18 didn't see the chapter, obviously -- but exactly -- I want  
19 to echo what Brian had said, and the fact that you are  
20 absolutely spot-in in terms of before one adds any other  
21 types of products to competitive bidding, coding is aligned  
22 with payment, and one needs to be able to perhaps recommend

1 that CMS needs to reform its HCPCS coding system, because  
2 the trend for CMS is to be able to take disparate products  
3 and instead of giving a new billing code or a HCPC code for  
4 a specific set of products, it will give a code that will  
5 say "any type."

6 So exactly what he had said, he was absolutely  
7 correct, is that you'll have disparate products, many  
8 defined technologies under one particular HCPC code, and  
9 it's -- they are all very different, and yet it will only  
10 have one price.

11 Just to let you know that in a 1998 GAO study,  
12 the Need to Overhaul Costly Payment Systems for Medical  
13 Equipment and Supplies, they summarized the current process  
14 results and codes that are so broad as to render CMS unable  
15 to identify what products Medicare contractors are  
16 reimbursing when they process claims.

17 So we would ask you to be able -- before you  
18 decide to be able to do that, we are happy to serve as a  
19 resource and we'd be happy to be able to meet with any of  
20 the MedPAC staff to be able to address this. And again, we  
21 have a whole group of people that can help you with this.

22 So thank you very much. We appreciate your

1 attention.

2 DR. CROSSON: Thank you. Seeing no one else at  
3 the microphone, we are now adjourned. We would ask our  
4 guests if they could move along and we'll be finished with  
5 this meeting in due course.

6 [Whereas, at 4:22 p.m., the meeting was recessed,  
7 to reconvene at 8:30 a.m. on Friday, November 3, 2017.]

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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, November 3, 2017  
8:34 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
AMY BRICKER, RPh  
KATHY BUTO, MPA  
ALICE COOMBS, MD  
BRIAN DeBUSK, PhD  
PAUL GINSBURG, PhD  
DAVID GRABOWSKI, PhD  
JACK HOADLEY, PhD  
DAVID NERENZ, PhD  
BRUCE PYENSON, FSA, MAAA  
RITA REDBERG, MD, MSc  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
PAT WANG, JD

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P R O C E E D I N G S

[8:34 a.m.]

1  
2  
3 DR. CROSSON: Okay. Good morning, everybody. I  
4 think it's time to begin our morning session. Welcome  
5 back, Commissioners, and welcome to our guests.

6 We have two topics this morning. The first one  
7 is going to be a discussion of the treatment of biosimilars  
8 in Medicare Part D. Rachel and Shinobu are going to  
9 present, and Shinobu is starting up.

10 MS. SUZUKI: Good morning. Today Rachel and I  
11 are going to discuss policy issues related to biologics and  
12 their follow-on products, or biosimilars, in Part D.

13 We first discussed this topic in the fall of  
14 2016. At that meeting, we discussed how certain Part D  
15 policies may affect the takeup of biosimilars in Part D,  
16 one of which was related to the price distortions created  
17 by Part D's coverage gap discount program.

18 In April of this year, the Commission again  
19 discussed this issue. At those meetings, we heard a  
20 general consensus for policies to treat the biosimilars and  
21 their reference products in the same manner. So based on  
22 your feedback, we are coming back to you with a Chairman's

1 draft recommendation.

2           In this presentation, I'll provide a quick review  
3 of some of the background materials on biologics and  
4 biosimilars and spending and use in Part D.

5           Rachel will describe Part D's coverage gap  
6 discount program as it relates to biosimilars and how that  
7 might affect the plan incentives to use biosimilars. She  
8 will review the Commission's 2016 recommendations that  
9 could help address some of the issues around plan  
10 incentives and also present the Chairman's draft  
11 recommendation.

12           The term "biologics" refers to therapies derived  
13 from living organisms and manufactured through biological  
14 processes. It includes a wide range of products such as  
15 insulin and therapeutic proteins used for conditions such  
16 as cancers and inflammatory diseases like rheumatoid  
17 arthritis and multiple sclerosis.

18           Biologics are typically injectable or infusible,  
19 and they tend to have high prices. Biosimilars are follow-  
20 on products that are highly similar to the originator  
21 biologic. As with generic drugs, biosimilars may be an  
22 important means for improving access while keeping the

1 spending down by introducing price competition.

2           But biosimilars are different from generics in  
3 important ways. Because of their complexity, biosimilars  
4 are not exact replicas of the originator product. But it  
5 should also be noted that even a manufacturer of an  
6 originator biologic may experience lot-to-lot variations.

7           Part D covers biologics that are self-injectable  
8 and dispensed through an outpatient pharmacy. Part D plans  
9 include their estimate of spending for biologics as part of  
10 the bid they submit to CMS for delivering the drug benefit.

11           Medicare pays plans a monthly capitated amount  
12 based on bids, and Medicare also provides individual  
13 reinsurance by taking on the risk of enrollees with high  
14 drug use and spending by paying 80 percent of spending  
15 above the out-of-pocket threshold.

16           From the combination of Medicare's payments and  
17 enrollee premiums, plans pay pharmacies rates they've  
18 negotiated with them. Plans also negotiate rebates with  
19 manufacturers.

20           Enrollees who use high-priced biologics tend to  
21 reach the out-of-pocket threshold, often early in the year.  
22 After that, they pay 5 percent of the price, which can

1 still be a lot of money. For example, above the out-of-  
2 pocket threshold, a drug that cost \$5,000 per month would  
3 mean out-of-pocket cost of \$250 per month. Medicare pays  
4 for 80 percent of that price for the remainder of the year,  
5 so the taxpayer bears most of the cost of the high price  
6 and use.

7           This table shows spending and use of biologics in  
8 Part D. In 2015, Part D's gross spending for biologics,  
9 before rebates, totaled \$18.7 billion, accounting for  
10 nearly 14 percent of total Part D spending. This is up  
11 from 8 percent in 2011. That's a growth of 29 percent per  
12 year, which is much higher than roughly 13 percent for Part  
13 D program as a whole.

14           Notice that prescriptions for biologics as a  
15 share of total has remained stable at less than 2 percent  
16 during this period. This means that prices are driving the  
17 growth in spending for biologics.

18           Three categories of biologics account for nearly  
19 80 percent of spending for biologics: insulin and  
20 therapies for inflammatory diseases like rheumatoid  
21 arthritis and multiple sclerosis. Those three categories  
22 accounted for nearly 90 percent of the growth in spending

1 for biologics between 2011 and 2015.

2           Insulin makes up the largest share -- about 60  
3 percent 2015, followed by therapies for inflammatory  
4 conditions and multiple sclerosis. Between 2011 and 2015,  
5 average prices for medications in these three categories  
6 grew by between 16 percent to 20 percent annually.

7           We discussed some of the hurdles that biosimilars  
8 may face in gaining market share in our previous sessions.  
9 They're also summarized in your mailing materials. The  
10 remainder of this presentation will focus on one specific  
11 Part D policy: the coverage gap discount. If biosimilars  
12 are going to win much in the way of market share, their  
13 manufacturers will need to get on the Part D plans'  
14 formularies. Generally, you would expect plans and PBMs to  
15 be excited about biosimilars because we expect them to have  
16 lower prices than the originator and offer highly similar  
17 therapeutic effects. Putting lower-priced therapies on  
18 formulary or on a preferred tier is what plans and PBMs do  
19 to keep premiums low.

20           However, this coverage gap discount program only  
21 applies to originator biologics and not biosimilars, which  
22 distorts their relative prices. From a plan's perspective,

1 this means it will often be preferable to put the  
2 originator product on its formulary. And from a  
3 beneficiary's perspective, under current rules the enrollee  
4 is likely to have higher cost sharing with the biosimilar.

5 Now Rachel will show you how this works.

6 DR. SCHMIDT: This slide shows the Part D benefit  
7 structure in 2020, with an originator biologic on the left  
8 and a biosimilar on the right. We're looking at 2020  
9 because that's the year that Part D's coverage gap is  
10 scheduled to be phased out.

11 Let's focus first on the right-hand side -- the  
12 biosimilar. You can see that the coverage gap is phased  
13 out because the enrollee (in light blue) pays a consistent  
14 25 percent cost sharing all the way from just above the  
15 deductible until she reaches the catastrophic phase of the  
16 benefit. Generally, only the enrollee's own out-of-pocket  
17 spending counts towards the out-of-pocket threshold, not  
18 supplemental coverage. This is called "true out-of-  
19 pocket." So this orange area shows what is counted towards  
20 the out-of-pocket threshold for the biosimilar. After the  
21 enrollee reaches the threshold, she pays 5 percent, her  
22 plan covers 15 percent, and Medicare pays for 80 percent

1 through reinsurance.

2           Now let's look at the originator biologics on the  
3 left. Notice the gray area in the middle. That's the 50  
4 percent discount that the manufacturer pays in the coverage  
5 gap. It only applies to the originator biologic, so  
6 there's no gray area on the right. Under current law, that  
7 discount is counted as true out-of-pocket spending. It  
8 gets added to the enrollee's cost sharing for purposes of  
9 determining when she will reach the catastrophic phase. So  
10 here the orange area shows what's counted towards the out-  
11 of-pocket threshold for the originator biologic. You can  
12 see that by including the manufacturer discount, the  
13 enrollee reaches the catastrophic phase at a lower level of  
14 total spending than the biosimilar.

15           Now from the plan's perspective, they're only  
16 responsible for covering 25 percent in the coverage gap for  
17 the originator biologic compared to 75 percent for the  
18 biosimilar. So that's one financial advantage in favor of  
19 the originator. But, in addition, since the originator  
20 biologic pushes the enrollee into the catastrophic phase at  
21 a lower level of spending, after that point Medicare starts  
22 paying 80 percent, and then the plan only has to cover 15



1 percent. So that's a second way this is a financial  
2 advantage to the originator over the biosimilar. You can  
3 see that Medicare reinsurance pays for more of the  
4 originator.

5           This slide has a different view of what we just  
6 saw, using a numerical example from your mailing materials.  
7 It is comparing an originator biologic (on the top) and a  
8 biosimilar (on the bottom). Note on the left that the  
9 invoice price for the originator is \$30,000, and the  
10 manufacturer offers a 20 percent rebate. The biosimilar  
11 has a price that's 15 percent lower (\$25,500), and its  
12 manufacturer also offers a 20 percent rebate. If you look  
13 along the axis at the bottom of the chart, the length of  
14 the bars reflects those prices net of rebates. If there  
15 was just this simple comparison and the two products worked  
16 equally well, the plan would want the biosimilar on its  
17 formulary because it has a lower price. But that's not  
18 what happens.

19           The bars show the sources of funding for each  
20 product after you apply the Part D benefit structure, from  
21 the beneficiary cost sharing, manufacturer discount, plan  
22 benefits, and Medicare reinsurance. In the top bar, you

1 can see that the originator biologic has a light gray piece  
2 to it. That's the manufacturer discount. There's no gray  
3 area or discount in the bottom bar for the biosimilar. The  
4 darker parts of the bars show what the plan is responsible  
5 for covering, and you can see that the plan liability is  
6 much larger for the biosimilar than the originator. That's  
7 because the manufacturer discount gets counted as though it  
8 were the enrollee's spending, so she reaches the  
9 catastrophic phase more quickly. The plan sponsor has a  
10 strong financial incentive to put the originator on its  
11 formulary. The flip side is that Medicare reinsurance is  
12 paying a bigger proportion of the spending.

13 Now let's look at a different policy option in  
14 which the coverage gap discount applies to both products.  
15 You can see this by the fact that there's now a gray  
16 section in both the top and bottom bars. Also under the  
17 policy option, the discount would not count as true out-of-  
18 pocket spending for either the originator biologic or the  
19 biosimilar. This is consistent with the Commission's 2016  
20 Part D recommendations, which I'll review in a minute.  
21 With standardized use of the coverage gap discount,  
22 incentives are better aligned. Now, the plan liability for

1 the biosimilar is a little bit lower than for the  
2 originator biologic because it's reflecting the fact that  
3 the biosimilar has a lower price rather than a lopsided  
4 manufacturer discount. A lower plan liability means plan  
5 sponsors would be more inclined to put the lower-priced  
6 biosimilar on their formulary. Under the policy, Medicare  
7 would also pay lower reinsurance.

8           This chart compares current law with the policy  
9 option. Under current law, shown on the left, the 50  
10 percent discount applies to brand-name drugs, including  
11 originator biologics, but does not apply to biosimilars.  
12 Also under current law, that 50 percent discount gets  
13 counted as though it were the enrollee's own out-of-pocket  
14 spending -- again for brand-name drugs and originators, but  
15 not biosimilars. The right side shows the policy option in  
16 which the coverage gap would apply to biosimilars as well  
17 as originators. Consistent with the Commission's 2016  
18 recommendations, the option would also discontinue counting  
19 the 50 percent discount as true out-of-pocket spending for  
20 brand-name drugs, originators, and biosimilars.

21           We've focused on brand-name drugs and biologics  
22 because they account for about 75 percent of gross

1 spending. Kathy, when we've talked about this before,  
2 you've asked why we don't apply a discount to generic  
3 drugs, too. One reason is that even though we've seen some  
4 big price increases for certain generic drugs, in general  
5 generics' prices are relatively low. We don't want an exit  
6 of generics. They're an important source of price  
7 competition. Given that prices for brands and biologics  
8 are relatively high, a 50 percent discount for them in the  
9 coverage gap can be sizable, but the discount would not be  
10 nearly as large for generics.

11 In 2016, the Commission recommended a package of  
12 changes to Part D, some of which relate to the coverage gap  
13 discount. The Commission recommended changes because we  
14 saw that Medicare had been taking on more of the benefit  
15 risk over time, and there's been rapid growth in Medicare's  
16 reinsurance payments. The core idea was to give plan  
17 sponsors greater incentive and more tools to manage  
18 spending for enrollees who reach the catastrophic phase.

19 I'm not going to go through all the details, but  
20 I want to point out those bullets that are highlighted  
21 here. One part of the recommendation was to discontinue  
22 counting the coverage gap discount as true out-of-pocket

1 spending. At the time, we talked about how the coverage  
2 gap discount disadvantages generics relative to brand-name  
3 drugs and acts in a similar way as a co-pay coupon,  
4 encouraging beneficiaries to use higher-priced therapies.  
5 But we also recognized that some enrollees would pay more  
6 in cost sharing. To put a limit on that burden, the  
7 recommendation eliminated cost sharing about the out-of-  
8 pocket threshold. That same dynamic would take place under  
9 the policy option I just described. Some beneficiaries  
10 would have higher cost sharing, but there would be a hard  
11 out-of-pocket cap. We think that these pieces of the 2016  
12 recommendation would work in concert with the Chairman's  
13 draft recommendation that I'm about to show you.

14           So the draft recommendation reads: The Congress  
15 should change Part D's coverage gap discount program to  
16 require manufacturers of biosimilars products to pay the  
17 coverage group discount by including biosimilars in the  
18 definition of applicable drugs and exclude biosimilar  
19 manufacturers' discounts in the coverage gap discount from  
20 enrollees' true out-of-pocket spending.

21           We do not yet have an estimate of the spending  
22 implications of this option. We will consult with

1 Congressional Budget Office. Remember that few biosimilars  
2 that fall under Part D are as yet on the market, so the  
3 near-term savings are likely to be small. However, over  
4 the longer term, we expect more entry of biosimilars that  
5 would be covered under the pharmacy benefit, so savings  
6 could be larger. We think the draft recommendation would  
7 send better price signals and could make it more likely  
8 that Part D plan sponsors put lower-priced biosimilars on  
9 their formularies.

10           Relative to current law, manufacturers would pay  
11 more in discounts. Medicare would continue to pay the same  
12 74.5 percent subsidy for Part D, but there would be more  
13 spending covered by plan liability and Medicare's capitated  
14 direct subsidy payments would be higher, and there would be  
15 less spending covered by Medicare's reinsurance. Enrollees  
16 with spending that reached the coverage gap would have  
17 higher cost sharing because the manufacturer discount would  
18 no longer count as their spending. However, under the  
19 Commission's 2016 recommendation, Part D would eliminate  
20 cost sharing above the out-of-pocket threshold, so there  
21 would be a hard cap. Because prices for biologics have  
22 been increasing faster than for Part D as a whole, that

1 hard cap would become more valuable over time. And to the  
2 extent that the Commission's recommendations led to net  
3 program savings, policymakers could consider lowering the  
4 out-of-pocket threshold.

5           Going forward, after your conversation today, we  
6 will take your comments and make any necessary revisions.  
7 Then we'll be back in January, when we would normally  
8 present a status report on Part D, for you to vote on a  
9 draft recommendation related to the coverage gap discount.  
10 Our intent is to include this as part of the Commission's  
11 March 2018 report to the Congress.

12           DR. CROSSON: Thank you, Rachel and Shinobu.

13           We're now open for clarifying questions. Okay.  
14 I saw Kathy and then Jack and Paul.

15           MS. BUTO: Thanks, Rachel and Shinobu. Do we  
16 know what's actually happened in practice, even though  
17 there are very few biosimilars, in terms of Part D plans  
18 putting them on formulary or not and what the experience  
19 has been with the use of biosimilars?

20           MS. SUZUKI: So it's a little bit early, and it's  
21 not technically biosimilar, but we have checked a couple  
22 plans' formularies for Basaglar, the insulin analog that's

1 now a follow-on product, and it depended on the plan. Some  
2 plans did have that on the formularies; others did not.

3 DR. SCHMIDT: But it's kind of a special case  
4 because it was approved through a different pathway, and  
5 technically, that manufacturer is subject to the coverage  
6 gap discount.

7 DR. CROSSON: Jack.

8 DR. HOADLEY: So I just wanted to clarify on  
9 Slides 9 and 10. On 10, you're very specific about sort of  
10 incorporating the 2016 recommendation in terms of the  
11 brand-name drugs. On Slide 9, where you're showing the  
12 policy option, you're not incorporating the reinsurance,  
13 the shift in the share of reinsurance that's in our 2016  
14 recommendation. Is that right?

15 DR. SCHMIDT: Right. This is just applying the  
16 coverage gap discount and the true out-of-pocket treatment.

17 DR. HOADLEY: So, I mean, it might be useful at  
18 some point just to have even if it's a second version of  
19 that graphic to show if our -- if all of our  
20 recommendations were taken into account, what would this  
21 look like? It might just be useful to illustrate the sort  
22 of joint effect.



1 DR. CROSSON: Yeah, I think, you know, just maybe  
2 as a philosophical point -- I don't know -- we very much  
3 consider these recommendations as part of our -- you know,  
4 as an extension of but in many ways part of our  
5 recommendation in 2016. So our hope would be that if this  
6 totality of recommendations was considered by Congress,  
7 that they all be taken together.

8 DR. HOADLEY: Right, and that's why I thought it  
9 would be useful sort of where we're showing the effect of  
10 our policy option, we could show it alone if we want to,  
11 but it would also be useful to show it in conjunction with  
12 those other recommendations.

13 DR. CROSSON: That is the intent.

14 DR. HOADLEY: Exactly in that spirit.

15 DR. CROSSON: Paul and Brian.

16 DR. GINSBURG: Yeah, I was wondering if the  
17 current policy with the way that the manufacturer's 50  
18 percent discounts, you know, does not affect the patient  
19 cost sharing is analogous to the coupon issue outside of  
20 Medicare, where in a sense the Medicare program does not  
21 permit coupons, but as far as the deal in Part D changes  
22 under the ACA, the Congress actually permitted a coupon

1 scheme within Medicare for drugs in the coverage gap.

2 MS. SUZUKI: We agree with that, that it does act  
3 -- by lowering the cost sharing for the beneficiary at the  
4 point of sale and getting them to the catastrophic more  
5 quickly, it has the effect similar to co-pay coupons.

6 DR. CROSSON: Brian?

7 DR. DeBUSK: On Chart 7, I thought that was a  
8 really good graphic for describing the incentives and how  
9 to align -- well, actually, the whole presentation was, but  
10 that chart really brought it to a head about the  
11 misalignment of incentives. And I really appreciate where  
12 you're taking us, you know, again, trying to correct these  
13 market price signals.

14 Is there another layer here, though, when you  
15 look at how these plans, particularly when a PBM puts  
16 together a formulary -- is there another layer here that we  
17 could be missing around the rebates that get paid on, say,  
18 a preferred brand versus on a generic? Is there one more  
19 set of misaligned incentives that we should at least be  
20 aware of or factor into our calculations, and could you  
21 speak to those?

22 I'm a little bit interested in particular about

1 the Pfizer and J&J lawsuit regarding Remicade. That would  
2 be a great one to focus on. Could you speak to that?

3 DR. SCHMIDT: I don't know that I can speak to  
4 that particular case, but the general issue about rebates,  
5 we had a presentation -- was it April? -- where we kind of  
6 described some of that. And I think Bruce has brought up  
7 this issue before about how the Medicare program makes a  
8 decision about how much of the rebates to hold onto to  
9 offset its costs of reinsurances versus how much the plan  
10 retains. I don't know if you remember that conversation or  
11 not.

12 So the way that allocation takes place now, we  
13 have some concerns about it's more generous to the plan,  
14 perhaps, but I don't know that that's getting at what  
15 you're asking.

16 DR. DeBUSK: What I was looking at is let's say  
17 you have a biologic that is on, say, tier 5, but it's  
18 paying a very generous -- or it's paying some type of  
19 rebate back to the PBM, which again has to be handled  
20 through DIR.

21 What happens of a biosimilar comes in or a  
22 generic in general? This isn't really restricted to

1 biologics. They want a more favorable place on the  
2 formulary, on the tier, but due to the rebate -- I mean,  
3 basically, there could be a rebate, an incentive that would  
4 encourage the plan or the PBM to want that higher-tier  
5 drug. Again, I need to dig in a little bit more on this  
6 Remicade thing, but it seems like there were sort of some  
7 overwhelming barriers that that particular biosimilar was  
8 going to have to come up with to overcome that originator  
9 biologic.

10 DR. SCHMIDT: Yeah. I think I've seen financial  
11 analysts refer to that as a rebate trap, where, yeah, you  
12 could lose all of your rebates on one drug if you switch to  
13 the biosimilar, and they're very sizeable, indeed. So that  
14 is a big problem.

15 DR. DeBUSK: And again -- and I'll get off this  
16 subject for a second -- I love this work. I would just  
17 hate to see us maybe not take that next step where we claim  
18 75 percent of the problem, but there's still this other  
19 issue there regarding the "rebate trap." I like that term.  
20 I'm going to use that.

21 [Laughter.]

22 MS. SUZUKI: One thing I'll comment on is in our

1 June 2016 recommendation, we had a policy to shift more of  
2 the catastrophic risk to the plans, and in those cases, we  
3 thought some of those incentives that may have been  
4 misaligned would be addressed.

5 DR. DeBUSK: That's a great point.

6 DR. CROSSON: Let's see. I have Dana, Jon, and  
7 Amy.

8 Dana.

9 DR. SAFRAN: Thanks.

10 So I also really appreciated this graphic on 7 to  
11 show the misaligned, and the graphic on 9 really made a  
12 strong case for correcting the pricing signals.

13 The question I have relates to when you got to  
14 the kind of implications of the policy recommendations and  
15 the fact that we could be facing higher beneficiary out-of-  
16 pocket costs in a coverage gap piece, and I just wondered  
17 whether you considered -- could you go to slide 10? --  
18 whether you considered having the discount treated as out-  
19 of-pocket across the board rather than taking it away and  
20 then keeping the out-of-pocket cost share after the  
21 catastrophic level.

22 Maybe financially, that doesn't work, and it just

1 costs too much. But it just felt -- I just wondered  
2 whether the beneficiary would have a better experience and  
3 also whether you'd get better acceptance from the industry  
4 if you kept the out-of-pocket treated as -- the discount  
5 treated as out-of-pocket and just added in the biosimilars  
6 to that. Did you consider that?

7 DR. SCHMIDT: Well, the implications of it are  
8 that so that the dollar point at which the reinsurance  
9 kicks in, so from this graphic on the left-hand side.  
10 You'd see a similar thing happening over on the right-hand  
11 side now. So Medicare reinsurance would be paying for a  
12 whole lot more of it, and it would start at a lower level  
13 of spending and subsequently pay for more of the price of  
14 the drug.

15 I suppose if you were able to implement the 2016  
16 recommendations where the reimbursement of the reinsurance  
17 from the federal government was at 20 percent instead of 80  
18 percent, that might alleviate some of that higher cost, but  
19 it is much higher program spending.

20 Go ahead.

21 MS. SUZUKI: I would just add that the original  
22 idea about not treating the gap discount as true out-of-

1 pocket was that it was the brand versus generic comparison.  
2 So you would continue to have that issue.

3 DR. CROSSON: Jon.

4 DR. CHRISTIANSON: Yeah. Back to slide 13. I  
5 think the last time we talked about this issue, we  
6 acknowledged that some beneficiaries could have higher cost  
7 sharing, but we also said that putting a hard cap would  
8 benefit some beneficiaries. So there was a little bit of  
9 give-and-take there.

10 But I think what's new on this slide -- and it's  
11 probably worth having you walk us through very quickly --  
12 is this notion that the value of the hard cap would grow  
13 over time, which would seem to me to imply a better  
14 situation maybe for beneficiaries than we've talked about  
15 in the past.

16 MS. SUZUKI: So one thing that happens is  
17 beneficiary parameters grow by the average spending in the  
18 Part D program, and that historically has been lower than  
19 the growth rate we see in the prices of the high-priced  
20 products. So it may be something like 4 to 5 percent  
21 growth in the benefit parameters versus 16 to 20 percent  
22 price growth for certain medications.

1           So what happens is the people who take those  
2 expensive medications get to the catastrophic threshold  
3 quickly in the year, and that value grows over time because  
4 of the discrepancy in the growth rate.

5           DR. CHRISTIANSON: Okay. Thank you.

6           DR. CROSSON: Amy and then Bruce.

7           MS. BRICKER: So Brian touched on this with some  
8 outstanding litigation that's pending between two  
9 manufacturers, and that's separate, though, from -- what's  
10 mentioned in the chapter is reference to some pay-for-delay  
11 settlement agreements. Particularly, you reference one  
12 from AbbVie and Amgen.

13           But you go on to mention that there are no  
14 reporting requirements to the FTC with respect to those  
15 settlement agreements. Can you comment on that further?

16           DR. SCHMIDT: Sure. So under the Medicare  
17 Modernization Act, back in 2003, they established a  
18 reporting requirement that was basically under the context  
19 of Hatch-Waxman. So it was thinking of pay-for-day or  
20 settlement agreements related to generic and brand  
21 manufacturers, and at the time, this biologics pathway  
22 wasn't even law. Of course, that happened later.



1           So the large-molecule drugs are not subject to  
2 this reporting requirement. So as a result, the FTC is not  
3 getting settlement information for situations like the one  
4 that's described in the paper at all.

5           DR. CROSSON: Bruce.

6           MR. PYENSON: Thank you very much. I think the  
7 graphics are really terrific.

8           I would wonder about the value of creating  
9 similar graphics and analysis for the low-income subsidy  
10 population, which I think is a pretty significant portion  
11 of the total Part D spend and in particular the Medicare  
12 cost implications of that in this situation.

13          DR. SCHMIDT: So you're saying that because of  
14 the fact that the low-income subsidy is picking up so much  
15 of the cost sharing for the LIS, you would like to see that  
16 demonstrated, right?

17          MR. PYENSON: Yes. And the low-income subsidy  
18 population uses more specialty tier drugs than the regular  
19 population, so this might even be a leverage impact.

20          DR. MILLER: I have no objection to the notion of  
21 showing the LIS effect. I mean, you know, mapping is out  
22 for the LIS. The LIS aren't incurring any out-of-pocket,

1 right?

2 MS. SUZUKI: Is what you're asking that once the  
3 biosimilar is on the formulary that the cost sharing  
4 subsidy implication is there as well? Is that what you're  
5 getting at?

6 MR. PYENSON: Well, I was more concerned with the  
7 federal share since CMS is picking up the --

8 MS. SUZUKI: They pick up the 100 percent cost --

9 MR. PYENSON: -- of what it would be in cost  
10 sharing. And there's not a manufacturer discount.

11 MS. SUZUKI: Right.

12 MR. PYENSON: So some of the dynamics -- I was  
13 thinking as you -- to see that split out by CBO. When you  
14 talk to them about the budget impact of this, that to  
15 consider those two pieces separately, the two populations  
16 separately.

17 DR. CROSSON: I thought I saw -- yeah. Pat.

18 MS. WANG: Would you just for clarity sake, going  
19 back to slide 7 -- can you kind of verbally redraw what  
20 this would look like under the policy option that's being  
21 proposed? I guess, can you just describe what the change  
22 in this picture would be if we were to adopt the

1 Commissioners' recommendation? The biologics and  
2 biosimilars would be treated identically, but how would  
3 this work?

4 DR. SCHMIDT: Right. So I guess the one on the  
5 left, you'd see kind of maybe the enrollee cost sharing  
6 continuing up to maybe a comparable height, as the one on  
7 the right, but there would be a gray area in both the right  
8 and the left. So the enrollee cost sharing would be 25  
9 percent, and the manufacturer would be paying 50 percent  
10 but up to a higher level of spending, up to a higher price  
11 there. Does that make sense?

12 MS. WANG: I think so.

13 So it's essentially -- I was looking on the --  
14 well, it doesn't really matter -- on the left-hand side.  
15 As you say, this solid section would rise the manufacturer  
16 and the plan shares above initial coverage would be split  
17 just they --

18 DR. SCHMIDT: Exactly. So all of those layers in  
19 the middle there, what's called the "coverage gap" on the  
20 left-hand side would be up higher --

21 MS. WANG: Okay. Thank you.

22 DR. SCHMIDT: -- kind of to a comparable height

1 to the right.

2 MS. WANG: Okay.

3 DR. MILLER: We went around and around internally  
4 on how to visualize this.

5 The other answer to her question is that's what  
6 we were trying to do, I think, with 9 and 10, although it's  
7 displayed a bit differently than this because we tried to  
8 do it with this picture, and things got a bit hairy. And  
9 so we moved to these to try and make the point, and the  
10 difference between the dark area on 8, I think -- if you  
11 can back up one? -- and the plan liability shift between  
12 this picture and then 9, which is what we were trying to  
13 show, and you see a more comparable layout. You see both  
14 50 percent discount and plan liability.

15 MS. WANG: Got it, got it, got it, got it.

16 DR. MILLER: But this is kind of grouping all of  
17 the spending together --

18 MS. WANG: Yes.

19 DR. MILLER: -- as opposed to the other picture,  
20 which parsed it out by people, discount plan, all of that.

21 MS. WANG: Yes, yes.

22 DR. MILLER: And it just got hairy, and so this

1 is what we were trying to do to get at that variable.

2 MS. WANG: And I see that. I just --

3 DR. MILLER: We've messed around with that  
4 picture for a while --

5 [Laughter.]

6 DR. MILLER: -- and then finally, Shinobu said,  
7 "That's enough."

8 MS. WANG: And can I just ask -- and I apologize  
9 for not knowing this. The implications of the phase-out of  
10 the coverage gap are represented here already because it's  
11 a 2020 view. What does it look like today? Like I don't  
12 actually understand how the phase-out works, like what the  
13 implications are for beneficiaries or the program. I don't  
14 understand what it means.

15 You had many references to it in the paper, which  
16 was great, but for me, anyway, it was just like I need just  
17 one more, like backing up, one more piece, if you wouldn't  
18 mind.

19 MS. SUZUKI: So currently, enrollees' cost  
20 sharing is higher than the 25 percent. So if you look at  
21 the originator biologics on the left-hand side, that  
22 manufacturer discount is 50. Plan liability is lower than

1 the 25 percent. So there is a little bit of shift there.

2 It gradually takes down the enrollee cost  
3 sharing, and in 2020, it's 25 percent.

4 DR. CROSSON: Just as an editorial comment, my  
5 own experience with this particular policy area has been  
6 that every time we enter the coverage gap, it's like  
7 abandon all hope. You enter here.

8 [Laughter.]

9 DR. CROSSON: It's one of the more complicated  
10 pieces of analysis I think we do here at the Commission.

11 Okay. Yeah. Rita.

12 DR. REDBERG: Thanks. The chapter was great, and  
13 I like the graphics.

14 But I'm just having a really hard time  
15 understanding this manufacturer's discount and how it  
16 actually works. Like say the drug costs \$5,000. Does then  
17 the manufacturer say, "Oh, it's \$2,500," and then the plan  
18 only pays \$2,500, or does the plan pay \$5,000 to the  
19 manufacturer, and then the manufacturer takes \$2,500 and  
20 hands it back to the plan? Who gets this discount? I  
21 don't understand it.

22 DR. SCHMIDT: Neither of those.

1 [Laughter.]

2 DR. REDBERG: Okay.

3 DR. SCHMIDT: Yeah. It's kind of applied on top  
4 of the benefic structure. Whatever plan the enrollee is  
5 in, they might have a deductible that they go through, and  
6 so the \$5,000 price deductible applies towards that. And  
7 then there is this initial coverage range of spending where  
8 there's about 25 percent cost sharing or copay equivalence  
9 to that, and that's all applied to the \$5,000 price.

10 And then you hit the coverage gap, and at that  
11 point, it's where the manufacturer is providing a 50  
12 percent discount at the point of sale. So that's where  
13 there's some billing that takes place that ultimately is  
14 between the plan and the manufacturer to cover the 50  
15 percent, but it's only in that range of spending. Does  
16 that help at all?

17 DR. REDBERG: So it only kicks in at the time you  
18 enter the coverage gap, that black hole area, but at that  
19 time, I'm still interested in how does that money exactly -  
20 - who is getting -- is there actual money changing hand?  
21 Is it just the price is reduced in that period? I'm having  
22 a hard time understanding the mechanics.

1 DR. SCHMIDT: It's changed over time. It used to  
2 be that the Medicare program would kind of front some of  
3 that money until they could reconcile exactly that a claim  
4 had been paid, and then there was a billing that would take  
5 place to the manufacturer, but now I think it's more  
6 direct.

7 Bruce, you sounded like you wanted to speak to  
8 it.

9 MR. PYENSON: There is a coverage gap discount  
10 liability that the manufacturers have to book on their  
11 financial statements. The cash is fronted by the Part D  
12 plan, and then through reporting from the federal  
13 government, there's periodic charges against the Part D  
14 plan.

15 In recent years, due to reporting issues, some of  
16 the pharmaceutical companies have under-accrued the  
17 liability for the Part D discount, and they had actually  
18 report that in their financial statements as it got  
19 corrected.

20 So it's sort of a classical insurance runout  
21 cash-flow issue.

22 MS. BUTO: [Speaking off microphone.]



1           MR. PYENSON: I am looking at Rachel for  
2 confirmation.

3           [Laughter.]

4           DR. SCHMIDT: That makes sense. We haven't gone  
5 and audited anybody's books or anything like that.

6           MR. PYENSON: You can actually see line items in  
7 the publicly traded companies at the end of the year for  
8 that liability that they're going to owe.

9           DR. MILLER: But beyond the accountability, what  
10 was the question about how the money changes hands?

11          DR. REDBERG: Well, I'm interested in who is  
12 benefitting from that 50 percent discount. Like did the  
13 plan now pay less, or did Medicare get the money back, the  
14 patient get the money back, or they just charged -- do you  
15 see what I mean? And then you're saying it's this --  
16 whatever it is, it occurs only during the coverage gap.  
17 Then the price goes up. So it's just a way to get to  
18 Medicare paying 80 percent faster.

19          MS. SUZUKI: So the idea behind closing of the  
20 coverage gap was to have enrollees pay 25 percent  
21 ultimately in the coverage gap phase, and the plan benefit  
22 would cover 75 percent. But it's expensive to provide that

1 extra coverage, and the manufacturer's gap discount helps  
2 with the closing of the coverage gap.

3 So instead of plans, which means the plan bid and  
4 subsidy and everything goes up by that amount, that's  
5 reduced by the manufacturer discount. Does that make --

6 MR. PYENSON: It's not a point-of-sale discount;  
7 that is, nobody sees a smaller retail price or transaction  
8 price at the pharmacy. So it's handled in the back,  
9 background.

10 You can imagine an expensive drug that starts in  
11 the initial coverage zone, and so the discount only applies  
12 to the portion that's above the beginning of the coverage  
13 gap. And then it stops at the catastrophic, so it's a  
14 retrospective calculation.

15 MS. BRICKER: And the plan's benefitting. You  
16 said, "Who's benefitting?" The plan's benefitting. And  
17 the enrollee, and that --

18 DR. HOADLEY: And the enrollee. The beneficiary  
19 at the point of sale is seeing a lower out-of-pocket cost  
20 even though the invoice cost at the point of sale wouldn't  
21 look lower.

22 DR. REDBERG: So I can see the plan benefits, the

1 beneficiary benefits, and Medicare pays a lot more. And  
2 then, you know, so it's a way to kind of keep up the higher  
3 prices and just shifting those higher-price costs to the  
4 federal government.

5 MS. BRICKER: Yeah, I mean, Medicare pays more  
6 because you're getting through that catastrophic -- that  
7 coverage gap phase faster.

8 DR. MILLER: Right.

9 MS. BRICKER: So that's how they pay more.

10 DR. CROSSON: Okay. Rachel and Shinobu, thank  
11 you for taking us on the perilous journey once again  
12 through the coverage gap. I think we survived it.

13 So now we'll have general discussion. Normally,  
14 we start with the recommendation. We have a recommendation  
15 on the table. But I did solicit requests yesterday, and so  
16 Jack and Amy are going to begin the discussion. We'll  
17 start with Jack.

18 DR. HOADLEY: So thank you for this chapter, and  
19 there's a lot of good material in the reading materials  
20 well beyond what you've covered, had time to cover today.  
21 And I think, you know, taking us back to the starting point  
22 that you started us from, which is that biologicals are, in

1 fact, a major source of the rising costs that Part D is  
2 facing, much more than traditional drugs, and that it's  
3 price more than use, I think those are just important  
4 markers. And because a lot of these are clinically  
5 important drugs, the price is really sort of holding the  
6 program and the beneficiaries hostage to a degree. You  
7 know, these are drugs that people need; therefore, you  
8 know, those prices get paid, and it comes out of the  
9 pockets of beneficiaries; it comes out of the program.

10 And the biosimilars really should give us, as you  
11 pointed out, the potential to create some savings, and what  
12 we've got is a number of barriers that are getting in the  
13 way of that. I mean, there are some important barriers  
14 that we're not talking about today because they are not  
15 Medicare specific, but it's the whole process of getting  
16 these biosimilars through the FDA. That's obviously going  
17 a lot better than we thought it might some years ago.  
18 There's the interchangeability policies that the FDA still  
19 is working through. There's the patent disputes that have  
20 already been referenced where manufacturers -- the  
21 originators are blocking the biosimilars from coming to  
22 market even when they've got FDA approval. There's what

1 you called the "rebate trap," the various maneuvers that  
2 the originator manufacturers are using to try to protect  
3 their market share. And then there's the state laws that  
4 limit the automatic substitution of the biosimilars at the  
5 pharmacy in some states and require that -- only allow that  
6 to be done in a comparable way to what we see with  
7 traditional generics, you know, if that interchangeability  
8 requirement or other kinds of ways that states have done  
9 that.

10           So we've got a set of barriers that are not  
11 Medicare-specific barriers, and I think it's important, and  
12 I know you do in the chapter talk about a lot of these, to  
13 keep those on the table. You know, we may decide that  
14 they're outside of our scope, although I think it's worthy  
15 to keep talking about those issues and whether there are  
16 any levers that we have to sort of raise those.

17           What you've got here -- and I think it's an  
18 important one -- is the fact that Medicare has, probably  
19 unintentionally, created another barrier through the way  
20 the coverage gap discount rules work. And I think that the  
21 recommendation is an important one in terms of sort of  
22 correcting, again, what I think is probably an

1 unintentional -- at least I'd like to believe it's an  
2 unintentional design flaw and, therefore, you know, might  
3 not be so controversial to get fixed.

4           And I think, you know, putting that in the  
5 context of our 2016 recommendations is important, and I do  
6 think in terms of just language, we had, I think, in the  
7 language that you put up the notion of the exclusion from  
8 the true out-of-pocket cost. And I think it's important  
9 that in the text we make it clear that that should be done  
10 in conjunction with -- and, Jay, you've already really made  
11 that statement -- the 2016 recommendations, because I would  
12 hate to see Congress sort of going in and grabbing this  
13 little piece and still treating the biosimilars in a  
14 different way than other drugs, than other regular brand  
15 drugs are treated. So, you know, we need to emphasize --  
16 figure out what's sort of the best way within our document  
17 to emphasize that these continue to be as part of a larger  
18 package.

19           We had some back-and-forth back in 2016 over the  
20 specifics of getting there. We ended up with a package  
21 that folks could agree on around this table, and so I think  
22 it's important to keep it in that context.

1           One other thing you mentioned in the chapter was  
2 the question of -- and this, again, relates to the 2016  
3 recommendations -- what are the CMS rules for adding a  
4 biosimilar to a formulary midyear. And I think to the  
5 extent that if you think that what we said there  
6 incorporates -- you know, applies to biosimilars the same  
7 way that we intended it to apply elsewhere, we should make  
8 sure to make that point. Maybe it doesn't need to go in  
9 the recommendation, but it is, again, part of the text that  
10 is sort of aligning our package of recommendations  
11 together.

12           The only other thing I wanted to mention -- and I  
13 know on Slide 13 you specifically reminded us of the very  
14 last bullet there, that to the extent that the  
15 recommendations result in a net savings, we could consider  
16 lowering the out-of-pocket threshold. I think in that  
17 context it's worth pointing out -- and it's not something  
18 that everybody's familiar with -- that there's actually  
19 scheduled in 2020 to be a substantial increase in the out-  
20 of-pocket threshold -- some are calling it a "cliff" --  
21 because of the way the law was structured held the out-of-  
22 pocket threshold to a lower growth rate between the time

1 that law was created in 2010 and 2020. And then that  
2 particular provision expires, so there's this sort of  
3 catch-up. It goes back to where it would have been, and it  
4 amounts, from what I've seen, to about a \$1,200 increase in  
5 the out-of-pocket limit in 2020. And so we've already sort  
6 of said that ideally we'd like to see that out-of-pocket  
7 threshold lowered, you know, in this contingency. I think,  
8 A, at the very least that's worth flagging in our  
9 discussion, and I actually would love to see us maybe think  
10 about sort of incorporating that somehow in this  
11 recommendation to not have that increase step in because  
12 that's going to be a significant increase in out-of-pocket  
13 costs, as well as, in the absence of other changes,  
14 government reinsurance costs.

15 DR. CROSSON: Well, at the very least, I think  
16 that -- and I was not aware of that. I would think that  
17 that would provide context for this point that's being made  
18 here.

19 DR. HOADLEY: Absolutely. At the least we need  
20 to reference it, put that in that context, and if we felt  
21 the willingness to go further, you know, that would be  
22 great.



1 DR. CROSSON: Thanks, Jack. Amy.

2 MS. BRICKER: Slide 12. Thank you both for the  
3 chapter and for the recommendations. I am in support of  
4 both of them as outlined and agree with what Jack has  
5 mentioned around it's really hard to just pull out this  
6 piece and address this piece of the Part D benefit without  
7 also considering all of the other implications to the Part  
8 D plan. And so to ensure that we're casting a wider net as  
9 part of the recommendation, I think it's important.

10 I want to pick up from a comment or question that  
11 I had earlier in the session around the pay for delay or  
12 settlements that are now occurring with and between  
13 manufacturers. You know, we sit here today thinking about  
14 how we can ensure that policy is aligned or biosimilars,  
15 yet I fear we will not see biosimilars come to market in  
16 the way that we absolutely need. It was surprising to me,  
17 I wasn't aware, you know, as MMA was constructed and  
18 designed, that FTC would not have access to the settlement  
19 agreements that today are being made in this space. And if  
20 nothing else, I would encourage us to encourage the  
21 Congress to change that.

22 AbbVie in the case of Humira, Humira is the

1 number one drug in specialty spend, \$16 billion a year.  
2 And the settlement agreement, as I understand it, between  
3 AbbVie and Amgen now delays access to that biologic in the  
4 United States until 2023. And yet as part of that  
5 settlement, they're allowing the biosimilar to be allowed  
6 in the EU. So Europe will see the biosimilar for Humira  
7 and the United States will not -- for years. And this is  
8 the thing that I think is most critical to addressing the  
9 spend in Part D. We have to have competition, and we have  
10 to have disincentives for manufacturers to, you know,  
11 together work through these settlement agreements, and yet  
12 taxpayers are on the other end of those deals.

13           So I'm in support of this, but I think we've got  
14 to have a louder voice with respect to what's going on in  
15 this space and ensure that actually biosimilars do come to  
16 market.

17           DR. CROSSON: Thank you, Amy. And I think in  
18 writing this up, we can broaden the context a bit to  
19 include some of the points you made.

20           Warner, yes?

21           MR. THOMAS: I just would echo Amy's point, and I  
22 think that, you know, just the -- and I appreciate, Rita,

1 having you go through just what's the rationale behind the  
2 rebates, which we all know the rationale behind it is to  
3 keep the patient in a more expensive option and to push  
4 more of that cost to the Medicare program.

5 I would agree with Amy's point that -- I mean,  
6 what she just referenced really doesn't make a lot of  
7 sense, and it is not fair to the program to be able to push  
8 this type of cost on to the program.

9 I would just also -- you know, we constantly kind  
10 of talk about drug costs, and I think in Part D this is a  
11 place where we could be challenging ourselves and the  
12 program to look at setting pricing around drug costs. And  
13 it is essentially we are -- here Medicare is purchasing  
14 drugs directly, essentially. We are using Medicare funds  
15 to do that. And I think it's an opportunity for us to take  
16 a broader approach. I agree with the recommendations that  
17 are here, but I would like to see us in the chapter  
18 indicate that due to these situations, due to the  
19 escalating costs, due to the issues that Amy comments on,  
20 this warrants a broader look at pricing and setting drug  
21 pricing in the Part D program.

22 DR. CROSSON: Okay. Again, I think we're hearing

1 some request to broaden the context and, you know, both in  
2 re-referencing the 2016 recommendations and making sure  
3 that this recommendation is incorporated in the sense of a  
4 unified set of recommendations, but also broadening the  
5 problem statement, if you will, that we're trying to  
6 address. I think that's right.

7 Yes, Alice, Kathy, and Bruce.

8 DR. COOMBS: So I really appreciate Jack and  
9 Amy's comments. One of the things I thought about was, you  
10 know, the reversal of the reinsurance so that -- one of the  
11 recommendations in 2016. The amount that that would  
12 contribute back to the program in conjunction with the  
13 current recommendations, as we have discussed, only because  
14 I think that large number will persuade to take the whole  
15 menu, to look at the whole menu, because it will be more  
16 persuasive in terms of looking at the impact of that, the  
17 dollar amount. And so I guess we could go back to the  
18 chapter that we had previously and just kind of --

19 DR. SCHMIDT: I just want to clarify, though. So  
20 by bringing the reinsurance down, that was -- actually, we  
21 were keeping the overall Medicare program subsidy the same,  
22 so about 75 percent of it. So we were just -- we were

1 substituting a capitated payment for back-end reinsurance.  
2 So to the extent there are program savings, it would be  
3 from having stronger incentives for plans to be managing  
4 really high cost folks.

5 DR. COOMBS: Right.

6 DR. SCHMIDT: I just don't want to leave the  
7 impression that all of that, bringing the 80 percent to 20  
8 percent wasn't going to be pure program savings. Some of  
9 it will go back to the plans as --

10 DR. COOMBS: And you did a calculation of how  
11 often that happens that you're in that phase, so I think  
12 that's kind of important that if we were to reverse the  
13 reinsurance such that the government would be on the hook  
14 for only 20 percent versus 80 percent back in the 2016  
15 recommendations, in conjunction with what we're talking  
16 about now in terms of the percentage of discount within the  
17 catastrophic phase, the out-of-pocket.

18 DR. MILLER: Yeah, I have to say for myself I  
19 need another pass at that. Actually, let me say one thing.  
20 Were you saying that you wanted to see the impact of this  
21 in the context of the other recommendations? Is that what  
22 you were saying?

1 DR. COOMBS: Exactly [off microphone].

2 DR. MILLER: Okay. Our intent, like we always  
3 do, is to try and have those ranges of impacts, and I am  
4 assuming that when we get that and work with CBO to get it,  
5 it's going to be in the context of our larger package as  
6 opposed to a one-off, which, you know, to Jack's original  
7 comments, we're considering this all in the context of our  
8 2016 recommendations. Can I get a nod there? Okay. So --

9 DR. COOMBS: So this cost savings that would be  
10 accrued because of the two together.

11 DR. MILLER: Right, but what I -- and I'm going  
12 to want another nod, so -- which I don't get often. What I  
13 might not -- and I don't know if you're asking this, but  
14 what we may not be able to do and I would guess that we  
15 were unlikely to do is tell you the separate effect of  
16 adding this to the old package as opposed to here's the  
17 whole deal now including this.

18 DR. COOMBS: So that's exactly what I'm asking  
19 [off microphone].

20 DR. MILLER: Yeah, and I'm not sure we're going  
21 to be able to say okay and these ten dollars are  
22 specifically related to this change as opposed to here's,

1 you know, the new range of estimates. And, remember, we  
2 don't produce -- for very specific reasons -- point  
3 estimates on these policies. We give ranges in our  
4 consultation with CBO. So I think that's a long way around  
5 of you're not going to see the actual point estimate I  
6 think you're asking for, if I understand your question.

7 DR. COOMBS: So we can't get a number with the  
8 two together as to this is the savings that would --

9 DR. MILLER: No, I think we can give you a big  
10 blobby range of the whole thing together, meaning this new  
11 thing and our old thing. But if you said yes, but I want  
12 to know the specific number of this change on the whole  
13 package, I'm not sure we're going to be able to produce  
14 that. Is that correct, guys?

15 DR. SCHMIDT: And bear in mind it's usually a  
16 one-year/five-year time frame, and there's, you know, very  
17 little on the market now in the Part D space.

18 DR. MILLER: Right, that's the other --

19 DR. SCHMIDT: We'll see in five years.

20 DR. CROSSON: Okay. Kathy, Bruce, and then Pat.

21 MS. BUTO: So terrific work, as usual, and I'm  
22 always very struck by the fact that this issue again

1 highlighted the importance of changing the structure above  
2 the catastrophic cap because ultimately, even though what  
3 we're talking about is level playing field for biosimilars  
4 and originator biologics, the real constraint will come  
5 from having the plan continue to have skin in the game  
6 above the cap to manage through the cap and then above it.  
7 So I was very struck by that, and I really hope you'll  
8 highlight that interrelationship between the two.

9 I still have some concerns about the  
10 beneficiaries in the coverage gap if the 50 percent  
11 discount for both the originator and the biosimilar doesn't  
12 count, and I can't remember the number of beneficiaries who  
13 we estimated would not reach the cap as a result of that  
14 change, at least just on the originator side. Do you  
15 recall what that number was? It was some percentage or  
16 some fairly large --

17 MS. SUZUKI: Right, we wrote up something where  
18 we thought that roughly half of the people would end up  
19 with higher cost sharing because they do not -- no longer  
20 get to the catastrophic phase of the benefit.

21 MS. BUTO: Right.

22 MS. SUZUKI: But we also thought that half the



1 people will reach the catastrophic phase and benefit from -  
2 -

3 MS. BUTO: And they'll get the zero co-pay -- or  
4 the zero coinsurance.

5 MS. SUZUKI: Right, exactly. But that was 2013  
6 data, didn't have behavioral effect. We just sort of took  
7 the data as it is and tried to estimate that.

8 MS. BUTO: Okay. So just in my mind and back to  
9 Dana's question, it raised the question of whether we think  
10 that the changes in the -- above the catastrophic cap in  
11 the plan picking up a bigger share of cost would actually  
12 mitigate some of the savings we would have gotten by not  
13 having those 50 percent actually enter the catastrophic  
14 cap. But I realize we don't have that specificity right  
15 now. Just a question that I still have about the policy.

16 And, lastly, I just want to comment on sort of  
17 the tone around the manufacturer's motivations. I was  
18 involved in some of the discussions -- not on the Hill but  
19 really internally -- and there was a lot of pressure during  
20 Part D coming from beneficiary groups to reduce cost  
21 sharing in the coverage gap, and the government did not  
22 want to pick up the cost. And so as part of the working

1 together to try to get some of the changes made, the  
2 industry agreed to the discount. I think true to what  
3 people have been saying, the industry quickly realized  
4 that, you know, given this structure and the government  
5 picking up so much after hitting the cap, that, in fact,  
6 that would benefit manufacturers. There's no question  
7 about that.

8           But I just want to make sure people understand.  
9 There wasn't a cynical view that if the discount was  
10 provided that, oh, boy, this is terrific for us. It was  
11 pressure on the other side to do something to make this  
12 more accessible for beneficiaries, at least at the time of  
13 the discussions. Now, a lot has happened since then.

14           DR. CROSSON: On that point, Jack?

15           DR. HOADLEY: On Kathy's first point, I mean, I  
16 think one of the things to keep in mind from our previous  
17 recommendation discussion -- and it goes right to what  
18 Shinobu said about the numbers -- there were some people  
19 who would be worse off, and that's partly why we added that  
20 notion. It was in that bottom bullet of potentially if  
21 there were enough savings to spend some, to get the out-of-  
22 pocket threshold down.

1           But the people who benefit, the beneficiaries who  
2 benefit, particularly benefit from the highest-spending  
3 beneficiaries, who were now protected by a cap on out-of-  
4 pocket spending, was a key element of that. It's a cap on  
5 out-of-pocket spending comparable to a lot of the out-of-  
6 pocket caps we've seen in other federal policies, and the  
7 people who were benefitting were generally benefitting for  
8 a lot of dollars. Some of those were liable for thousands  
9 of dollars of out-of-pocket cost, up above the catastrophic  
10 cap.

11           And even in terminology, we talked about a  
12 catastrophic cap, but it's sort of a leaky cap. And so we  
13 were proposing to make that, and so I think it's -- you  
14 know, it was a complicated tradeoff that we all had  
15 different sort of pros and cons of, but I think one of the  
16 big pros was that some of the people who were being hit the  
17 hardest, beneficiaries who were being hit the hardest would  
18 now be protected.

19           DR. CROSSON: Bruce.

20           MR. PYENSON: Thank you.

21           In listening to the discussion this morning, I'm  
22 struck by the contrast between two approaches. On the one

1 hand, the 2016 approach, which as Kathy put it, kept the  
2 plans with skin in the game because of the liability they  
3 would have, the increased liability they would have in  
4 catastrophic. That would create incentives to manage costs  
5 and hopefully reduce costs, since that's our goal.

6 The other, I contrast that with the interest in -  
7 - affect price controls on particular drugs, and those  
8 could, of course, both happen. But I want to point out  
9 that those are probably two distinct policy options and  
10 could be presented that way.

11 In particular, if we don't do the one and create  
12 the incentives to reduce cost through the 2016  
13 recommendations, then there's perhaps no choice but to  
14 recommend the price caps.

15 From the standpoint of the price controls, I  
16 think the place where we have the recommendations and the  
17 structure in place to pursue further is on the Part B drug  
18 side, where there is a direct schedule and process for  
19 direct federal payment. And I think that would be the  
20 place to start the process, if we want to go there.

21 As Commissioners may recall, I spoke out in favor  
22 of not an inflation cap, but a deflation requirement as

1 appropriate in that structure.

2           So I just want to contrast those two different  
3 policy options. One is the 2016 recommendation, which  
4 would have, I think, important incentives that would reduce  
5 costs, and compare that to what could appear to be throwing  
6 up our hands and saying, "Well, instead of that, let's keep  
7 our current structure and recommend something with price  
8 controls."

9           DR. CROSSON: Okay. Thank you.

10           Warner.

11           MR. THOMAS: It's just a question because I just  
12 don't know the answer to this, but going to Kathy's comment  
13 around that it's kind of a collaboration to do the rebate  
14 for the patient, which I think is great, do we do that in  
15 other parts of the program? Can you do that in -- can  
16 hospitals do that? Can they do rebates? Can other -- I  
17 mean, I just don't know.

18           MS. BUTO: Actually, there have been efforts over  
19 the years even for physicians to waive --

20           MR. THOMAS: Right.

21           MS. BUTO: -- the 20 percent coinsurance, and I  
22 think there's a long history at the Inspector General's

1 office saying that, yeah, it's a violation of either anti-  
2 kickback or something else. And so it was pretty clear  
3 that if they were going to do something like this, they'd  
4 have to do it in statute. It really wouldn't pass the  
5 anti-kickback stuff.

6 MR. THOMAS: It might just be something to note  
7 as well that it's inconsistent with the rest of the  
8 program.

9 DR. CROSSON: Pat.

10 MS. WANG: You know, just to pick up on comments  
11 of several of the Commissioners, I would also -- the way  
12 that I would describe it is -- I mean, Bruce described it  
13 as kind of like two really different approaches, and I  
14 don't disagree with that.

15 I think the thing that's important to note in  
16 this recommendation, which I think is a good recommendation  
17 -- the 2016 efforts, I wasn't here at the time. What we're  
18 talking about is shifting risk for the cost. That's really  
19 largely what these proposals have been to do.

20 There's a belief if the plans have more skin in  
21 the game, as Kathy put it, something will happen maybe, and  
22 some plans might be in a better position to do that than

1 others. But the fundamental issue of the size of the cost  
2 is really not -- is the big elephant -- Woolly Mammoth in  
3 the room here. And so these proposals are really  
4 important, but I think that it's hard for us as  
5 Commissioners to ignore the fact that what we are talking  
6 about is just trying to shift who takes the risk for the  
7 cost, the beneficiary, the plan, Medicare and the  
8 catastrophic, what have you, but that the real big issue  
9 here and the reason that people are grappling with this is  
10 that the size of that cost box is just way too big.

11           And just even the simple things that Amy  
12 mentioned, just greater transparency, so that taxpayers can  
13 actually see why the size of that cost box is as big as it  
14 is or some of the drivers. The fact that even those  
15 fundamental things are not there or the fundamental ability  
16 to kind of really understand what's going on is a problem.

17           So I think that however we talk about this, I  
18 realize that it's sensitive, but it's hard to -- people who  
19 run the Medicare program are not alchemists, and so it's a  
20 matter of just shifting risk.

21           The second thing that I wanted to just encourage  
22 -- and I think that you guys are going to do this -- is

1 somebody asked the question before about sort of the take-  
2 up of biosimilars, and since it seems like Europe is going  
3 to have a big head start on availability of biosimilars, I  
4 guess I would be curious to know.

5           They're not interchangeable. The molecules are  
6 different. It's not a generic substitution kind of thing.  
7 I think that we should continue to track the factors that  
8 either seem to support, encourage, or just look at the  
9 take-up, clinician acceptance of biosimilars, that kind of  
10 thing, because I suspect there will be other kinds of  
11 barriers there besides what happens in the coverage gap.

12           DR. CROSSON: Thank you.

13           I saw Rita and then Alice.

14           DR. REDBERG: I support the recommendations.

15           I did want to share Pat's concern because we are  
16 talking, and it's very important because the plan -- the  
17 cost to Medicare for the reinsurance part has grown very  
18 rapidly. But the bigger -- the Woolly Mammoth, as you said,  
19 is that these drug costs are just astronomical. I mean,  
20 who could conceive of a drug launching at a half million  
21 dollars per year? It's more than average income in this  
22 country, and there are lots more of these drugs, clearly,



1 that are getting approved. And that the first or the  
2 second two CAR-D drugs are now approved, you know, the  
3 drugs that have been approved in the last few years.

4           There won't be biosimilars. I mean, we're just  
5 talking about huge costs. We're just now talking about  
6 we're all paying for it -- Medicare, taxpayers, private  
7 plans. And some of the issues, it's very disturbing how  
8 biosimilars have bene so slow to come to market, as Amy  
9 referenced what you outlined in the chapter, the Humira  
10 case with AbbVie and Amgen entering an agreement so that  
11 even though the patents expire in 2016, there won't be any  
12 biosimilars launched until 2023 in the U.S.

13           And then there's also, again referenced in the  
14 mailing materials, Allergen is attempting to transfer its  
15 patent to the Mohawk Tribe in order to lengthen the patent.  
16 I mean, these incredible extensions on these very expensive  
17 drugs are all of great concern because we're talking about  
18 when there are biosimilars available, but this is large  
19 prices and not a lot of competition in the market.

20           So I think this is a big area for program  
21 integrity going forward because these costs are just  
22 inconceivable, just to mention because it impacts the

1 program. We don't have control, obviously, on all of those  
2 pricing things, but we hope that the Congress is certainly  
3 attentive to it.

4 DR. CROSSON: Thank you.

5 Alice.

6 DR. COOMBS: I support the recommendation.

7 Pat made me think of one of the reasons why I  
8 asked the earlier question. It's not only that you're  
9 shifting the risk, but does that change behavior, and does  
10 it change decision-making for the different entities? And  
11 I think that's an even more important question, is how does  
12 that risk translate to what happens to the beneficiaries in  
13 terms of choices and what happens with the action on the  
14 manufacturers, the plan's part, and the prescriber as well.  
15 So I think those are the things that we don't often think  
16 of in terms of carrying it out to the beneficiary.

17 And my question was just if the catastrophic  
18 reinsurance was a more important -- the reinsurance was a  
19 more important strategy. I know we can't prioritize and  
20 say this is the number one thing that we want; number two,  
21 if we had a choice.

22 You know, to say that all of the things on the

1 list are equally important, I think they are, but there's  
2 some things that actually rise to the surface and have a  
3 greater impact. And I don't know whether or not that's  
4 something we're interested in doing.

5 MS. WANG: I think the thing that is very  
6 concerning to me is that what we're talking about here with  
7 these high-cost drugs, these are sole-source specialty  
8 drugs. Like there is no sort of management of beneficiary  
9 trying to encourage them to take the cheaper drug until  
10 biosimilars perhaps really have some take-up here. People  
11 are kind of -- I mean, honestly, these are very important  
12 drugs. They're life-saving drugs, but as far as the cost,  
13 you're kind of held hostage. There is no management of  
14 beneficiary choice and options. It's not a generic  
15 substitution.

16 DR. CROSSON: Okay.

17 MS. BRICKER: Just on that point.

18 DR. CROSSON: Yeah.

19 MS. BRICKER: There is. I agree that there isn't  
20 a biosimilar or a generic to these, but Part D institutes  
21 prior authorization and ensuring that you can't just willy-  
22 nilly get the drug. You have to meet certain criteria.

1           But completely agree with what you're saying that  
2 we've got -- you know, we're the largest payer of  
3 prescription drugs in the country, the benefit, this plan,  
4 the largest payer of prescription drugs. And while we  
5 would think about how could we modify policy with respect  
6 to the beneficiaries certainly and access, we have to  
7 encourage competition and think about this differently than  
8 we would, I think traditionally in all of our other  
9 discussions. What is it that we're doing? And as part of  
10 our recommendations, it's either stifling competition or  
11 encouraging competition, and especially in this space, I'm  
12 very concerned that we just won't see the problem that  
13 these policies aim to address because we won't see  
14 biosimilars in the market in a way that we absolutely must.

15           For pharma to be able to have these settlements  
16 or make these deals in silos, behind closed doors, and  
17 there really isn't anyone that's looking into that to say,  
18 "Hang on a second," do you know who that hurt? That hurt  
19 the taxpayers. So that's what I'm hoping we can become a  
20 little bit louder about as a Commission.

21           DR. CROSSON: Bruce and then Jack.

22           MR. PYENSON: Just a comment on what we're

1 spending money on. Many of the -- the biggest category of  
2 biosimilars are the insulins, right? Those are biologic  
3 drugs, no question about it, and they're interchangeable.  
4 Some may -- not technically interchangeable, but you look  
5 at how Part D plans have switched, you know, formularies  
6 and so forth. They're interchangeable.

7 I think the interchangeability argument is one  
8 that needs to be picked at, and in some of the -- just  
9 because of the history of that, there's other categories,  
10 the growth hormones and so forth.

11 So I'm not satisfied with saying, well, the  
12 biologics, we have trouble managing because of X, Y, and Z.  
13 I think challenging some of those assumptions would be  
14 really instructive.

15 The European experience there has been pretty  
16 interesting, where, of course, a single-payer system can  
17 wholesale and move the entire population from one product  
18 to another, and some of those countries have very good  
19 tracking of what the outcomes are.

20 So I think to the extent that Medicare has  
21 concerns or rules in place that restrict  
22 interchangeability, I think that's something that we could

1 address in this process.

2 DR. CROSSON: Okay. Jack.

3 DR. HOADLEY: Just a couple of quick follow-up  
4 points. On Amy's last point, I mean, she's exactly right.  
5 Plans have tools, things like prior authorization. They're  
6 tools in the nature of, okay, you're being held hostage on  
7 price, so you go to prior authorization. You go to other  
8 restrictions on use. That becomes a limitation on access.  
9 It's the right strategy from the plans, from the PBM's  
10 point of view, but it plays out in the system in a  
11 particular way. And I think what we're trying to do is  
12 figure out ways to avoid needing that.

13 Second, going back to Amy's earlier point on the  
14 FTC reporting, I think that's a really important thing and  
15 maybe is one where I wonder if we couldn't certainly raise  
16 that very strongly in the text. I mean, I'd love to see it  
17 also as a recommendation. It is something that goes back  
18 to Medicare Modernization Act. So even though it's not  
19 directly a Medicare policy, it has been legislated in the  
20 context of Medicare legislation in the past.

21 Bruce kind of already said this, but, I mean,  
22 Pat, you raised the question of the European experience,

1 and I think we've seen some of that in the materials in  
2 these chapters. But there is some interesting experience  
3 where they've been willing to do substitution on drugs that  
4 at least so far are not rated as interchangeable, partly  
5 because we haven't sort of gone that path yet in this  
6 country.

7 But it does seem -- there's various hints that  
8 the standard that FDA is looking at for interchangeability  
9 may be stricter than clinicians are willing to work with.

10 And then last point was based on what Rita  
11 mentioned, the CAR-D drugs. We are beginning to see some  
12 of these value-based contracting things. They're difficult  
13 to do in Medicare; in some cases, probably impossible to  
14 do. But it may be something -- and I'm not convinced  
15 whether all of the different value-based contracting  
16 schemes that are appearing in the commercial sector are  
17 necessarily all good ones, but maybe it's something to look  
18 at down the road on whether there looks like a good  
19 experience there and whether that's something where there  
20 could be or should be adjustments in Medicare rules to  
21 allow some of that.

22 I don't know if they're good, but I think it

1 might be something to look at.

2 DR. CROSSON: Okay. Kathy and Dana.

3 MS. BUTO: Jack reminded me of something, which  
4 is that CMS and FDA have a relationship around Medicare  
5 coverage. There's even the possibility of joint coverage  
6 decision-making.

7 So I'm wondering whether, I guess, a hook into  
8 the FDA could be something like our looking at greater  
9 exchange of information at the time of coverage or  
10 approval, collaboration around studies. There might be  
11 some things that would get at this disconnect between some  
12 of the issues of FDA approval and CMS decision-making.

13 I'm not sure exactly what those are, but I would  
14 say why not at least raise the question because there's  
15 already some statute in that direction.

16 DR. CROSSON: Last comment, Dana.

17 DR. SAFRAN: So just to pick up on the point that  
18 Warner made about kind of how unique this is within the  
19 rest of what Medicare does and understanding that there's a  
20 long history here, I'm just sitting here wondering. We  
21 heard this incredibly powerful presentation yesterday about  
22 how competitive bidding has helped us in the DME space. So



1 I just wonder why we can't contemplate that here.

2 I understand there's a very long challenging  
3 history to overcome, but I just put that out there.

4 DR. CROSSON: Okay. So this has been a good  
5 discussion.

6 My sense of it -- and I'm going to test this, but  
7 in terms of the recommendations that we actually have on  
8 the board there, I did not hear any opposition. So failing  
9 that, I think our plan, as Rachel laid out, was to come  
10 back in January with the same recommendations that will be  
11 then incorporated into the March report.

12 However, I did find a couple of valuable themes  
13 here. One was, I think, the notion -- and I strongly  
14 support that -- that we make clear that this is to be  
15 considered part, an extension in part of our 2016  
16 recommendations.

17 And the second one is the latter part of this  
18 conversation, which was a lot about not just expanding the  
19 context that we create in this particular write-up, which I  
20 think is very important, but longer term, challenging the  
21 Commission to at least repeatedly emphasize, if not try to  
22 take on in some new and different ways, that elephant or

1 Woolly Mammoth or larger question here, which is are we on a  
2 path, particularly with the newer drugs, that is simply  
3 unaffordable for the nation, and I firmly believe that that  
4 is the case. And that to the extent that we can do that  
5 within the construct of our mandate, that over time we  
6 should be doing that.

7 Rachel, thank you. Shinobu, thank you.

8 And we'll move on to the next discussion.

9 [Pause.]

10 DR. CROSSON: Okay. We're going to have our last  
11 discussion for the November meeting, and it's the third  
12 part of our mandated report on the use of telemedicine in  
13 the traditional Medicare program. Amy, Zach, and Andy are  
14 going to be presenting that, and, Amy, it looks like you're  
15 starting off.

16 MS. PHILLIPS: Good morning. This will be the  
17 third installment of telehealth this cycle. For this  
18 presentation we will be turning our analysis to how  
19 Medicare could consider expanding coverage of telehealth  
20 services.

21 In the larger context of our telehealth mandated  
22 report, this presentation specifically addresses the third

1 and final question of our mandate concerning ways in which  
2 telehealth services covered by commercial insurance plans  
3 might be incorporated into Medicare coverage.

4           In this presentation we will begin with an  
5 overview of the definition of telehealth; then summarize  
6 our comparison of Medicare and commercial plan coverage of  
7 telehealth that we discussed in detail at October's public  
8 meeting. Then we will go over the principles we have  
9 developed to evaluate telehealth services, and finally we  
10 will provide you with examples of how those principles can  
11 be applied within Medicare.

12           Telehealth services are defined broadly, and they  
13 continue to evolve. These services encompass a variety of  
14 combinations of clinical services, technologies, and  
15 modalities.

16           At our last meeting, you mentioned that you would  
17 prefer a narrower scope on what types of telehealth we are  
18 talking about when we mention the term.

19           As you read in your mailing materials and can see  
20 above, we have narrowed, for the sake of our discussion and  
21 Medicare focus, telehealth down to three forms.

22           Direct to consumer, or DTC, involves such

1 services as what Teledoc and American Well provide, simple  
2 acute illnesses revolved via two-way video at any time from  
3 any location.

4 Provider to provider, or PTP, encompasses such  
5 services as telestroke and tele-ICU where a clinician  
6 consults with a specialist in the presence of the patient.

7 Remote patient monitoring, or RPM, can involve a  
8 patient at home or in a facility being monitored by a  
9 clinician at a distant location. This is often used to  
10 monitor patients with chronic conditions at their homes.

11 To begin our comparison, I will first briefly  
12 review what we have discussed in our previous presentations  
13 about Medicare's coverage.

14 Medicare's coverage of telehealth is flexible  
15 throughout most of the program where taxpayers are  
16 indemnified against volume incentives including some parts  
17 of the physician fee schedule, within MA and CMMI programs  
18 and Medicare is most restrictive in the fee-for-service  
19 environment where volume incentives occur.

20 The table you see above has been compiled from  
21 results of our survey of the Medicare program and the 45  
22 commercial plans that we presented to you last month.

1           Focusing on the first three rows where the  
2 differences between the Medicare physician fee schedule and  
3 commercial plans are more pertinent, we see in the first  
4 row that Medicare and commercial plans diverge on payment  
5 incentives.

6           Within the physician fee schedule, there exists  
7 provider and patient volume incentives while commercial  
8 plans are able to use various tools to curb this incentive.  
9 These tools do not exist in the fee schedule.

10           Moving to the second row, we see that variance  
11 occurs in the originating site locations with Medicare only  
12 allowing rural originating sites and commercial plans being  
13 less restrictive, due in part to the prevalence of 24/7 DTC  
14 services for minor acute illnesses that allow any  
15 originating site.

16           In the third row we see that the Medicare  
17 physician fee schedule and commercial plans have taken a  
18 similar approach to cost sharing; however, Medicare  
19 beneficiaries are often shielded from cost sharing by  
20 Medigap plans.

21           Finally, in the second table on the slide, we  
22 move outside the physician fee schedule to a comparison of

1 Medicare Advantage managed care plans and CMMI testing and  
2 pilot programs with commercial plans. Here we see that  
3 there are differences in how telehealth is financed and  
4 where the focus of testing telehealth services differs.

5 We have developed three principles based on  
6 Commissioner discussion over four public meetings spanning  
7 2015 and 2017 related to telehealth that could be used as  
8 the basis for evaluating telehealth services or policies  
9 for potential incorporation into the Medicare program.

10 The first is expanding access, which includes the  
11 availability of services or providers (such as in the case  
12 of tele-mental health), facilitating more timely delivery  
13 of care (such as in the case of telestroke), and increasing  
14 convenience (such as for beneficiaries with disabilities).

15 The second is improving quality of care, which  
16 would be assessed through outcomes, patient experience, or  
17 added value.

18 The third is reducing cost for either the  
19 beneficiary or the Medicare program.

20 While a telehealth service may not possess all  
21 three qualities, it should strike a balance between them  
22 for consideration for implementation. For example, if a

1 service is going to cost more money, the service should be  
2 justified in the increase with greater value in access or  
3 quality.

4 Zach will now go into further detail on how these  
5 principles could be applied to telehealth services.

6 MR. GAUMER: Good morning. Several Commissioners  
7 expressed concern that expanding the coverage of telehealth  
8 under the physician fee schedule could increase the volume  
9 incentive of providers and that the program lacks the tools  
10 for controlling this incentive in the fee-for-service  
11 environment. In light of this concern, policymakers should  
12 use the three principles to evaluate telehealth services  
13 individually.

14 Based on the Commissioners' discussion, we have  
15 assembled four illustrative examples of how the principles  
16 could be used. Our use of these examples is not an  
17 endorsement of their inclusion in the Medicare program.  
18 But, instead, they are merely examples of how policymakers  
19 should rigorously evaluate these services.

20 The first example is telestroke. These services  
21 are currently covered under the Medicare fee schedule in  
22 rural areas. They are offered by several health systems

1 and paid for by many commercial plans. Policymakers could  
2 consider expanding telestroke to urban originating sites.  
3 By applying the three principles, we believe telestroke may  
4 improve access by enabling more timely care to  
5 neurologists, which some contend are in limited supply.  
6 This access improvement may result in improvements in  
7 quality, and the health systems we spoke to cite reductions  
8 in mortality and disability.

9           Telestroke services are likely to increase  
10 program costs because the program would begin paying for  
11 more of these consults. However, cost increases and the  
12 risk of misuse may be lower in this service because  
13 telestroke is not a common service every beneficiary is  
14 likely to use. In addition, some researchers assert  
15 telestroke might reduce long-term spending by reducing  
16 disability. Therefore, the Congress could decide that the  
17 improvements in access and quality justify the extra costs  
18 of telestroke services.

19           The second example is the expansion of telehealth  
20 to beneficiaries with physical disabilities and treatment-  
21 intensive conditions. We have observed some home health  
22 agencies and commercial plans using telehealth to serve



1 patients with chronic conditions. Policymakers could  
2 consider expanding telehealth coverage to patients with  
3 conditions such as Parkinson's disease or ESRD patients  
4 that use home dialysis. This policy may increase the  
5 convenience of care for patients with mobility limitations.  
6 This access expansion may improve quality, but the evidence  
7 of this quality improvement is thin to date. This policy  
8 is likely to increase program costs because it would  
9 generate more standard physician visits, which also  
10 increases the risk of misuse. However, these increases  
11 might be mitigated by the smaller chronic condition  
12 population groups we are considering and the potential to  
13 implement visit caps or prior authorization. Overall, the  
14 Congress could decide that telehealth coverage could be  
15 expanded to patients with physical disabilities and  
16 treatment-intensive conditions where improvements in access  
17 might justify the added costs.

18           Our third example is tele-mental health services,  
19 which are currently covered under the Medicare fee schedule  
20 in rural areas and by many commercial plans across urban  
21 and rural areas. Policymakers could consider expanding  
22 tele-mental health services to urban originating sites or

1 could go further and expand to patients' residences. Tele-  
2 mental health services may expand beneficiary access to  
3 mental health clinicians, which may be in short supply. It  
4 might also allow beneficiaries to avoid the stigma of  
5 seeking in-person services. Of course, this potential  
6 access expansion presumes that there is a mental health  
7 clinician available to provide service. If these  
8 clinicians are not available, the resulting expansion of  
9 access would be less.

10           Quality improvement is likely to stem from the  
11 greater availability of clinicians, but the evidence of  
12 this is unclear to date. Program costs are likely to  
13 increase as the result of expanding these services because  
14 the potential pool of users is large. This suggests the  
15 risk of misuse would also be high. Policymakers might  
16 mitigate potential cost increases by implementing visit  
17 caps or prior authorization. Overall, the Congress could  
18 decide that expanding access to mental health clinicians,  
19 especially in light of a perceived lack of access to mental  
20 health care, justifies the potential for significant cost  
21 increases.

22           Our fourth example is direct-to-consumer

1 telehealth services, which are not covered under the  
2 Medicare program, but are common among commercial plans.

3           Policymakers could consider covering DTC across  
4 all areas and for all beneficiaries. DTC may expand access  
5 to clinicians and improve convenience. The impact on  
6 quality is unclear because we do not know if DTC replaces  
7 or supplements existing in-person visits. DTC may  
8 significantly increase costs because the potential pool of  
9 users includes all beneficiaries, the service is patient-  
10 initiated from any location, and most beneficiaries have  
11 supplemental insurance that shields them from cost sharing.  
12 As a result, the risk of misuse is greater. Policymakers  
13 may curb some of this risk by implementing visit caps or  
14 prior authorizations. Overall, DTC would increase  
15 convenience, but at a potentially high cost to the program.  
16 Because the costs of this service may outweigh the  
17 benefits, policymakers could consider testing the use of  
18 DTC within Medicare's Center for Medicare and Medicaid  
19 Innovation before implementing in the fee schedule.

20           The Commission has also discussed adopting the  
21 strategy used by commercial plans to more methodically test  
22 specific telehealth services, like DTC, within CMMI before

1 implementing them within the fee schedule. CMMI does some  
2 of this, but not on the scale that it could. Within our  
3 mailing materials, we identify examples of four telehealth  
4 services where their value is unclear. In addition to DTC,  
5 these examples include pharmacological management services,  
6 nursing home-based services, and remote patient monitoring  
7 for patients with chronic conditions.

8           Now, moving on from the physician fee schedule,  
9 the Commission has also discussed the coverage of  
10 telehealth under Medicare's other fee-for-service payment  
11 systems, such as hospital inpatient and skilled nursing  
12 facilities. To date, the Commission has discussed that  
13 these payment systems incorporate the flexibility for  
14 providers and patients to use telehealth services, and this  
15 flexibility stems from the fact that telehealth services  
16 are contemplated as a part of the fixed payments that  
17 providers receive.

18           The Commission has discussed expanding the  
19 flexibility of two types of entities that bear financial  
20 risk under the Medicare program to use telehealth services.  
21 While this issue goes beyond the specific questions of our  
22 mandate, it applies to the Commission's general principle

1 that when entities accept financial risk, greater  
2 flexibility is warranted. Therefore, it may be reasonable  
3 to delegate the principle-based evaluation of telehealth to  
4 the entities that bear financial risk such as two-sided  
5 ACOs and Medicare Advantage plans.

6 Two-sided ACOs bear risk by agreeing to reimburse  
7 the program if a beneficiary's annual spending exceeds a  
8 benchmark. Currently, two-sided ACOs have a waiver to  
9 cover telehealth services permitted by the Medicare  
10 physician fee schedule in urban areas and from the  
11 patient's home. However, in line with the Commission's  
12 principles about risk-bearing entities, policymakers could  
13 decide to expand the flexibility of two-sided ACOs to cover  
14 telehealth services that go beyond their current waiver and  
15 beyond current Medicare fee schedule coverage.

16 Andy will now talk to you about Medicare  
17 Advantage.

18 DR. JOHNSON: Under current policy in the  
19 Medicare Advantage program, plans must cover the same  
20 telehealth services covered in Parts A and B of fee-for-  
21 service Medicare. These services are included in the  
22 plan's bid. Plans also have the option to cover additional

1 telehealth services beyond the Part A and B benefit. These  
2 additional services, also called "supplemental services,"  
3 are financed either by a rebate for plans bidding below  
4 their benchmark or by charging an additional premium.

5           Several Commissioners have voiced support for  
6 expanding telehealth coverage in the Medicare Advantage  
7 program beyond the current level of coverage and I'll now  
8 walk through two options for doing so.

9           The first policy option is to expand telehealth  
10 coverage in fee-for-service Medicare. This option would  
11 make no changes to the MA program or its payment policy,  
12 but it would expand telehealth coverage in Medicare  
13 Advantage to the same extent as it is expanded in fee-for-  
14 service Medicare. One issue to consider in expanding  
15 telehealth coverage is whether the basic Medicare benefit  
16 should be the same regardless of whether a beneficiary  
17 enrolls in fee-for-service Medicare or MA. The Commission  
18 has previously discussed this type of synchronization  
19 across fee-for-service Medicare, ACOs, and MA and generally  
20 favored consistency with respect to payments, quality  
21 measurement, and benefit design. Option 1, listed here,  
22 would favor maintaining the current level of consistency in

1 benefit design by having the MA benefit continue to track  
2 the fee-for-service benefit.

3           However, some Commissioners have also stated that  
4 in some circumstances risk-bearing organizations, and  
5 particularly MA plans, should be allowed greater  
6 flexibility in benefit design.

7           The second option would allow MA plans to include  
8 the cost of telehealth services in their annual bid. Under  
9 this policy, plans would bid on the basic fee-for-service  
10 benefit as well as any telehealth services they plan to  
11 offer. Therefore, Medicare payment for telehealth services  
12 would be included in the program's base payment to the plan  
13 and would not be financed by the rebate. Under this  
14 policy, we assume that the telehealth benefit included in  
15 the bid would be available to and mandatory for all plan  
16 members, meaning that all plan members would have access to  
17 the benefit and could not opt out of the telehealth portion  
18 in exchange for a lower premium.

19           This option would make the basic MA benefit  
20 offered by some plans different from the basic fee-for-  
21 service benefit. This difference may hinder our ability to  
22 evaluate market-level efficiency of MA and fee-for-service.

1 Therefore, to maintain an apples-to-apples comparison,  
2 plans would submit a bid that fully distinguishes the Part  
3 A and B benefit from the telehealth benefit. This  
4 separability of the benefit package exists in the current  
5 bidding process for supplemental services, so we think it  
6 should be feasible for plans.

7 Now I'll turn it back to Zach to wrap up.

8 MR. GAUMER: Over the course of this analysis, we  
9 have found that Medicare covers telehealth services in  
10 several areas of the program, commercial plan coverage is  
11 varied, and the differences between commercial plan  
12 coverage and the Medicare physician fee schedule reflect  
13 the payment incentives built into these systems.

14 Given the complexity of incorporating telehealth  
15 into the fee schedule, we identified three principles for  
16 evaluating telehealth. We provided several illustrative  
17 examples of how these principles might be used to evaluate  
18 individual services. In some cases, services demonstrate  
19 value and may be potential candidates for expansion. In  
20 other cases, the value of services is unclear, and testing  
21 through CMMI may be an option. Finally, we discussed  
22 entities that bear financial risk, and in these cases



1 Congress might consider expanding their flexibility to  
2 cover more telehealth services.

3           We would like to focus today's discussion on the  
4 structure of our report and solicit any questions or  
5 refinements you may have as we approach our landing spot.

6           To fully comply with our mandate, the structure  
7 of our report will mirror the materials provided to you in  
8 our three previous meetings. This will include background  
9 material, information on Medicare and commercial plan  
10 coverage, our principles, of course, and our examples that  
11 we have laid out. Following today's discussion, we will  
12 come back to you in January with a draft report, and you'll  
13 have an opportunity to provide comments at that time. We  
14 will then deliver this report to Congress in March.

15           Thank you for your time, and we're ready for your  
16 questions.

17           DR. CROSSON: Thank you, Zach, Amy, and Andy.

18           And we're now open for questions. I see Kathy.

19           MS. BUTO: So I was just wondering -- I've never  
20 been clear on this -- whether MA plans can substitute  
21 telehealth services for face-to-face without any -- even if  
22 they don't offer a supplemental benefit that's either paid

1 for through their savings or charging beneficiaries. Do  
2 they have that flexibility? is my question.

3 DR. JOHNSON: Not without adding or offering a  
4 supplemental package, and even in that case, the basic MA  
5 benefit must still be offered and available. It's just  
6 that in addition to in-person benefits, a telehealth visit  
7 could be available through the supplemental package.

8 MS. BUTO: So I guess I'm wondering can they --  
9 do they have flexibility to substitute other kind of non-  
10 covered services for Medicare benefits or face-to-face  
11 meetings if they think that will avoid a face-to-face  
12 meeting, an e-mail message, any of that sort of thing?  
13 It's not allowed without a supplemental?

14 DR. JOHNSON: There are certain service that are  
15 considered adjunct to the Part A and B benefit, so email  
16 and phone call could be offered under the current A/B  
17 benefit. It would be considered as part of what's a normal  
18 physician office visit and subsequent to under the A/B  
19 benefit. So that would be acceptable.

20 MS. BUTO: Okay.

21 DR. MILLER: Can I just get -- both Jay and I, we  
22 wanted to make sure that we were following this.

1           So in your response and in your question -- well,  
2 I don't know if you used the language, but you used the  
3 language of you have to offer a supplemental with sort of  
4 the words?

5           DR. JOHNSON: If in understanding Kath's  
6 question, if there is a telehealth video visit, I think  
7 that would have to be offered through a supplemental  
8 package. It just couldn't happen without being formally  
9 offered through the benefit as submitted through the bid  
10 and the supplemental package.

11          DR. MILLER: Right. But the financing for that -  
12 - and this is the clarification that I want to make sure  
13 that we get -- you can either finance that through a  
14 supplemental premium, or you could finance that through  
15 your rebate dollars.

16          DR. JOHNSON: Correct.

17          DR. CROSSON: Right. And that's the thing I  
18 wanted Kathy to be sure. That in exchange, when he said it  
19 had to be offered through a supplemental, it means -- I'm  
20 going to use different vocabulary. I'm sure everybody in  
21 the managed care industry is going to freak out. You have  
22 your basic A/B. You can offer these other services, and

1 you can finance them in one of two ways. You can charge a  
2 premium for them, or you can finance them through a rebate  
3 dollar.

4 And I think the distinction in saying it has to  
5 be supplemental is you were mainly driving at the fact that  
6 it's different than A/B, and you have to offer it as a  
7 different service than A/B.

8 MS. BUTO: And that's really what I was trying to  
9 get at, Mark, because to my mind, it's not different from  
10 A/B. If you can do a phone call or an email, why can't you  
11 do like a Skype? Where do you start considering it kind of  
12 a supplemental benefit that either has to be financed  
13 through the rebate or --

14 DR. MILLER: Right. And the main thing I didn't  
15 want people to miss is sometimes when people use the word  
16 "supplemental," a lot of people automatically mean, "Oh, so  
17 they have to charge a supplemental premium." I want to  
18 make sure that people understood you could do this.

19 Now, the reasoning -- and as I understand it,  
20 there is some bleed-over here. That people do include in  
21 the plans, they do include in basic A/B, some overlap,  
22 things like phone calls and that type of thing. But I

1 believe Andrew's answer is correct if you want to say, "I  
2 am offering you the Skype option of initiating a visit with  
3 your doctor," because that's not allowable in urban areas  
4 in Medicare. You have to treat that as a new -- you have  
5 to treat that as a separate benefit.

6 I mean, what we're talking about here is saying  
7 maybe there's different ways to think about that.

8 DR. CROSSON: Alice --

9 DR. MILLER: Is that all right, Andrew?

10 DR. JOHNSON: Yeah. Sure.

11 DR. CROSSON: Did I see you, Alice?

12 DR. COOMBS: Yes. I just wanted to clarify, but  
13 if an MA plan has as a part of its protocol that they don't  
14 have enough mental health providers, they can offer that.  
15 They just don't bill for it, right?

16 DR. JOHNSON: The MA plan still has to have  
17 adequate network coverage without telehealth.

18 DR. COOMBS: Well, true, true, true. But I'm  
19 just saying if that's something that's a part of their --  
20 that's just a part of their process in terms of patient  
21 care, they can offer it. They just can't bill for it under  
22 a -- say, for instance, you happen to be in an MA plan, and

1 they may be short on site providers or whatever, and they  
2 do a psych -- an E&M code. They can still offer that but  
3 that's under their whole cost of care for that beneficiary.

4 DR. JOHNSON: So the first part, I just want to  
5 make clear that when they say if a plan is short on  
6 providers, it still has to meet some basic adequate --

7 DR. COOMBS: Right, right.

8 DR. JOHNSON: But they could do better by  
9 offering --

10 DR. COOMBS: Right.

11 DR. JOHNSON: -- more -- increased access. So  
12 they could do that, but it would be financed through the  
13 rebate or through an additional premium.

14 DR. CROSSON: Pat, did you want to make a comment  
15 on that?

16 MS. WANG: It's a little bit confusing because  
17 people are using common sense to say, "Really?"

18 [Laughter.]

19 MS. WANG: But I think the distinction is the --  
20 like when a plan goes out during open enrollment and says I  
21 have a Skype option or I have -- you know, I'm using Tele-  
22 Doc, and you can use this. That's considered like a

1 supplemental benefit. The kinds of things that you guys  
2 are asking about, I'm aware of plans that may -- if they  
3 have members who have difficulty accessing mental health  
4 services may use what we're calling telehealth to increase  
5 access in lieu of kind of trying to find a psychiatrist  
6 who's like 20 miles away or something that's not  
7 convenient. I think that's the difference.

8 I didn't hear anything that you said, Andy, that  
9 there is a prohibition on plans or even ACOs using those,  
10 you know. I mean, sometimes -- and it's all within the  
11 budget that you have.

12 DR. JOHNSON: Right.

13 MS. WANG: I mean, some plans try to get housing  
14 for their members. It's not an extra benefit. It's kind  
15 of in the course of what they're trying to do for overall  
16 health, if it looks like that's going to be more valuable  
17 than paying for a hospital emergency room admission, is to  
18 find a supportive housing bed. So I think that's the  
19 distinction, is whether you -- I think. Right? Is that  
20 correct?

21 It's sort of like publicizing it like here's the  
22 benefits that I offer potential enrollees, like we offer

1 Tele-Doc or something like that. That sounds like a  
2 supplemental benefit as opposed to using a variety of  
3 different techniques in the course of taking care of your  
4 members.

5 DR. GINSBURG: Yeah. So, Pat, they're just  
6 talking about the distinction between a benefit for all  
7 enrollees or an accommodation for particular patients.

8 DR. MILLER: And this is what I meant by -- and I  
9 think Andrew is getting uncomfortable, but I'm going to  
10 still say some more things and then let him get fully  
11 uncomfortable.

12 I mean, this is what I meant, to some extent, by  
13 bleed-over. A physician could decide, "Well, I'm going to  
14 deal with this through email," and just sort of deal with  
15 it within the context of the larger budget, as you said, as  
16 part of their payment as opposed to saying, "Okay. We're  
17 going to create an entire new benefit and offer it in this  
18 way." That's what I meant.

19 But I don't know if now we've crossed a bunch of  
20 lines that Andrew wants to redraw.

21 DR. JOHNSON: I don't need to redraw anything. I  
22 think we're all on, generally, the same page.



1 [Laughter.]

2 DR. CROSSON: Okay. David.

3 DR. GRABOWSKI: Great. Thanks for this  
4 presentation.

5 So you took us through four examples of how we  
6 could expand telehealth under the physician fee schedule,  
7 and if I had to sort of summarize, I'll have the potential  
8 to improve access and quality, but I'll also have the  
9 potential to increase cost as well.

10 Two questions on that. One, you mentioned, Zach,  
11 in the first example of Telestroke, the potential for an  
12 offset and that maybe we would see a decrease in long-term  
13 spending on disability. I could imagine other potential  
14 offsets with hospitalizations. I don't think those are  
15 going to pay for the program. I wanted to encourage you to  
16 think broadly about sort of these spending offsets.

17 Then as sort of a second question, are there  
18 other examples where those spending offsets are more direct  
19 and might even pay for the program? I don't see that  
20 potential with any of these four examples, but later, you  
21 mentioned the nursing home setting where maybe we could  
22 offer services there, and that may -- it's a chronically

1 ill population with great medical need. Is there a  
2 potential there to offer services and potentially lower  
3 hospitalization?

4 So those two questions. Thanks.

5 MR. GAUMER: Yeah. So I think in the Telestroke  
6 example, that is the only one where we offer some kind of  
7 an idea about an offsetting long-term kind of spending  
8 decrease, and that came from some research that we found  
9 the CBO in scoring bills, you know, had released some  
10 information publicly that said that Telestroke could  
11 generate long-term savings due to the reduction in  
12 disability, patient disability long term.

13 So that is something that we don't include. In  
14 the other examples, we could do a little bit more research  
15 and put some other ideas in there to consider what else is  
16 out there, but the only reason we did that for Telestroke  
17 is because it was right there in our faces and had been  
18 thought about by researchers recently.

19 Did I at all answer your question?

20 DR. GRABOWSKI: I think you did, and I think just  
21 to move to the second question, are there other examples --  
22 and maybe this is pushing towards a Round 2 comment, but I

1 think there may be other examples in the program where we  
2 could think about a better alignment between kind of the  
3 application and potential savings elsewhere, so that we're  
4 targeting areas where we know there's a lot of hospitals,  
5 for example, and there's potential for telehealth to pay  
6 for -- or at least kind of largely pay for itself by  
7 generating savings elsewhere. I find those areas very,  
8 very productive and encouraging. Thanks.

9 MR. GAUMER: So the source of the examples that  
10 we have in the mailing material -- and I guess they're all  
11 here as well -- are things that we picked up in our search  
12 or in our site visits and interviews and also ideas that  
13 have come out of you guys. So if there are others out  
14 there that come to mind immediately, I think today is kind  
15 of the day to let us know, and we'll get cracking on it  
16 really fast.

17 [Laughter.]

18 DR. CROSSON: And I'm going to take that as a  
19 transition statement to Round 2. I see no further -- oh,  
20 more questions. Oh, sorry. Jack and Paul.

21 Go ahead, Jack. Sorry.

22 DR. HOADLEY: Mine is really sort of a process.

1 I think it's bene made clear that nothing that you're  
2 talking about here would be in the form of formal  
3 recommendations in this report, the formal recommendations  
4 that we vote on; is that right?

5 MR. GAUMER: So the plan here is to deal with  
6 this mandated report as we've dealt with the PAC-mandated  
7 report in previous meetings, where we would be -- you would  
8 be essentially voting for the entirety of the report and  
9 its contents as opposed to individual examples.

10 Have I described that accurately?

11 DR. MILLER: You have.

12 MR. GAUMER: Okay.

13 DR. HOADLEY: And sort of following that, for  
14 example, on the MA where you've got a couple of options,  
15 that's just part of that process of saying here's a couple  
16 of ways we can do things, or in the examples of these four  
17 clinical areas -- I mean, some people will quite likely  
18 read that as kind of a soft recommendation that we're sort  
19 of saying these are four potential areas for expansion.

20 I guess what the question is, if we're  
21 comfortable with that, or do we want a stronger sort of  
22 disclaimer language to say -- and you've used some of those

1 words, I think, but it seems like looking carefully at the  
2 wording around how we characterize those and then our  
3 comfort level with saying, "Yeah. This is kind of" --  
4 vaguely if this is a soft recommendation, that's fine, or  
5 language that says, "Yeah. We're not going that far.  
6 These are just examples with pros and cons associated."  
7 And whoever reads this can make sense of it. I'm just  
8 trying to get a little sense of where we want to --

9 DR. CROSSON: Right. I'd only point out that  
10 that sort of distinction, I think, may be derived from the  
11 next part of our discussion, which is where do we have  
12 support for the principles and where we have support for  
13 the examples, and that might then influence the relative  
14 strength or neutrality of what's in that final report.

15 I saw Paul, and then I saw another hand. No?  
16 Paul.

17 DR. GINSBURG: On two of the services, Zach -- I  
18 think it was Telestroke and Telemental Health, you  
19 mentioned that they would expand access, but that supply is  
20 very tight in those areas. And I just wanted to push you  
21 to think a little deeper about what does that mean. Does  
22 it mean, well, they may not expand access because supply is

1 tight, or it may expand access by having a reduction of  
2 other services that those short supplies, professionals  
3 provide, and thus, it won't cost much, if anything?

4 I know you don't know the answer, but it's just  
5 worthwhile making it clear what you were getting at.

6 DR. CROSSON: Okay. So I don't see any more  
7 questions.

8 Let's now turn to Round 2. Maybe you could throw  
9 up slide 17. Good.

10 The last two bullet points kind of, at least to  
11 me, summarize kind of the essence of the discussion here  
12 because it's kind of like, well, we have some principles  
13 here in the context of evaluating the incorporation of  
14 telehealth services into Medicare Advantage. Are these the  
15 right principles?

16 Then there are some examples created. I think  
17 maybe we're going to hear some more examples. Are they the  
18 right examples?

19 To what level do we have concern about -- well,  
20 let me put it this way. Let's take coverage of mental  
21 health services. What's the strength of feeling in terms  
22 of dealing with what we know are access problems that need

1 to be addressed versus the potential for abuse of mental  
2 health services?

3           So discussion around that, and then the second  
4 part of that is those sorts of things which are concerning  
5 enough, for which the value is not compelling enough, that  
6 we think they should be tested. We have some examples of  
7 that.

8           And then, finally, sort of adding on to the  
9 mandate, the question of whether or not we want to make  
10 some recommendations with respect to the Medicare Advantage  
11 program.

12           So thoughts about those issues that will help  
13 inform us, and to get back to Jack's question, how strong  
14 are the feelings in these different areas?

15           So let's open it up for discussion. I see Paul  
16 first.

17           DR. GINSBURG: Yeah. I'm comfortable with these  
18 principles. There's something missing, though.

19           After we're saying some services may add value  
20 greater than their potential cost, I think there's a need  
21 to say some services -- the value of some services may be  
22 less than the potential cost, and that's why we need to do

1 -- in many cases, we need to do testing rather than proceed  
2 to cover them.

3 DR. CROSSON: David. David, Kathy.

4 DR. NERENZ: This is generally fine, but there's  
5 a distinction that I think we touched on perhaps at one of  
6 the prior meetings, I just wanted to reinforce here.

7 Some telehealth services do seem, indeed, to be a  
8 different type of thing. They're new, and so it makes  
9 sense to think of them as a benefit. Either it's covered  
10 or it's not covered, but it's different.

11 But a lot of the things we're talking about  
12 strike me as just a different means to get to the same  
13 fundamental thing. Telepsych is an example. If you're a  
14 psychiatrist, I can go to your office, and we can spent an  
15 hour. And we can do an hour of one-on-one therapy, or I  
16 can appear by Skype in your office. And we do the exact  
17 same thing, and some other services are like that.

18 So it seems to me as we think about this issue of  
19 coverage, it may be worth at least trying to think about  
20 what's really a different service or, therefore, needs to  
21 be considered a separate benefit, and what's simply a  
22 different means or a different site, if we want to use that



1 terminology, to do something that's already a covered  
2 benefit? Maybe the path is easier at least down that  
3 second part if we can identify things that look like that.

4 DR. CROSSON: Let me just add onto that a little  
5 bit, David. I think we talked about this once before, but  
6 there's yet another set of values here that are really not  
7 on our table but are very important in considering the  
8 example that you just put forward, which is the sort of  
9 secondary value to the beneficiary whom might in fact be  
10 working or -- and in that case, the value to the employer  
11 of providing those same services but in a much more  
12 efficient way for those individuals and potentially for the  
13 employer if the beneficiary is still employed. And that's  
14 of substantive value.

15 From my own experience in the organization I used  
16 to work for, it's very cherished by the patients, the  
17 beneficiaries, but it's not necessarily a value that we're  
18 considering in these tradeoffs that we're taking into  
19 consideration. So that's an important point.

20 DR. GINSBURG: If I could add one more thing,  
21 you're right, David, that the telehealth mental health  
22 really is the same thing, roughly, as the in-person one.

1 But the change is that it's at dramatically lower cost to  
2 the patients by eliminating the time cost to the patient of  
3 scheduling the appointment, getting there, which really  
4 brings up the situation, you know, are these services that  
5 we're contemplating substantially reducing the price of,  
6 are they already overused or are they underused? And I  
7 think that's where the testing comes in.

8 DR. NERENZ: Oh, I agree absolutely, but I chose  
9 that example because we probably would tend to think of  
10 that as underuse, or if we're thinking, you know, off into  
11 the opioid territory, are we offering sufficient substance  
12 abuse services. So I'd be happy to add that concept as an  
13 overlay that we'd want to think down this line,  
14 particularly if it's an underuse area, rather than either  
15 known overuse or risk overuse.

16 DR. GINSBURG: We could even say that if this is  
17 an underuse area, we're not so concerned about the volume  
18 increases because they'd be more difficult, and it may be  
19 that we just have a win for the patients without a  
20 significant loss for the program.

21 DR. MILLER: Can I just -- in all this exchange,  
22 there's just one thing I didn't follow. I felt like

1 particularly on your last exchange there you might do  
2 something because you viewed it as under -- you know, a  
3 lack of need being met, like your psych example in your  
4 work. That's definitely what we were trying to do with, I  
5 think, number 3. We were trying to do that. We were  
6 trying to say, for example, in number 1, let's just -- and  
7 now let's just do pretend on everything, okay?

8           The first example, the outcome here is so  
9 positive, you might want to incur the cost, that it's this  
10 notion of cost -- or value exceeds cost.

11           Then there was the example of saying that there  
12 might be a value to a specific set of patients, and it's a  
13 closed enough group that the size of the cost, you know,  
14 you're kind of going, yeah, this is worth it. So a  
15 Parkinson's patient with mobility issues, you say I'm going  
16 to do this because, you know, people are trying to be  
17 Parkinson's, just to be very blunt about it.

18           And then number 3 became this issue that you're  
19 talking about, it's like there is an underservice here in  
20 the country, and the program may want to incur the cost in  
21 order to do that.

22           And then the fourth category -- although there

1 was a real question there of, you know, to take on. And  
2 then the fourth is it's unclear whether from an access or a  
3 quality point of view that value exceeds the cost, and so  
4 that you want to park into demo space.

5 So the only thing -- I was agreeing with  
6 everything you're saying, but perhaps we just didn't get  
7 that third point across well to you, and so I wanted to say  
8 that is one of the very principles.

9 DR. NERENZ: And I don't think there's any  
10 disagreement here at all. I was just pointing out that  
11 rather than always using the phrasing and the vocabulary to  
12 say, well, this is a new benefit, there may be reasons to  
13 say this is a different way to get an existing benefit, and  
14 we should think of it that way.

15 DR. CROSSON: On this point, Jack?

16 DR. HOADLEY: Yeah, on Mark's point, I actually  
17 kind of like that notion, and it changes a little bit of  
18 the tone of how those examples get read. So the way you  
19 just framed it to say the four examples are in a sense four  
20 prototypes or genotypes or whatever --

21 DR. MILLER: Illustration.

22 DR. HOADLEY: -- as opposed to, okay, we just

1 thought of four things that we've seen out there that  
2 happened to work and they're just sort of happening, and  
3 maybe this was there in the way it was written and I missed  
4 it. But I like that because it says we're not so much  
5 saying, oh, go pick out stroke, you know, mental health and  
6 so forth as things you might tick off in a piece of  
7 legislation. And we still might be okay if somebody did  
8 that, but what we're really framing is saying there's kind  
9 of these four genotypes of kinds of situations that we're  
10 now applying our principles to and using an example to play  
11 it through. I think that actually frames it really nicely.

12 DR. MILLER: That's what we were trying to do.

13 DR. HOADLEY: Yeah. Obviously, didn't quite get  
14 it all, but now I'm getting it.

15 DR. MILLER: I think it was Andrew.

16 [Laughter.]

17 DR. CROSSON: I've got Kathy, David G., Dana, and  
18 then Bruce.

19 MS. BUTO: I'm trying to sharpen what Jack is  
20 saying because I got the impression in reading the paper --  
21 tell me if this is right -- that these examples, especially  
22 the first three, were examples where partly based on what

1 Congress asked us to do, which is look at where this is  
2 being used commercially as well as in Medicare and where  
3 might there be some areas of opportunity to expand which  
4 are good for the program and beneficiaries, that these  
5 examples rose to the top. In other words, these aren't  
6 just examples. These are the ones that we're kind of  
7 struck based on experience as there could be real value.  
8 So I want to make sure we know where we are on this. Are  
9 we going to -- because I think some concern we have is that  
10 they don't just take these examples and say, oh, yeah,  
11 we'll add all these other categories that might meet one of  
12 your three criteria. I don't think that's the intention.

13           So I like the way it was framed, and I thought it  
14 went to the charge we were given to look at what the  
15 experience has been and where we think there's real value.

16           I would actually characterize these more --  
17 rather than as an expansion of benefit, more like  
18 flexibility in the way the benefit's delivered, back to  
19 David's point, for these areas, because there is a benefit  
20 behind each of these that we're allowing greater  
21 flexibility in the way that it's actually delivered by the  
22 provider.

1           And then on the fourth one, direct-to-consumer  
2 telehealth, I wondered if we could also consider mentioning  
3 greater flexibility in relation to the per beneficiary  
4 primary care management. Did we do that already in our  
5 primary care per beneficiary payment? Because this strikes  
6 me as one where, if that ever came to pass, this would be a  
7 terrific additional tool for primary care physicians who  
8 would like to be in touch but don't have enough office  
9 hours to accommodate everybody.

10           DR. MILLER: To try and answer your question  
11 directly, my recollection is when we did talk about the per  
12 person primary care payment, we said the dollars could be  
13 used for these coordination activities, and I thought we  
14 rattled this off as part of it.

15           MR. WINTER: Yes [off microphone].

16           MS. BUTO: We did? Okay.

17           DR. MILLER: It is, and so there's no --

18           MS. BUTO: So you might reinforce that here.

19           DR. MILLER: -- problem bringing it -- we could  
20 bring it back into this discussion.

21           MS. BUTO: Great. And then my last point is back  
22 to the MA issue. I would really -- I think it would help a

1 lot to differentiate when something's a supplemental  
2 benefit versus either delivery by a different way or just  
3 the service that Pat was talking about, where you're making  
4 an accommodation to help a beneficiary, and that's totally  
5 within the plan's purview. So we're not confusing about  
6 how rigid the rules are around MA plans.

7 DR. CROSSON: Okay. David.

8 DR. GRABOWSKI: Great. Thanks. First, I'll  
9 start with the bottom bullet there. I'm very much in favor  
10 of consistent, I think, with MedPAC philosophy that  
11 entities bearing financial risk under Medicare should have  
12 more flexibility and be allowed to cover telehealth. So  
13 I'm very favorable towards that idea.

14 Second, I sort of struggled similar to Jack with  
15 kind of the examples versus the principles, and I like kind  
16 of working from principles and using these examples to play  
17 that out. And I was trying to think of telestroke and  
18 these different examples, and I think flipping that and  
19 thinking the principles and then trying to use these  
20 different examples, I like that approach, Mark. So thanks  
21 for that.

22 Then, finally, similar to Paul, I'm very much in



1 favor of using CMMI to sort of test a lot of this, and I  
2 think all of these ideas we can think through sort of the  
3 potential quality and access impacts and the cost impacts,  
4 but actually testing this is quite important. So I would  
5 very much encourage us to put that as a recommendation to  
6 have CMMI test this.

7 Thanks.

8 DR. CROSSON: Thank you. Dana.

9 DR. SAFRAN: Yes, I also really like how this is  
10 taking shape and, in particular, feel like the flexibility  
11 for the MA plans and the ACOs is the right place to start.  
12 I am concerned that the traditional fee-for-service system  
13 that we'll see this being inflationary. And I hear us  
14 saying, well, maybe that's okay for some things. And maybe  
15 it is okay for some things, but I think there are some good  
16 reasons to begin with this being implemented and studied in  
17 the MA and ACO environments. And I might even go so far as  
18 to ask that as they are implementing, that they are  
19 indicating how it will meet the principles that you said.  
20 So how will it improve access if improving access is part  
21 of what they're doing? How will it improve safety or other  
22 outcomes? And how will it help to manage cost? In

1 particular, I'm really interested in our learning and  
2 having these organizations think about how it allows them  
3 to take cost out of their existing cost structure and move  
4 away -- as we started talking about last time, move away  
5 from building-centered care. And if we can get them  
6 thinking about that, you know, for example, some of the  
7 offsets of even by improving access to mental health, which  
8 might increase costs, because there are these offsets and  
9 because it allows them to provide care in a less expensive  
10 way, you know, I think you need these organizations that  
11 are rowing in the same direction as we're trying to row in  
12 terms of managing overall costs, to be the ones where this  
13 gets tested first would be my thinking. And I'd go so far  
14 as to ask them to help us understand how their  
15 implementation plans are going to support your principles.

16 DR. CROSSON: Bruce.

17 MR. PYENSON: I'd like to pick up on Dana's  
18 comment and also Paul's comment. Paul commented that  
19 telehealth could be very valuable for the beneficiary in  
20 terms of savings of travel time and so forth. And, Jay,  
21 you had a similar comment for the employer perspective.  
22 But then Dana was talking about the infrastructure cost

1 moving away from facility.

2           Now, if we think about a hypothetical situation  
3 where we had a doctor whose entire practice was telehealth,  
4 think about what that would do to the factors within RBRVS.  
5 So within RBRVS there's, you know, work expense, practice  
6 expense, and malpractice expense. The work component would  
7 stay the same. The practice component could go down to  
8 zero. There's no need for an office and any of the  
9 supplies and all the other kinds of things there. But  
10 under the current structure, that would be a very -- such a  
11 telehealth specialist would be getting a lot of money from  
12 Medicare without having the expense. It would be very  
13 profitable. Now, that's part of how telehealth companies  
14 do their thing, right? If a physician doesn't have an  
15 office, they don't need as much income.

16           So I see that heading in the direction of what we  
17 saw yesterday with the off-campus emergency rooms where,  
18 you know, you have a different kind of enterprise getting  
19 different kinds of patients, different kinds of questions.  
20 So I think if -- a consequence of broader coverage of  
21 telehealth by Medicare would need -- would require  
22 reconsidering the E&M codes, and we have an RBRVS structure

1 to think about that.

2           Now, that perhaps doesn't make sense if, you  
3 know, if a physician gets one or two telehealth calls a  
4 week. You know, the practice expense is still there. They  
5 can't shut down one of their -- you know, pay less rent or  
6 something like that. But if this takes off, we have  
7 actually an interesting potential to reduce that component  
8 of Medicare spending appropriately.

9           So what I would ask is some consideration that  
10 Medicare not overpay for the practice expense at telehealth  
11 grows.

12           DR. CROSSON: Good point. Alice and Jack.

13           DR. COOMBS: So I was looking at the bullets, and  
14 in the context of what Mark has said, the last bullet I  
15 actually have problems with in the sense that that's  
16 something that maybe I would say needs to be studied under  
17 CMMI, and I would include the MSSPs with that as well.

18           In terms of, I think, the greatest value, I would  
19 say it would probably be telestroke, and there's one other  
20 entity that I think you guys mentioned, or maybe I saw it  
21 in a former chapter, was Parkinson's disease, and so  
22 Parkinson's disease and telestroke. And just to let you

1 know, Paul, you asked a question about how are resources  
2 constrained, and I work at two different hospitals, and one  
3 is a very busy stroke center. And so someone in neurology  
4 gets the call that a stroke patient has arrived to a  
5 community hospital 10 minute, 15 minutes away. It's in the  
6 middle of the night, and they will telegraph the CT scan  
7 and they will actually read it, they will do everything  
8 necessary and say, okay, drop the tPA. And so sometimes  
9 they transfer them to us from the community setting, but  
10 whatever is done, it's done in such a way that you can have  
11 total resolution of a patient who's totally cadaveric on  
12 one side, cannot move anything. You drop the tPA, and  
13 hours later you see them moving, and it is dramatic. And  
14 you consider what would have happened 20 years ago. That  
15 patient would have gone to the hospital, stabilized, blood  
16 pressure control, and that patient would be your SNF or  
17 LTCH or IRF patient. And that hospitalization would have  
18 taken a long time. So I think the value of that is  
19 absolutely incredible, and also the cost savings that's  
20 accrued.

21           And just to let you know, it is the fifth leading  
22 cause of death. Every 40 seconds someone's having a

1 stroke, and every four minutes someone's dying of a stroke.  
2 So this is like one of those areas I don't expect for  
3 things to change in terms of population health measure  
4 immediately. It's going to be someplace where we need to  
5 be throughout the country.

6 DR. GINSBURG: Alice, I didn't imply that  
7 telestroke did not have value --

8 DR. COOMBS: No, no. I was just saying about  
9 constrained resources, and it may be that the neurologists  
10 are not available at wherever the patient is at St.  
11 Elsewhere. And so it doesn't mean that they necessarily  
12 don't have all the FTEs working there, but it may be that  
13 specialty in and of itself may be deficient in that region.

14 DR. GINSBURG: So actually, when I was listening  
15 to you, there may be examples where neurologists are in  
16 short supply. If they don't have to come down to the  
17 hospital, they can do more. They can provide that wisdom  
18 on a telehealth basis, and in a sense nobody else misses  
19 out on neurologist services because they're spending time  
20 consulting on stroke patients.

21 DR. COOMBS: And that very reason, my brother  
22 actually had a stroke, and I called from Boston and asked

1 if a neurologist could see him in Los Angeles. And I was  
2 actually able to fly from Providence, Rhode Island, to  
3 California and see him before a neurologist came in his  
4 room. Needless to say, he had permanent sequelae because  
5 of the stroke. So just that piece alone is huge in terms  
6 of having someone available.

7           And then mental health services, I think mental  
8 health services are really important. I don't know, MA  
9 plans -- Pat, you were very helpful in kind of elucidating  
10 how the process works. But I think that mental health  
11 services are probably another high priority area, as has  
12 been mentioned already. And probably because patients --  
13 it's a stigma sometimes going to see a mental health -- a  
14 psychiatrist or a psychologist. And having telemedicine is  
15 an easy way for them to actually see someone without the  
16 stigma, and patients feel a little bit more comfortable  
17 because of confidentiality. So I just would like to say  
18 that that last bullet is one that I'm not very comfortable  
19 with, granting greater flexibility without further study.

20           DR. CROSSON: Okay. Jack, Warner, Pat. Let's go  
21 up this whole row here. Jack.

22           DR. HOADLEY: So, thank you for all this work and

1 I know you guys have done a lot of work on this on a pretty  
2 abbreviated schedule and it's impressive. And I think  
3 we're ending up in a pretty good place overall.

4           Just a variety of little comments. I'm struck  
5 that -- and I think this is there, but on the MA options,  
6 you know, the discussion we were having about trying to  
7 tease out the details, the extent to which the option --  
8 either of the options you've laid out sort of fix those  
9 problems, or how they address that sort of ambiguity, just  
10 make sure we've made real clear sort of the linkage between  
11 this -- maybe we can tease out a little more from this  
12 discussion of the circumstances that telehealth gets used  
13 or doesn't get used in MA, and whether -- and the whole  
14 complexity of paying for it gets fixed by this. I mean, I  
15 think that was the -- I mean, it's clear that was the  
16 intent.

17           Second, sort of going to this whole discussion of  
18 how we think about the tradeoffs and the whole notion, and  
19 one of the early slides of exercising caution, you know, I  
20 think we're teasing that out really well, both in what  
21 you've written and in how we've talked about it, and it  
22 does strike me that there significant areas where improved



1 access is worth some investment of additional costs. The  
2 one I think, on the other side, the one that struck me, is  
3 some of the potential roles for some of these vendors. You  
4 know, we've seen, in so many areas, you know, you start out  
5 designing something that makes a lot of sense, the way it's  
6 being done, the way it's initially done just works and is  
7 sensible, and then certain kinds of vendors or companies  
8 get a hold of it and they say, "Okay, boy, we've got this  
9 thing. Now we can just push these services into people."

10 I think we got some of that out of the commercial  
11 insurance experience, and that may be something where we  
12 can sort of pull out that notion as one of the potential  
13 pitfalls, and that goes, again, to some of the potential  
14 for testing some of these things in a CMMI context,  
15 although I suspect that through a controlled demonstration  
16 is not where you get the playout of that exploitation of  
17 something. That comes later. Okay, you test it, it's all  
18 very clean and controlled, and it works in that controlled  
19 situation. And any insights, whether from private  
20 insurance or elsewhere, of how to sort of prevent the  
21 exploitation, again, often driven by certain kinds of  
22 vendors that we can put in there, seems like a useful

1 point.

2           But it does go back to saying -- that caution of  
3 trying to figure out the tradeoffs and that framing of  
4 these different examples and where the tradeoffs -- where  
5 the risks of those exploitations seem less, or how we think  
6 of them in those different examples. I think that's a nice  
7 way to frame all of this up.

8           The last comment is simply that it struck me, and  
9 it was on your Slide 3 or something, where you talked about  
10 the comparisons of what you learned in the commercial, that  
11 in the commercial sector generally was not making the  
12 distinctions of rural versus urban in the way that Medicare  
13 -- and I was somewhat expecting that we might have more of  
14 a stronger observation around that point, that maybe the  
15 distinction about focusing this strictly on rural areas is  
16 not the most useful way to -- and maybe one way to think  
17 about that is that some of these other thoughts we're  
18 building in these four scenarios are a better way to think  
19 about, you know, a service that has an unmet need as  
20 opposed to, you know, it's just a rural thing. So we can  
21 have shortages of neurologists in any particular community,  
22 temporary perhaps, you know, longer term, whatever, as

1 opposed to sort of making the blanket assumption that rural  
2 and general has shortages and urban doesn't. And so, you  
3 know, maybe there's a statement -- again, we're not framing  
4 any of these as, you know, bold-faced recommendations, that  
5 the urban-rural distinction that we've used to date isn't  
6 capturing some of the things that we're thinking of.

7 DR. CROSSON: Thank you. Jack, I just want to  
8 emphasize, I have the similar concerns that you do,  
9 particular about the extension of telehealth mental health  
10 services, and I can see the need here, which we've all  
11 expressed. I can also see, you know, the potential that  
12 you've described. And I just wonder, in terms of thinking  
13 about ways that, you know, we might suggest something could  
14 be done about that, and I'm not sure I know what that is,  
15 exactly. I'm not a particular fan of preauthorization, but  
16 something -- you know, or even limits. But there may be  
17 some notions that we could conceive of where we could at  
18 least caution in that regard, or perhaps make some  
19 suggestions about how that could be forestalled.

20 DR. HOADLEY: Yeah. I think that's right, and  
21 prior authorization doesn't really feel -- I mean, it seems  
22 like that's a hard way because it creates a lot of barriers

1 --

2 DR. CROSSON: Right.

3 DR. HOADLEY: -- a lot of burden. Again, we've  
4 seen this in so many other areas and we've talked about  
5 different parts of an industry that come in. We talked  
6 about it yesterday with some of the freestanding ERs, you  
7 know, ones that simply come in to say, okay, there's a  
8 profitable area to move into. It's nothing about the need  
9 of a community, and how do we draw distinctions.

10 Now there we've got mileages and things we try to  
11 play with. It's a lot harder to think about how you would  
12 do it here.

13 DR. CROSSON: Right. I'm sorry, Kathy, on this  
14 point.

15 MS. BUTO: On Jack's point, my impression, when I  
16 was reading this, was that actually most of our expansions  
17 are into urban areas, from a benefit that is largely  
18 available to rural. But I agree with Jack. I think that  
19 doesn't -- that shift in our thinking, based on the  
20 analysis of what commercial plans do, doesn't come through  
21 as strongly as it should.

22 And just on the point of the two options for MA

1 plans, isn't the first option just status quo? It's  
2 essentially whenever Medicare expands a benefit, MA plans  
3 expand a benefit?

4 DR. JOHNSON: It would be status quo, but just  
5 pointing out that if there some expansion under fee for  
6 service, given a renewed effort as a result of our report  
7 perhaps.

8 DR. HAYES: Yeah. It just didn't feel like a  
9 real option to me, because I know that that's what we do  
10 now. Then I wondered, did we really just have the one  
11 option, although I guess the other aspect would be you can  
12 always continue the supplemental premium and rebate  
13 approach, right?

14 DR. HOADLEY: That would be the point, then, to  
15 emphasize. I didn't think that all the way through. But  
16 to emphasize the point that Option 2 accomplishes some of  
17 these things in a way that Option 1 doesn't. Option 1 does  
18 this much, in terms of if we make other adjustments, but  
19 Option 2 would take -- would go ahead.

20 DR. CROSSON: Okay. Rita.

21 DR. REDBERG: Thanks. And I think I like -- I  
22 agree with a lot of the Commissioners' statements and the

1 principles and the plan you've set out going forward,  
2 because I think there is certainly a lot of potential to do  
3 good in telehealth, but I think it makes sense to start in  
4 risk-bearing MA and ACO entities. I do worry about the  
5 volume incentives in physician fee for service, particular  
6 before we have a lot of evidence. I think, like a lot of  
7 new things, but this is clearly a new thing.

8           We really want to see evidence that it does  
9 adhere to the principles, and, in particular, improve  
10 outcomes, because, you know, there's all kinds of things,  
11 as we've said, that can be telehealth. There's, you know,  
12 tons of now health analytics, and blood pressure things,  
13 and we don't even know if they work. I mean, if the put  
14 outcomes just on a quality level -- you know, the FDA is  
15 still trying to figure out what has to be regulated, what  
16 isn't. But we know there are a lot of things on the market  
17 that purport to tell consumers things about their health  
18 that we have no idea if they actually do or not. And so I  
19 think it's good to kind of go slow and look for the  
20 evidence, and involve CMMI, too, in some of the innovation  
21 projects.

22           So I like the potential and I think the examples

1 you chose are good ones, the Telestroke, and certainly the  
2 mental health. I've had patients that have tried that and  
3 really like it, because of the privacy issues. And also  
4 some patients have used it when they're not native English  
5 speakers, to have someone who they can -- done  
6 internationally, so that they have someone that they feel  
7 more comfortable talking to in their own language. So I  
8 think it's a great summary.

9 DR. CROSSON: Warner.

10 MR. THOMAS: So I would just want to echo Alice's  
11 comments around especially stroke and mental health, and I  
12 think the more that we can provide flexibility into rural  
13 areas, I think this is a huge opportunity to continue to  
14 expand capabilities of rural facilities. We were talking  
15 about, you know, critical access hospitals yesterday, that  
16 they are declining utilization, because they don't have the  
17 folks that kind of keep people local, so they ship  
18 everybody out. Stroke telemedicine is one way. We  
19 actually have about 60 hospitals on stroke telemedicine,  
20 and we have about a 90 percent retention at those hospitals  
21 of patients versus before it was probably, you know, 40 to  
22 50 percent of patients would be retained locally.

1           So I think there's more opportunities, with  
2 certain conditions, that can be treated locally with the  
3 right telemedicine and clinical capability being connected  
4 to them.

5           I'm a little different than where a lot of other  
6 folks are on this. If I was going to bet on an innovation,  
7 this would be one I would bet on, because it is relatively  
8 low cost, frankly. I think you could price it so it was  
9 low cost, and I think the impact is potentially pretty  
10 substantial. Right now we don't control, you know, when  
11 people go to the doctor or go to an ER, and we were talking  
12 yesterday about ER utilization. This is a potential to  
13 potentially avoid ER utilization, frankly. If you get the  
14 right telemedicine consult and you're told, you know, how  
15 to handle your medical condition, you're less likely to go  
16 to an ER, especially if you have to wait four, five, or six  
17 hours.

18           So, you know, I think we should do more things  
19 through CMMI. I think those are great places to test. But  
20 I would be more inclined to give more flexibility, and I  
21 know the direct-to-consumer component is a little  
22 sensitive, but today people can access services whenever



1 they want anyway. So I don't think it's like someone is  
2 going to get a telemedicine consult and then go get, you  
3 know, an office visit if they don't have to. So I just  
4 would ask us to think about that.

5 But I would encourage us to -- I would actually  
6 say, on the stroke side and on the mental health side,  
7 let's make sure we set the adequate reimbursement, to get  
8 more people to do it, because it is life-saving and life-  
9 changing in those services.

10 DR. CROSSON: Yes, Pat.

11 MS. WANG: So I actually generally think that  
12 Option 1 is the correct way of sort of thinking about this.  
13 I definitely think it's like a no-brainer, based on what  
14 everybody has said and what the literature has shown and  
15 what you wrote about. The Telestroke is a benefit that  
16 should be made available to beneficiaries who live in urban  
17 areas as well as rural areas, so expand that out.

18 Tele mental health, I have to say it sounds  
19 really good. The thing that's a little different about,  
20 you know, the flexibility to use it when you're an ACO or  
21 an MA plan, you know, on a person-specific basis, to  
22 declaring it part of the Medicare A/B benefit is -- you

1 know, I just want to take a pause there, because that has  
2 its own implications, at least to me, and I'm not sure that  
3 I feel that enough is known about how that would actually  
4 work. I think it's definitely beneficial for many people,  
5 but unlike Telestroke, which is going to be beneficial to  
6 anybody, everybody, tele mental health is still a little  
7 bit young in the development of the service. I'm just a  
8 little concerned about sort of saying, you know, put it  
9 into the A/B benefit, you know, for the whole country. I'm  
10 just a little hesitant to do that.

11           The other thing that I just want to make sure  
12 that I understand is the final bullet here about  
13 flexibility given to MA plans and two-sided ACOs, you know,  
14 as a general principle, of course, you know, I think that's  
15 right. I just want to make sure that the way that I  
16 interpret that is, so, under Option 1, something goes into  
17 fee for service. It does become sort of like a mandatory  
18 benefit that everybody offers. This has to do with the  
19 things that we described that think entities at risk do  
20 now, which is on a person-specific basis, try different  
21 approaches. That flexibility remains.

22           I'm not sure that I would agree that that

1 flexibility should extend to I am now going to advertise  
2 and offer a direct-to-consumer telehealth benefit to all of  
3 my MA enrollees. It's not a supplemental benefit. I'm  
4 going to pay for it within the premium, but it is a  
5 different benefit. Again, it does that step-up. It's sort  
6 of like part of the A/B package now, as opposed to what  
7 plans are doing now, which I think is flexible enough. Do  
8 you know what I mean?

9           So I just want to kind of just draw that  
10 distinction a little bit. I think you do -- I don't think  
11 it's a great idea to start -- for Medicare to start going  
12 down two different tracks. Entities at risk can kind of  
13 put any benefits that they want to in there, and fee for  
14 service is still wanting to experiment, to see whether it's  
15 -- it just feels a little funny. So I feel like Option 1,  
16 with the current flexibility that risk entities now have to  
17 use telehealth, is kind of the right thing.

18           DR. CROSSON: Brian.

19           DR. DeBUSK: Talk about terrible timing of  
20 comments, because I'm about to advocate for mental health -  
21 -

22           [Laughter.]

1 DR. DeBUSK: -- and for Option 2. So I'm sitting  
2 here thinking, did she read my notes and just go with the  
3 opposite?

4 MS. WANG: No, I read your mind.

5 DR. DeBUSK: Yeah, read my mind. That's even  
6 scarier. Thank you.

7 I want to advocate for going ahead, going forward  
8 with mental health. I will tell you I like the way that it  
9 made it as one of our four illustrations. I hope we can  
10 find a way to maybe even lift it above just an illustrative  
11 example in this report and maybe even set it aside as its  
12 own case study, area, whatever. And here's my rationale.  
13 I think we're missing an opportunity in this  
14 congressionally mandated report to send a message that says  
15 when you have 50 percent participation rates by  
16 psychiatrists, when you have a particular discipline that's  
17 somewhat checked out of a payment area, that the program is  
18 prepared to respond aggressively to fill that void.

19 And you can imagine what opening this up to  
20 telehealth means. I mean, what it really means is that any  
21 psychiatrist, anywhere, could provide this mental health  
22 benefit. I mean, you're breaking down all these geographic

1 barrier. I would see that as a pretty aggressive response,  
2 but I would also see that we would be doing this in an area  
3 where the providers aren't participating at rates that are  
4 -- that we typically see for other categories of providers  
5 in the program.

6           So I hope we don't miss that opportunity to say,  
7 you know, if you don't participate, we're going to do some  
8 pretty aggressive things to make sure that our  
9 beneficiaries are taken care of.

10           The second thing I want to talk about is this  
11 Option 2 on Chart 16. I really like Option 2, and I  
12 completely get it in that you wouldn't just want to let fee  
13 for service start billing telehealth. I mean, it would be  
14 inductive. We'd get a lot of new spending. And I also get  
15 it if you're in a fully capitated, let's say an ACO, a Next  
16 Gen, per-member, per-month, you'd really want to be very  
17 lenient there, because they have a lot of incentives.

18           MA is a little bit of a gray area, because they  
19 are fully capitated but their benchmark, or their bid is a  
20 function of anticipated spending. So it sort of falls in  
21 that gray area of it's not truly, truly capitated. It's  
22 capitated and comingled with a benchmark that has

1 anticipated spending.

2           But consider this. Let's say that I'm at my full  
3 rebate, my 70 percent rebate on an MA plan. When I bid, if  
4 I were to bid below the benchmark and not incorporate that  
5 spending, I'm going to get 70 percent of those dollars  
6 back. So, really, I want us to hope we can look at this  
7 way. Really, for only a 30 percent incremental cost, we're  
8 going to have the opportunity to let MA plans just  
9 basically go unfettered in this telehealth space.

10           To me, it seems like if we're only putting 30  
11 cents on the dollar truly at risk -- and I don't know what  
12 the average blended rebate is. It's probably closer to 50  
13 percent or so, maybe -- but we're getting to work with  
14 telemedicine at a discounted rate, because we're using  
15 dollars that presumably would be coming back to these plans  
16 as rebates anyway. To me, my inclination -- Bruce, is it  
17 lower than 50 percent?

18           MR. PYENSON: They have to use the rebates for  
19 benefits.

20           DR. DeBUSK: That's what I'm saying. Let's say  
21 that I allow them to incorporate in the benchmark now, so  
22 their bid is going to be a little bit higher, right?

1 DR. MILLER: Well, that's the \$64,000 question.

2 DR. DeBUSK: Well, let's assume their bid is a  
3 little bit higher. They're going to -- either way, a  
4 portion of that money -- let me just sort of step back in  
5 in a more general way. Either way, a portion of that money  
6 would find its way back to them, that they could then  
7 presumably use on extra benefits. Like if they wanted to  
8 incorporate telehealth, and we stuck them with just Option  
9 1, they could also just bid below the benchmark, get a 70  
10 percent, 50 percent, 60 percent rebate, and then apply that  
11 rebate, right, toward extra benefits. There's nothing that  
12 would stop them from adding the telehealth benefit through  
13 funding it through the rebate. Correct?

14 DR. MILLER: Including right now.

15 DR. DeBUSK: Yes, right now. Including today,  
16 right? So the point is, if we go to Option 2, where we  
17 allow them incorporate really as much telehealth as they  
18 want, but they get to build that into their bid, their bid,  
19 I guess, worst case would go up.

20 DR. MILLER: Let's say it goes up. I mean, you  
21 know, what everybody says is this saves mountains of money  
22 --

1 DR. DeBUSK: Right.

2 DR. MILLER: -- and then the argument is, I want  
3 to build it into my bid, and the assumption is that the bid  
4 will go up, which is a little counterintuitive, but go on.

5 DR. DeBUSK: Well, but that's the point. Even if  
6 the bid goes up and they are participating in this plan,  
7 let's take the delta of how much the bid would have gone up  
8 anyway. If they had subtracted that delta in their  
9 original plan -- let's say they said, okay, we're not going  
10 to build this into our plan. Let's say we stuck them with  
11 Option 1. So, presumably, their bid would go down by that  
12 delta. That differential between their bid and their  
13 benchmark, they're going to get 50, 60, 70 percent of that  
14 back in rebate dollars anyway.

15 The argument I'm trying to make is --

16 DR. MILLER: And in this instance, to the extent  
17 -- I think I'm following you now. It took me a little  
18 while to catch up. But I think the distinction is whether  
19 it's a 100-cent dollar or a 70-cent dollar.

20 DR. DeBUSK: Yes.

21 DR. MILLER: Right?

22 DR. DeBUSK: I'm making -- and I probably should



1 have said this at the first -- I'm making an incremental  
2 cost argument, is what I'm making, and what I'm saying is  
3 that granted that MA plans aren't true, true capitation in  
4 that they get this bid benchmark mechanism, but when you  
5 consider the incremental cost of 30, 40, 50 percent -- I  
6 mean, we would be buying that telehealth, in theory, at a  
7 discount of sorts. To me, the opportunity to turn these  
8 guys loose and really see what they can do with telehealth  
9 and study it closely, knowing that we get to buy it at  
10 somewhat of a discount, to me seems like a pretty good  
11 bargain.

12                   So those were my two points, telehealth and  
13 Option 2 on Chart 16.

14                   DR. CROSSON: So, Brian, can I just -- I just  
15 want to clarify a little on your first point, because I  
16 thought I heard potentially two things that were a little  
17 bit disparate. Your first point was that because of a  
18 shortage of mental health services available to Medicare  
19 beneficiaries, and partly as a consequence of mental health  
20 providers not taking care of Medicare beneficiaries or not  
21 doing it through the Medicare program, that you would favor  
22 expansion of fee for service -- in the fee for service Part

1 A, Part B expansion of telehealth for mental health  
2 services.

3 But then I thought I heard you say, towards the  
4 end, that you were concerned about induction of services if  
5 we expanded --

6 DR. DeBUSK: Sorry.

7 DR. CROSSON: You're saying --

8 DR. DeBUSK: Let me clarify.

9 DR. CROSSON: -- you're saying that's your  
10 general principle --

11 DR. DeBUSK: Yes.

12 DR. CROSSON: -- but with respect to mental  
13 health services you're making a special case.

14 DR. DeBUSK: Yes. Mental health would be a  
15 special case. In general, I think just turning fee for  
16 service loose with telehealth could be -- could have  
17 serious spending ramifications. And then back to the other  
18 comment about Option 2 on Chart 16, again, I just see the  
19 opportunity to purchase telemedicine services in MA plans  
20 at a somewhat of a discount or a marginal discount --

21 DR. CROSSON: I got you.

22 DR. DeBUSK: -- and I hope we take advantage of

1 that.

2 DR. CROSSON: I got that. Okay, Paul.

3 DR. GINSBURG: Just two things. You know, first  
4 of all, I wanted to say that I'm very enthusiastic when the  
5 staff uses site visits as part of its projects, and I think  
6 it really came through on this project. I think that's  
7 been a significant part of the value that this report will  
8 have, is really what you learned through the site visits.  
9 So I just wanted to say that as a general thing.

10 In this debate about Option 1 or Option 2 for  
11 Medicare Advantage, it appears to me that, for at least  
12 several years, the MA plans or their actuaries won't really  
13 know whether, you know, providing a telehealth benefit is  
14 going to increase or decrease costs. And so we probably  
15 shouldn't take this too serious, and we probably should  
16 acknowledge that this is going to be a great area of  
17 uncertainty, rather than just assuming, oh, you know, there  
18 must be an answer and actuaries will find it.

19 [Laughter.]

20 MR. PYENSON: Nobody listens to my answers  
21 anyway.

22 DR. GINSBURG: But obviously they'll be doing

1 their best but they won't be that precise. So I think we  
2 should acknowledge that this is going to be a very vague  
3 area.

4 But I do think that Option 2 is the way to go.

5 DR. CROSSON: Warner and then Bruce.

6 MR. THOMAS: Just real briefly, I think the other  
7 thing that is not covered in the report that could be  
8 helpful is just the whole issue around licensing, and, you  
9 know, that there are some states that are still dragging  
10 their feet around the whole licensing issue, and it is a  
11 limitation, frankly, for some states. I don't understand  
12 all the issues around that besides parochialism, but  
13 perhaps there could be a comment in here about that that's  
14 an important consideration to the implementation and the  
15 effectiveness of this service.

16 MR. PYENSON: I may have missed this in the  
17 material, but having an option that would allow MA plans to  
18 include telehealth services in their bid as a voluntary  
19 option, as opposed to a new mandatory --

20 DR. JOHNSON: Meaning voluntary for the  
21 beneficiary or voluntary for the plan to offer?

22 MR. PYENSON: For the plan.

1 DR. JOHNSON: I think the way we were envisioning  
2 it would be that if a plan wanted to offer particular  
3 telehealth services they could include that in the bid, and  
4 any telehealth services that they would offer would be in  
5 the bid and funded through the program's base payment rate.

6 MR. PYENSON: So the last bullet on page 16, that  
7 would apply to just the MA plans that --

8 DR. JOHNSON: Correct.

9 MR. PYENSON: Okay. Thank you.

10 DR. CROSSON: Okay. This has been an excellent  
11 presentation, an excellent discussion. We will be  
12 incorporating the range of ideas here. There are some  
13 disagreements. They can be constructed, I think, as  
14 options in the final report. We will be seeing it again in  
15 January for a final vote.

16 Before we proceed with the public comment period,  
17 I cannot end today's discussion without an acknowledgement  
18 of the fact that this is the last meeting for Mark Miller,  
19 after 15 years of exemplary leadership of MedPAC. I have  
20 enjoyed 10 of those years myself, both professionally, as a  
21 member and later Chairman of this Commission. I think the  
22 Medicare program and the public at large have benefitted

1 dramatically from the intelligence and leadership and  
2 sensitivity and occasional sense of humor manifested by  
3 Mark, and I just want to publicly acknowledge his work.

4 [Standing ovation.]

5 DR. MILLER: Thank you.

6 DR. CROSSON: So we will proceed with the public  
7 comment period. If there are any members of the public who  
8 would like to comment on issues that we have discussed  
9 today, please come to the microphone so I can see -- it  
10 looks like we have a substantial line there. Let me just  
11 wait a second for the clearing-out process.

12 I would like to remind you and others in the  
13 audience that there are a number of ways to provide input  
14 to MedPAC and the staff -- directly through e-mail, through  
15 written correspondence. Public comment period is one of  
16 those, not necessarily the best because it occurs after the  
17 discussion has taken place.

18 For those of you who are going to make comments I  
19 would ask you to identify yourselves and any organizations  
20 that you are representing or are associated with. And I  
21 would ask you to keep your comments to two minutes. When  
22 this red light goes out, that will indicate that the two

1 minutes have expired. Thanks very much.

2 MS. TRUJILLO: Thank you. It will be brief.

3 Sylvia Trujillo with the American Medical Association, and

4 I am actually commenting on both sessions.

5 So with regard to the discussion around the Part  
6 D program and biosimilars, just an observation during the  
7 time that the ACA was being debated and the biosimilar  
8 provision conferring the FDA with authority for approval of  
9 interchangeable biosimilars, interchangeable products to an  
10 innovator versus the biosimilar. A lot of our physicians  
11 made clear that this new regulatory regime could create a  
12 lot of confusion about whether or not the products were  
13 truly interchangeable. So the only observation I have with  
14 regard to that is the one thing that we strongly support is  
15 your effort to remove perverse incentives that would  
16 encourage people to use the innovator when a biosimilar  
17 would be equally appropriate, but caution that any changes  
18 that would force switching between either biosimilars or  
19 the innovator, if it's not truly interchangeable, we  
20 encourage you to be mindful of. So that's on the first  
21 session.

22 On the second session, just very quickly, first,

1 we applaud the structure that was outlined today with  
2 regard to the three criteria and our categories for  
3 evaluating expansion of telehealth. I do want to flag that  
4 there is a distinction between telehealth and remote  
5 patient monitoring, and in the Medicare program the AMA  
6 supports the definition of telehealth as a two-way audio-  
7 visual exchange. And we do caution that we don't consider,  
8 nor does the program consider telephony to be telehealth.

9           And with regard to the licensure issue, we do  
10 have an interstate compact that the AMA and many in the  
11 Federation of Medicine and the Federation of State Medical  
12 Boards have been strongly advocating for, and we already  
13 have 22 states that are adopting it to facilitate things  
14 like telehealth. And I would note that a lot of telehealth  
15 and remote patient monitoring doesn't necessarily go across  
16 state lines. It's normally a hub intrastate of a medical  
17 center and out to rural areas or urban areas.

18           So our understanding and belief that for  
19 physicians the big questions are, will I get sued, so  
20 addressing liability issues, and will I get paid. But even  
21 before that, their question is, does it work? And to that  
22 end, we have submitted previously and we strongly support



1 the three examples you all used in Options 1, 2, and 3,  
2 with regard to telemental health, individuals with physical  
3 limitations or complex chronic conditions that make it  
4 difficult for them to receive care, as well as specialty  
5 areas that are underserved currently, such as neurology,  
6 when you have a Telestroke scenario.

7 DR. CROSSON: Please conclude.

8 MS. TRUJILLO: Thank you very much.

9 DR. CROSSON: Thank you. Thank you very much.

10 MS. DROBAC: Hi. I'm Krista Drobac. I'm with  
11 the Alliance for Connected Care. It includes stakeholders  
12 like Stanford Health Care.

13 I have three -- or two comments, separating  
14 remote monitoring and telehealth. Remote monitoring is not  
15 subject to the 1834(m) restrictions that telehealth is. So  
16 the first thing is I would encourage you to reexamine the  
17 definition of remote monitoring, on page four. It is  
18 widely considered to be remote monitoring of biometric data  
19 that is asynchronous, not necessarily a two-way video  
20 exchange.

21 Also, there is coverage of remote monitoring in  
22 Medicare today. We have implantable devices that are paid

1 remotely. Just yesterday, in the physician fee schedule,  
2 CMS unbundled the code 99091, which is the remote biometric  
3 monitoring of a patient.

4           Then, also, I would like to just say that on  
5 Slide 12, on remote patient monitoring value not being  
6 tested, there is voluminous amounts of data around the  
7 value of remote patient monitoring, even in the Medicare  
8 program, because a lot of hospitals are paying for this out  
9 of their operational budget, which has created a lot of  
10 evidence.

11           And then on telehealth, I was hoping that you  
12 might consider including another example, which is post-  
13 acute care. There is evidence that telehealth is very  
14 advantageous in post-acute care. For example, the Obama  
15 Administration created eight new codes under the CCJR Demo  
16 and the Cardiac Care Demo, in part because they believed  
17 that there was a lot of value in having telehealth visits  
18 once a patient leaves the hospital.

19           And then the other thing is, last thing, is I  
20 would love to encourage you to acknowledge the data coming  
21 out of the Veterans Administration around both direct-to-  
22 consumer care and telemental health, because there is

1 significant evidence in VA, and TRICARE just added  
2 telehealth, and there's also DoD telehealth, so the other  
3 parts of the government that have shown a lot of cost  
4 savings, actual cost savings, so I would love to see that  
5 acknowledged.

6 Thank you.

7 DR. CROSSON: Thank you so much.

8 DR. FLANNER: I'm only slightly nervous here.  
9 I'm David Flannery, Medical Director of the American  
10 College of Medical Genetics and Genomics, which is a  
11 specialty society representing clinical genetics  
12 specialists. Every specialty has its own organ system.  
13 Ours is the human genome. Consequently, we see patients  
14 from infancy through mature adulthood.

15 With increasing rise of precision medicine there  
16 is increasing need for patients to see medical geneticists.  
17 We are a small but mighty band of specialists. There are  
18 currently 1,600 active M.D. geneticists in the U.S.

19 In addition, we are not well dispersed, primarily  
20 being in academic medical centers. ACMG recognizes that  
21 telemedicine increases access to quality medical genetic  
22 services, as documented in many publications, which I will

1 be happy to share with you -- I have a multi-page  
2 bibliography of that for you -- and we promote the use of  
3 telemedicine for genetic services.

4 I can speak from personal experience. Prior to  
5 my position, I was on the faculty of Medical College of  
6 Georgia for 29 years. I started using telemedicine to see  
7 genetic patients in 1995, and by 2014, I had three half-day  
8 genetic clinic by telemedicine, seeing patients all around  
9 the state.

10 It is ironic that if geographic limits persist  
11 for Medicare beneficiaries in cities like Macon, Savannah,  
12 and Columbus, Georgia, they would have to travel to see a  
13 geneticist in the only two locations, which are Augusta or  
14 Atlanta, and this is something that should certainly be  
15 fixed.

16 Thank you.

17 DR. CROSSON: Thank you.

18 MS. BOYLE: Hi. My name is Lynne Boyle and I am  
19 representing University of Virginia Health System. I just  
20 want to say thank you to the MedPAC staff for coming to  
21 visit us. We really appreciate the opportunity to share  
22 our information with you. We are -- the UVA Health System

1 is working with -- in 153 sites across the commonwealth in  
2 over 60 subspecialties.

3 I just want to express my appreciation for the  
4 comments around the examples that were used around  
5 Telestroke, telemental health. Obviously those are service  
6 that we provide. I just also want to make a distinction or  
7 a comment around substance abuse. So it's a really  
8 opportune time right now, and we provide those services as  
9 well.

10 Just as a follow-up to some of the comments  
11 around remote patient monitoring, it is an area that we do  
12 provide, and we have seen exceptional savings in that, in  
13 terms of sending home our cardiac patients with remote  
14 patient monitoring, and we've seen a reduction in about 40  
15 percent of hospital readmissions there. So that is  
16 definitely one area that we see savings to the Medicare  
17 program.

18 And, last, in vis-à-vis the discussion around  
19 Medicare Advantage, in Charlottesville there is not a lot  
20 of Medicare Advantage. We are still fee for service quite  
21 a bit. And I just think that is just a basic understanding  
22 that needs to be reiterated in the report.

1 Thank you very much.

2 DR. CROSSON: Thank you. Seeing no one else at  
3 the microphone, we are now adjourned until our December  
4 meeting. Safe travels, everyone.

5 [Whereupon at 11:34 a.m. the meeting was  
6 adjourned.]

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