MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:44 a.m.]

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

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

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

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

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

There has been improvement in some measures of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Thank you very much.

We'll now take clarifying questions.

MR. ARMSTRONG: Jay, actually this is for you. In the chapter, there were recommendations on a whole

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

DR. CROSSON: Sorry. What are we --

MR. ARMSTRONG: The employer MA bid.

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

DR. CROSSON: Previous --

MR. ARMSTRONG: Okay. Thank you.

DR. CROSSON: Clarifying questions?

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

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

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

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

to have below average fee-for-service spending.

DR. NERENZ: In that county?

DR. HARRISON: In that county.

DR. NERENZ: Thank you.

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

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

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

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

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

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

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

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

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

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

DR. JOHNSON: Sure.

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

Medicare have health risk assessments?

DR. HARRISON: I have no idea.

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

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

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

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

DR. JOHNSON: It's possible, yeah.

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

DR. JOHNSON: Right.

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

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

MR. THOMAS: Okay. Thank you.

DR. JOHNSON: Yeah.

DR. CROSSON: Kathy.

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

DR. JOHNSON: That's right.

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

DR. JOHNSON: Right.

DR. CROSSON: Rita.

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

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

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

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

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

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

DR. REDBERG: Maybe we could revisit that.

DR. CROSSON: Scott.

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

but there are real exceptions in certain systems.

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

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

DR. JOHNSON: Yes.

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

DR. CROSSON: Other clarifying questions?

[No response.]

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

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

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

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

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

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

discussing and voting on are predicated on those principles.

So, if we could turn to page six --

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

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

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

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

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

the foundational issues for the two are separate.

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

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

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

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

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

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

DR. CROSSON: Other comments? Scott.

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

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

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

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

those double bonus payments in those counties.

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

DR. CROSSON: Cori, and then Mary.

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

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

DR. CROSSON: Mary.

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

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

[Laughter.]

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

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

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

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

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

DR. CROSSON: Jack, and then Bill.

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

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

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

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

DR. CROSSON: Bill.

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

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

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

concrete, easily identifiable, and requiring some action.

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

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

DR. CROSSON: Thank you, Bill.

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

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

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

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

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

DR. CROSSON: Rita and then Warner.

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

DR. CROSSON: The quality measures relevant to?

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

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

DR. REDBERG: Sure.

DR. CROSSON: Okay. Warner?

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

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

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

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

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

DR. CROSSON: Other comments?

[No response.]

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

I think I'd make this comment about the

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

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

DR. CROSSON: Yeah, yeah.

[Laughter.]

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

Are you keeping score?

DR. MILLER: I would move on.

[Laughter.]

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

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

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

So all those in favor, please raise your hand.

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

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

DR. COOMBS: I strongly support Recommendation 2.

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

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

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

DR. CROSSON: Kate?

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

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

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

DR. CROSSON: Cori.

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

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

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

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

DR. CROSSON: Other comments? Mary?

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

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

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

So I'm strongly supportive of this

recommendation.

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

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

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

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

DR. JOHNSON: Correct.

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Yeah. Go ahead, Kate.

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

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

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

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

[Laughter.]

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

MR. THOMAS: That's right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Craig and Kathy and then Scott.

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

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

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

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

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

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

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

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

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

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

Sorry. Go ahead.

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

DR. MATHEWS: Yes.

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

[Laughter.]

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

and then just one clarification. You said "visit

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

DR. CROSSON: Just parenthetically, I hope it

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

[Laughter.]

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

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

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

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

So I'll leave it there.

DR. CROSSON: Thank you.

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

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

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

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

[Show of hands.]

DR. CROSSON: Opposed?

[Show of hands.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Okay. Thank you very much.

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

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

[Pause.]

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

You have the floor.

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

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

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

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

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

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

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

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

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

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

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

volumes.

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

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

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

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

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

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

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

underpay for Medicaid.

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

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

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

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

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

provide less than the median.

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

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

Now, last month, we described how a change in

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

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

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

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

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

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

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

data would be phased in over three years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

accuracy.

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

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

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

audited by CMS.

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

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

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

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

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

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

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

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

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

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

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

MR. KUHN: Yeah.

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

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

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

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

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

MR. WINTER: 170.

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

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

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

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

MR. KUHN: Okay.

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

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

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

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

MR. KUHN: Thank you.

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

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

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

MS. BUTO: Okay.

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

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

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

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

MS. BUTO: Is still higher, yeah.

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

MS. BUTO: Right, okay. Thank you.

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

DR. STENSLAND: Correct.

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

possible that it would be quite different?

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

DR. HOADLEY: Okay.

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

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

DR. STENSLAND: Yes.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Other clarifying questions?

[No response.]

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

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

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

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

Now, having said that, a lot of the difficulty

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

[Laughter.]

DR. NERENZ: This is really --

DR. MILLER: Factually incorrect [off microphone].

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

DR. NERENZ: No, no, no.

[Laughter.]

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

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

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

preference, but we are.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So the top line of the recommendation, fine,

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

DR. CROSSON: Thank you. Other comments? Warner.

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

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

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

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

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

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

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

So, that's just my comments about it.

DR. CROSSON: Thank you.

Herb.

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

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

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

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

DR. CROSSON: Thank you, Herb.

Other comments? I see Kathy.

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

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

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

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

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

So, again, I support the recommendation.

DR. CROSSON: Warner.

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

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

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

MR. THOMAS: Yeah.

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

MR. THOMAS: Okay.

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

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

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

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

I'm concerned.

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

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

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

DR. CROSSON: Thank you, Kate.

Jack.

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

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

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

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

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

potential changes in policies.

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

DR. CROSSON: Thank you, Jack.

Other comments?

[No response.]

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

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

[Show of hands.]

DR. CROSSON: All those opposed.

[Show of hands.]

DR. CROSSON: Abstentions.

[No response.]

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

We will now proceed to the public comment period.

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

[Pause.]

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

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

Having said that, Bruce, you have the floor.

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

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

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

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

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

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

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

Thank you.

DR. CROSSON: Thank you.

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

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

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

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

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

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

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

less accessible sites of delivery.

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

Thank you very much.

DR. CROSSON: Thank you.

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

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

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

Thank you.

DR. CROSSON: Thank you.

MR. HUNTER: I'll just lean down.

[Laughter.]

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

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

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

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

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

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

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

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

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

DR. CROSSON: Please sum up.

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

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

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

Thank you.

DR. CROSSON: Thank you.

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

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

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

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

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

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

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

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

AFTERNOON SESSION

[1:16 p.m.]

DR. CROSSON: Okay. Let's gather ourselves together and move on with the next part of the agenda.

I hear a little buzzing. I don't know what that is.

DR. MILLER: It's a door out in the hallway.

DR. CROSSON: Okay. Okay. A third "okay" gets very dangerous.

So we are opening the afternoon session with a period of expedited voting. So to remind the Commissioners, but particularly for those of you who have joined us, we are going to be discussing relatively succinctly the seven areas of payment updates, physicians and other health professionals, ambulatory surgery centers, skilled nursing facilities, home health services, hospice services, and long-term care hospital services.

Now, the reason for this is, for those of you who were not here at our December meeting, we not only discussed each one of these in somewhat great depth, but we also took a straw poll, if you will, and reached a unanimous vote on all of these seven areas, and so rather

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

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

[Laughter.]

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

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

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

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

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

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

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

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

So I'll conclude and can take any questions.

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

Alice.

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

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

DR. COOMBS: Okay.

DR. CROSSON: Thank you.

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

[Pause.]

DR. ZABINSKI: All right. Ambulatory Surgical Centers.

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

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

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

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

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

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

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

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

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

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

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

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

And finally, ASCs would incur some administrative

costs to submit the cost data.

And that concludes the presentation.

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

Are there any Commissioner questions or comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

Now I will turn the session back to Jay.

DR. CROSSON: Thank you.

Any Commissioner questions or comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

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

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

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

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

trends in inpatient hospital use.

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

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

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

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

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

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

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

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

align payments and costs.

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

For beneficiaries, access for medically complex patients will increase.

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

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

DR. CROSSON: Thank you, Carol.

Are there any Commissioner questions or comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Thank you very much, Carol.

[Pause.]

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

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

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

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

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

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

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

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

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

chains to expand their presence in the sector.

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

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

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

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

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

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

with rebasing.

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

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

DR. CROSSON: Thank you.

Any Commissioner, questions or comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Evan, thank you very much.

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

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

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

So first a couple facts about hospice in 2014.

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

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

Hospice use also increased. About 47.8 percent

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Kim.

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

MS. NEUMAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Other questions or comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

DR. CROSSON: Thank you, Kim.

[Pause.]

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

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

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

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

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

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

Second, the LTCH admission must be immediately

preceded by an acute care hospital stay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

With that, I turn it over to you.

DR. CROSSON: Thank you, Stephanie.

Any Commissioner questions or comments?

[No response.]

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

[Show of hands.]

DR. CROSSON: All opposed.

[No response.]

DR. CROSSON: Abstentions.

[No response.]

DR. CROSSON: Thank you very much, Stephanie.

That concludes the expedited voting process for this afternoon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

payments that are higher than warranted.

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

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

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

Our finding that some IRFs may systematically be

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

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

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

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

reducing the base payment amount for all IRF cases.

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

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

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

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

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

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

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

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

happy to take any questions.

DR. CROSSON: Thank you very much, Dana.

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

DR. MILLER: Okay.

MR. KUHN: Is there a distinction there?

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

[Laughter.]

MR. KUHN: Sorry, guys.

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

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

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

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

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

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

MR. KUHN: Okay.

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

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

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

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

outweighing our concern about the distribution of outlier payments currently.

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

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

DR. CROSSON: Alice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MILLER: I'll leave this here.

[Speaking off microphone]

Evan, there was a question from Herb.

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

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

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

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

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

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

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

DR. CROSSON: Clarifying questions. Jack?

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

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

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

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

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

DR. CROSSON: Clarifying questions. David?

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

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

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

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

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

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

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

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

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

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

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

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

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

I spoke with some practitioners who both treat

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

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

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

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

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

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

DR. CROSSON: Clarifying questions. Kathy.

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

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

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

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

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

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

DR. CROSSON: Other clarifying questions?

[No response.]

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

[No response.]

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

Herb.

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

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

DR. CHRISTIANSON: [Speaking off microphone.]

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

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

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

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

[Laughter.]

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

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

DR. MILLER: Yeah. I mean, yes.

[Speaking off microphone.]

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

sure Dana and I follow each other.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Well said.

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

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

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

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

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

DR. CROSSON: Okay.

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

DR. CROSSON: Thank you. Other comments?

[No response.]

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

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

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

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

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

All Commissioners in favor, please raise your hand.

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

All Commissioners in favor?

[Show of hands.]

DR. CROSSON: Opposed?

[No response.]

DR. CROSSON: Abstentions?

[No response.]

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

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

[Pause.]

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

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

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

So, to start us off and prepare us for the spring, Rachel and Shinobu are here to take us back a little bit and then forward with respect to Part D.

DR. SCHMIDT: Good afternoon. Each year, we bring you an update on the status of Part D, Medicare's outpatient drug benefit.

In Part D, private plans deliver drug benefits to enrollees, and in return, Medicare pays plan sponsors monthly capitated amounts and other more open-ended subsidies. Part D uses a competitive structure to provide strong incentives for plan sponsors to offer attractive drug benefits, yet manage drug spending and keep enrollee premiums low.

In this presentation, we'll describe general trends and tell you about the growing effects of high-cost

enrollees on program spending. We'll look at trends and prices and how plan sponsors are trying to manage benefit spending. We'll look at average out-of-pocket spending and finish up by previewing what's ahead for the spring.

In 2015, out of 56 million Medicare beneficiaries, about 39 million, or 70 percent, were enrolled in Part D plans. Another four percent got drug benefits through former employers that were the primary insurer for their retirees in return for Medicare subsidies. This is called the retiree drug subsidy. About 14 percent received drug coverage at least as generous as Part D through other sources, such as TRICARE, FEHBP, and VA. Approximately 12 percent had no drug coverage or coverage less generous than Part D.

Part D program spending totaled $78 billion in 2014, mostly for payments to private plans, but with about $2 billion of that for the retiree drug subsidy. And, Medicare Part D makes up nearly 13 percent of total Medicare outlays.

As has been true for a number of years, surveys continue to show high enrollee satisfaction with the program.

In 2016, Part D's defined standard benefit has a deductible of $360, and then the enrollee pays 25 percent of covered benefits and the plan pays 75 percent. After the enrollee reaches about $3,300 in total spending, there is a coverage gap in which enrollees get some plan coverage plus a 50 percent discount on brand name drugs from manufacturers. But, generally, enrollees pay quite a bit more than the 25 percent cost share they had earlier. The coverage gap will phase out by 2020. For an enrollee with spending of about $7,500 or more above that threshold, they pay five percent, the plan pays 15 percent, and Medicare picks up 80 percent through reinsurance. This is the defined standard benefit, but in practice, nearly all Part D plans use different benefit designs, typically with fixed-dollar copayments. For about 12 million low-income beneficiaries, Medicare pays for nearly all of their premiums and cost sharing through the low-income subsidy.

Here are some key trends we've observed since the start of Part D. Enrollment grew from 24 million in 2007 to 39 million in 2015. That's about six percent per year. Enrollment among beneficiaries who do not receive the low-income subsidy has grown faster than growth among those

with the low-income subsidy. Since 2010, some of that growth has been associated with employers that quit taking the retiree drug subsidy and instead set up employer group Part D plans for their retirees. Today, 30 percent of Part D enrollees receive the low-income subsidy, which is down from 39 percent in 2007.

There's a lot of variation in Part D premiums, but on average, they've grown at about three percent per year and they've been especially flat at $30 per month between 2009 and 2015.

We saw that Medicare pays 80 percent of benefit costs above Part D's out-of-pocket threshold through reinsurance, so at the same time that average enrollee premiums have been flat, there's been much faster growth in spending on Medicare's reinsurance payments to plans, especially since 2010.

Here are a few highlights about the plans enrollees chose in 2015 and what's available for 2016. In 2015, 61 percent of enrollees were in stand-alone prescription drug plans, which is down from 2007 levels. For 2016, PDP offerings are down by 12 percent, but beneficiaries will still have a broad choice of plans.

In 2015, 39 percent of Part D enrollees were in Medicare Advantage drug plans, which is up from 2007. For 2016, the total number of MA-PD offerings increased by about five percent.

Thirty percent of all enrollees received the low-income subsidy in 2015, compared with 39 percent in 2007. Twenty-eight percent of LIS enrollees are in Medicare Advantage drug plans, which is much higher than at the start of Part D, but still, most LIS enrollees are in stand-alone drug plans. For 2016, there are fewer PDPs with premiums below regional benchmarks, which means LIS enrollees would not have to pay a premium to enroll in those plans. Still, in most regions of the country, the number of qualifying PDPs ranges from three to ten.

This slide shows the Medicare Trustees' estimates of major components of Part D program spending. The key take-away is that Medicare's reinsurance payments to plans, which are shown in red, have grown much faster than the rest, and as of 2014, reinsurance makes up the largest piece of Part D spending. The direct subsidy payment, in dark gray at the bottom, is the monthly capitated payment to plans. That's become a smaller portion of program

spending. At the top is Medicare's spending for the low-income subsidy, which is the second-largest component.

With growing spending on reinsurance, you might wonder how many beneficiaries reached that threshold where Medicare starts to pay for reinsurance, what we refer to as high-cost enrollees. In 2013, which is the latest year for which we have claims data, 2.9 million enrollees, or just under eight percent, were high cost. About three-quarters of those were beneficiaries with the low-income subsidy. However, the number of high-cost enrollees without the LIS increased faster than those with the LIS. One important reason is a change in law that allows the 50 percent manufacturers' discount on brand name drugs in the coverage gap to count towards the out-of-pocket threshold.

The percent of spending accounted for by high-cost enrollees has increased from 40 percent in 2011 to 47 percent in 2013. In other words, there's been a shift in the distribution of drug spending. Generally, all Part D enrollees are using more generics. For enrollees who only fill a few prescriptions, as they've switched to generics, their spending hasn't grown so much. Meanwhile, the eight percent of beneficiaries with high costs are taking a lot

of both generics and brand name drugs, and their share of overall spending has grown. For high-cost enrollees, growth in the average price per prescription has been driving overall spending growth, much more so than the quantity of prescriptions that they filled.

Looking more broadly, growth in prices for brand name drugs is starting to outstrip the moderating influence of generics. These lines show price indexes for Part D but do not reflect rebates and discounts. Overall, prices rose 47 percent between 2006 and the end of 2013. That's the gray line in the middle. When generic substitution is taken into account, prices only rose by two percent over the same period. So, the use of generics has really kept down overall Part D prices. Part D plans have been effective at encouraging enrollees to use more generics, and we've also had good timing in that many patents expired over the past several years.

However, the moderating influence of generics has started to lessen. You can see in the top line that between 2006 and 2013, prices of single-source brand name drugs grew by 114 percent. One-year growth between 2012 and 2013 was substantial. Meanwhile, the bottom line,

which reflects generic substitution, began turning upward in 2013 at the highest rate we have seen since Part D began. This uptick occurred even as the average generic dispensing rate in Part D increased from 81 percent in 2012 to 84 percent in 2013. So, while generics have played a very important role in constraining price growth, it appears that brand price growth has started to overtake the moderating influence of generics.

MS. SUZUKI: The steep price in brand prices we have seen through 2013 is likely to continue, with even more upward pressure on prices going forward. Industry reports by the IMS Institute and PBMs confirm that 2012 was a peak year for patent expirations, with a drop in patent expiry since then. That means less opportunity to offset price increases with new generics.

While generics helps to keep overall prices down, we've all seen news reports about generic drugs with large price increases. Warner and Jack, you've raised this issue before. Last spring, we showed you how some generic drugs had a one-year price increase that were on the order of several hundred to several thousand percent. Such spikes in prices can be due to things like lack of competition

with only one or two manufacturers in the market, shortage of raw materials, or manufacturing delays due to quality issues.

Another major source of upward pressure is the drug pipeline that's increasingly focused on higher-priced specialty products. According to a report by PricewaterhouseCoopers, FDA approvals of specialty products have surpassed that of traditional drugs, and an analysis by the IMS Institute shows a strong growth in specialty pipeline. According to that report, this trend is expected to continue, as 42 percent of the late-stage pipeline are specialty products.

Related to the pipeline issue is the unprecedented launch prices of the new therapies. These days, it is not uncommon to hear reports about high prices of drugs to treat conditions such as cancer and cystic fibrosis. We are also seeing high launch prices for products that could be used by broader populations, such as PCSK9 inhibitors to treat high cholesterol. Major insurers and payers are concerned because of the $14,000 a year price tag, about double the value-based benchmark as estimated by the Institute for Clinical and Economic

Review, or ICER.

Use of drugs with very high prices pose a challenge for Part D because the use will likely grow and put significant upward pressure on Medicare spending for reinsurance and low-income subsidy. We're already seeing an increase in the use of high-cost products. Between 2009 and 2013, the share of high-cost enrollees who filled at least one prescription for a biologic product grew from eight percent to 12 percent. Trustees have recently reported that spending for the new hepatitis C therapies have led to a large spike in Part D program spending in 2014. As more expensive therapies become available, larger numbers of beneficiaries will reach the catastrophic phase of the benefit, where Medicare pays for 80 percent of the cost through individual reinsurance.

Plans use formularies to structure competition among therapies and negotiate rebates with manufacturers and to shift utilization towards lower-cost drugs. Some plan sponsors have tightened their formularies while others have kept them nearly the same. The use of utilization management tools have grown over the years, which are typically used to encourage the use of lower-cost therapies

or to prevent misuse or abuse. We're also seeing a greater use of coinsurance rather than flat copayments, particularly for non-preferred brand name drugs. In effect, this puts more of the risk of price increases on beneficiaries.

But plan sponsors are limited in the use of certain management techniques because they have to meet CMS's formulary requirements. For example, they have to include at least two drugs per class and cover all or substantially all drugs in six protected classes. While plan sponsors are generally free to make mid-year formulary changes that are positive, such as adding a new drug, they must obtain CMS approval for negative changes, such as adding a prior authorization. This may be particularly problematic for a new high-cost drug launched mid-year.

These are the kinds of issues that will need to be considered when we discuss policy options to share more of the insurance risk with plan sponsors in March.

Plan strategies for managing enrollees' drug spending have implications for program spending, because Medicare subsidizes Part D spending, including payments for cost sharing for the low-income subsidy enrollees. Plans

are using new tools to affect enrollee behavior. For example, we're seeing the majority of plans use lower cost sharing for preferred generics than for other generic drugs. We're also seeing rapid increase in the use of tiered pharmacy networks that typically offer lower cost sharing at preferred pharmacies.

But since cost sharing amounts for LIS enrollees are set in law, they don't face plans' benefit designs that are intended to encourage the use of lower-cost drugs or pharmacies. The difference between plans' cost sharing requirements and the LIS copay amounts are paid by Medicare's low-income subsidy. If LIS enrollees do not choose a lower cost option, Medicare does not get the savings that could have been achieved if the plans' management tools had worked. And under certain circumstances, not choosing the lower cost option could result in higher costs for Medicare.

Growth in spending affects enrollees' out-of-pocket spending, as well. The most obvious place is through its effects on monthly premiums. As Rachel mentioned earlier, the average monthly premium has remained relatively stable, at about $30, but there's a wide

variation across plans and the stability we've seen is likely due to several factors.

One is because premiums are based on plan bids, not actual spending, so spending for reinsurance has not always been fully reflected.

Second, the influx of younger enrollees likely has kept premiums low.

And, finally, more people are enrolling in MA-PDs with lower premiums, which is partly due to their ability to use the rebate dollars to reduce premiums.

Jon, last year, you expressed concerns when we talked about rising prices that perhaps plans might shift more of the costs to the enrollees. We did a new claims analysis and found that between 2007 and 2013, on average, beneficiary out-of-pocket for cost sharing has remained stable or decreased, depending on the level of total annual spending which affects the benefit base people reach.

The decrease seen for non-LIS enrollees appears to reflect their behavioral response to plans' cost sharing incentives, such as lower cost sharing for generics and preferred drugs. Some of them are affected by the richer benefit as a result of the phase-out of the coverage gap.

LIS enrollees have cost sharing protection, so their out-of-pocket spending has been stable. However, the amounts paid by Medicare's low-income cost sharing subsidy have increased. Some of this increase is likely due to the plans -- because the plans' management strategies that use cost sharing differentials are not affected for this population.

So, to summarize, Part D enrollees continue to say that they're generally satisfied, they have many plan options, and their premiums and cost sharing have been stable. But the cost trends are increasingly of concern. Costs for reinsurance is growing much faster than premiums, and prices of single-source drugs continue to grow aggressively and has begun to outstrip the price moderating effect of increasing generic use. The trend in the drug pipeline is shifting towards higher-cost biologics and specialty drugs, putting more upward pressure on the program costs, particularly the reinsurance, which is the fastest growing and now the largest component of program spending.

So, a key question for the future is whether plan sponsors will be able to negotiate lower prices for these

newer therapies. In general, plan sponsors have less bargaining leverage when there are no therapeutic substitutes.

In March, we'll pick up our discussion from last November about the policy approaches that may slow the growth in program spending. We'll come back to you with a combination of policy approaches discussed briefly in November that attempts to balance the competing goals of the program. First is providing stronger incentives for plans to manage spending for high-cost enrollees while at the same time providing them with more flexibility and tools to manage costs. We may want to combine these with policies to provide more out-of-pocket protection for enrollees, and in light of the new strategies plans are using to manage spending, we may also want to revisit the LIS copay recommendation from 2012.

DR. CROSSON: We were talking.

[Laughter.]

DR. CROSSON: Sorry.

All right. Let's -- you were talking, too. We weren't passing any notes, though.

Let's take clarifying questions.

DR. CHRISTIANSON: This is just a quick one on Slide 9, just to make sure I understand it. What you've displayed on the slide there I think are price data. The title of the slide is "Growth in brand prices more than offset effects of generic use." There's nothing in this slide about use, so is there another slide to sort of substantiate this in the chapter? I've forgotten.

DR. SCHMIDT: It's probably just a poor title.

DR. CHRISTIANSON: But have you done that analysis to actually substantiate that claim that's in the title of the slide? I've forgotten. You know, the chapter is pretty complicated, and I've just forgotten whether you've done that.

DR. SCHMIDT: I think the only -- no. I should say no, right?

MS. SUZUKI: One thing we did say in the chapter is that generic use has increased over time, but the effects of generic on the overall drug prices, factoring in the generic substitution, has diminished over time. So we're comparing by, you know, 12-month period, what's the effect of increasing generic use on moderating the price increases? And in the most recent 12-month period, we've

seen less of an effect than in previous years.

DR. CHRISTIANSON: Okay, because this statement came back at the end when you were stating what you found out. So if you haven't done the analysis, you probably should include it in the next version of the chapter.

DR. CROSSON: Clarifying -- let me just say we're going to -- here's the kind of plan for the discussion. We're going to have clarifying questions, and then we're going to have kind of a two-part discussion, and we'll do them simultaneously, I think is the easiest part. One would be suggestions for the chapter, you know, increase this, emphasize that more, this less, whatever. That won't be the only opportunity. You'll have an opportunity in writing later on as the chapter is finished. But also then reflecting on the last slide and beyond, presaging our work in the spring, are these the ideas we should be working on, or are there other ideas? Or within the ones that you find on the last slide, do you see one approach more important than the other? So we're still on clarifying -- are you clarifying my clarification?

DR. REDBERG: No. Actually, I was just looking for the page -- I thought on page 40 it kind of addressed

Jon's question, just showing between December 2012 and 2013, Part D prices accounting for generic substitution grew by 6.6 percent. So even though there were more generic prescriptions from 81 to 84, because prices of generics have gone up and overall drug prices have gone up, that was how I read it, that we weren't going to see the same kind of moderating effect of increasing use of generics that we have in the past.

DR. SCHMIDT: Right. It was a combination of -- I think Shinobu actually just summarized things pretty well. So we have seen the GDR go up, but we've seen the sharp increase in brand-name prices, and the indexes that were on that slide we just showed you are specifically price indexes, not overall expenditures. Is that the nature of your question?

DR. CROSSON: Okay. Not to confuse things by clarifying further, but we're on clarifications.

MR. GRADISON: Of course, I realize that in the past we've expressed concerns about the lack of incentives for LIS covered people who use lower-cost pharmaceuticals. But there's something here that really confuses me. You indicated on Slide 6 that 30 percent of all Part D

enrollees received LIS, down from 39 percent. That's a very dramatic change, it would seem to me, over that period of time. But on Slide 15, that amounts paid by Medicare's low-income cost-sharing subsidy have increases.

I can understand how that could happen, but could you explain what actually does explain the one --

DR. SCHMIDT: Right. So --

MR. GRADISON: The two lines going in different directions.

DR. SCHMIDT: So the percentage share being smaller today than at the start of Part D I think is partly the Baby Boomers entering Medicare in larger numbers. They're younger. They tend to use fewer drugs. And we also have this influx of employer group plans from people who used to have their employer as the primary insurer moving into these forms of Part D plans. So there's been a big increase in enrollment generally, and the LIS population has stayed relatively stable. It's grown a little bit, but not nearly as much as the rest of things. Meanwhile, the costs have been going up, so that's how you explain the two.

MR. GRADISON: That's helpful. Thank you [off

microphone].

MR. THOMAS: On Slide 9, the chart, I just want to make sure I understand. Is this chart just capturing pricing changes, or does this capture volume changes as well?

DR. SCHMIDT: So this is a chain-weighted price index prepared for us by a contractor, so the weights of the prices of particular drugs do change a bit over time as utilization changes. By and large, it's designed to reflect changes in prices. It's a little bit confusing, I understand, but that's how it's built.

DR. MILLER: If you could only give [off microphone] one answer, it would be it is measuring price.

MR. THOMAS: What if you could give more than one answer?

[Laughter.]

DR. MILLER: If you gave more than one answer, what you would say is that, remember, whenever you do something like this, you might have, like, bread and meat. And if, you know, one is 50 percent of what you buy and the other is 50 percent, you'd be following those prices. But if those proportions changed, then they would affect the

price because the proportion of what you're buying changes. And what this tries to do is track that change in the mix over time. It is a way of measuring price, but also understanding that your underlying mix might be shifting over time. That's the longer answer.

MR. THOMAS: Okay. So it strikes me that there's probably three -- well, there's probably more than three, but there's at least three drivers of cost, right? The number of people going into the plans, right? The price. And then the volume of the drugs kind of per person. Is that right?

DR. SCHMIDT: [Nods yes.]

MR. THOMAS: So do we have clarity or is there kind of an understanding of how those three are kind of driving the total cost? I guess that's one.

MS. SUZUKI: This wouldn't reflect the number of people going in. I would think of it more like -- Mark explained it perfectly, but --

DR. MILLER: [off microphone] write that down.

[Laughter.]

DR. SCHMIDT: Actually --

MS. SUZUKI: It's a market basket concept.

DR. SCHMIDT: Yeah.

MS. SUZUKI: So we're trying to capture a snapshot of market basket of goods, drugs purchased by Part D enrollees in each of these periods. But because new drugs come onto the market, we need to factor that in over time. So that's what the chain-weighted does. It gradually changes. But it tries to measure --

DR. SCHMIDT: There is something in the mailing materials that I think gets to what you're asking, though, on Table 11 on page 53 of the mailing materials. I think Scott may have asked before what's driving trend, and so here it's looking for all Part D enrollees. The average price per prescription changed very little between 2007 and 2013, and that's largely reflecting generic use. And the number of prescriptions per month went up a little bit, by about 2 percent per year, for all Part D enrollees. But then --

MR. THOMAS: Which page again?

DR. SCHMIDT: This is page 53, Table 11. But if you look particularly at those that reached that out-of-pocket threshold where reinsurance is starting to pay, then

that's where we have a separate point saying that actually it looks like growth in the average price per prescription seems to be driving things. So for the high-cost enrollees, the average price per prescription grew by almost 7 percent on average over the period, but the number of prescriptions changed by about 1 percent.

MR. THOMAS: Okay. I guess as part of this report is the -- just so I understand kind of what we want to accomplish. So as our goal to really just kind of give a status of this or to also as part of that have discussion or recommendations on how to mitigate escalation in cost?

DR. MILLER: So what I think is happening here is, you know, we're sort of required to do, you know, once a year the update stuff, look at each of the sectors. In MA, we had recommendations. In Part D, we're looking at the sector. And in the March meeting, we're going to come back to at least this array of issues and start looking at how to mitigate some of the growth that we're seeing, particularly in the reinsurance portion of the benefit, which is where the rapid growth is.

So in March, we're going to return to this and sort of talk more about policy and start to get consensus

here. This conversation is twofold, just the way Jay said a second ago. Anything in the information chapter, is this all straight questions, that type of thing. And then looking ahead, do you have specific things you want us to focus on? So March, we're going to start to really firm that up, but that's what this slide is about -- the last slide. I'm sorry.

DR. CROSSON: Okay. We're still on clarifying questions.

MR. KUHN: Just one question about the use of tiered pharmacies, and there was a discussion in the paper about that and the fact that it was -- I think the reference was that it was a little controversial because not all beneficiaries had access to all the pharmacies that are -- or might not have access to pharmacies.

So I guess my question was: What percent of drugs now come through mail order and what percent are coming through pharmacies in the Part D space?

MS. SUZUKI: We expect it to be low. We haven't looked at that recently. It's information that's not readily available on the claims.

DR. SCHMIDT: I think it's less than 10 percent,

is my guess [off microphone].

MS. SUZUKI: When we last looked at this, it's been less than 10 percent.

DR. CROSSON: Okay. So, again, at the risk of confusing things, we're going to have two issues on the table at the same time because they're a little bit interrelated. One is a first cut at suggestions for the chapter, realizing that you'll have time later on, if you want, to review it in its final phase. Jim, that would be sometime when?

DR. MATHEWS: Depending on the caliber and depth and breadth of your comments here today, ideally we'd like to get the chapter out for external review early next week.

DR. CROSSON: Okay. So comments on the chapter that you see now, after having read it, is one item.

The second item, going back to the last slide again, and anticipating our discussions in March, and the point here being what can be done with respect to Part D drug costs. Are these the issues? Are there other issues, other approaches that you have in mind, that you've thought of that we should consider to prepare for March? And among the ones that are listed, do you have a prioritization? Do

you see one or more as much more important than the other for us to consider? I guess that's three items at the same time. And if we get all bollixed up, I'll separate them out.

MR. GRADISON: Maybe this is already covered, but I wish I had a better understanding of the relationship between B and D, specifically Part B and Part D. Sometimes I understand that on discharge from a hospital, the hospital will provide let's say the first week or month or whatever of prescriptions. I guess that's Part B. But if it isn't, if it is Part D, I think we were told earlier today that there's some problems in terms of payment, and maybe I misunder- -- I'd just like to understand that better. I could be more specific, because we talked about it earlier today, I believe. But I just want to make sure we tie those things together, if only for my own understanding, which is, as you can tell from my questions, somewhat limited.

DR. CROSSON: Okay. So something to address in March is that interrelationship, to the extent that there is, between B and D.

MR. GRADISON: The payment aspect is a question,

too.

DR. CROSSON: Yeah.

MR. GRADISON: Yeah. If I get the prescription -- if I'm handed the prescription on discharge, I know that's D. If I'm handed the medications, I'm not quite as clear how that works in terms of paying for it as a beneficiary.

DR. CROSSON: I'm sorry. Do you mean incidental medications when you're in the hospital?

MR. GRADISON: No. On discharge.

DR. CROSSON: Okay. I guess I'm missing the point here. Could you say it again?

MR. GRADISON: Am I wrong that -- Bill nodded yes. Aren't there circumstances on discharge where you're provided with an initial supply of medications?

DR. HALL: Yeah.

MR. GRADISON: Okay. How's that paid for?

DR. HALL: I'm not sure.

MR. GRADISON: Well, I'm not either. That's why I raised the question.

DR. SCHMIDT: I would have guessed part of the Part A payment.

DR. MILLER: I'll tell you what, we can come back and add to this. I think it's fairly plain answers, that it's part of, you know, A, and then what happens in B, and then you have a co-payment if you're in the outpatient setting in B. But I think it's a relatively straightforward two-sentence answer when we roll back in in March, just to not do it on the fly -- for me not to do it on the fly and screw it up.

MR. GRADISON: Thank you.

DR. CROSSON: Well, as best I can tell, there's nobody at the table who's ready to do it on the fly.

DR. NERENZ: Since we're kind of unsure and we're guessing, I'll just throw one more of those. It seemed to me that in the draft HRSA guidance about 340B there was some specific mention of so-called discharge medications. And if that's a Part B thing and not a Part A thing, that suggests to me that maybe Part B is what's going on. But I don't know that for sure either. But for what it's worth.

DR. CROSSON: All right. Well, we'll nail that down.

MS. BUTO: So just a sidebar. You'll recall that, last year maybe, we talked about at least an

outpatient, how should the hospital deal with giving away Part D drugs versus can they write them off versus blah, blah, blah. Anyway, we can bring that up when we talk about the relationship, but there are lots of questions about those relationships, including what happens when a Part D plan provides essentially what is a Part B drug, which some plans do -- many plans do.

But my question really is about this chapter. You asked, Jay, you know, what should the chapter have, and is there anything we'd like to see. I would like to see some acknowledgment of the work that was done by really Rachel and Shinobu for the June report, which it's almost like that's not even, you know, acknowledged here, so that we acknowledge the extremely good work that was done on the whole issue of risk corridors, risk -- all we have to do is allude to it and say we're coming back to it in the June report, something. But if you read this, it's as if we had never done that work or talked about it, when, in fact, it's in the June report.

So maybe there is a tradition here where we don't cross over between the reports, but it just seems to me a good thing to do because a lot went into that.

DR. MILLER: I don't know -- I'm not aware of any tradition.

[Laughter.]

DR. MILLER: So we can refer back to it. Have you guys got a problem with that? Okay.

DR. CROSSON: All right. But this in itself is establishing a tradition.

DR. MILLER: I'm not buying into that.

[Laughter.]

DR. MILLER: I want to be clear.

MR. ARMSTRONG: So a couple of different things.

First, with respect to the chapter for the near term, I just want to, much as Kathy was doing, compliment the staff. It is, I think, a great advancement over where we were like a year ago, and we are, I think, pushing hard on laying out a good objective evaluation of the issues that set us up then for some of the real policy questions. I actually don't have any suggestion for improving on that.

Second, yeah, I guess Slide 17, just a couple of comments here.

First, generally -- and I know no one will be surprised by this -- looking at ways in which we can

provide plans with more flexibility to manage costs I think is an area for us really to pay attention to. So I would encourage us to do that. And I think the chapter in several places offers information that would help support the argument that that's a good idea.

And then the second point I would make would be it seems, at least for me, one of the headlines from the analysis was the rate at which the reinsurance costs for the Medicare program are skyrocketing.

And so my question with respect to work ahead around policy would be: Well, what is a policy approach to dealing with that issue? And I'm not really sure. But I'd be interested in spending our time pursuing what kind of answers to that question we might put on the table.

DR. MILLER: And the only other thing I would say about that, to those of you who are close to MA, if there are certain flexibilities that you think are good ideas -- you know, we have email, too -- you can send it to us. And you should know that we're then out talking to plans trying to control the water and whatever that analogy was and bring in those ideas. And we have something of a list, but, you know, we're accumulating, so feel free if there's

somebody on your staff you want to forward something.

DR. CROSSON: Okay. So we will go around this way. Sue?

MS. THOMPSON: Just quickly. I think to understand, because we see a lot of "all drugs and biologics" used in the same sentence, but I think there's perhaps a piece to understand what's the impact of the biologics on this discussion. I mean, obviously, but what is that? Can we quantify that?

DR. CROSSON: Okay. So, Sue, are you suggesting this for both the chapter and then potentially for a focus later in the year, both?

MS. THOMPSON: [Nods head.]

DR. CROSSON: Thanks. Not that I was putting words in your mouth.

Okay. So, over here. Alice?

DR. COOMBS: Just in consideration of one of the issues with LIS copayment, I thought we did something in 2012, and maybe it would be great to have enough data on what the LIS population looks like. I thought we did something on some demographic information back then in that

chapter. Did we look at the demographics?

DR. CROSSON: I don't remember.

DR. MILLER: Yeah. I'm not sure I'm remembering either.

DR. SCHMIDT: I know that there is demographic information that Shinobu puts together each year for our data book --

DR. COOMBS: Yes.

DR. SCHMIDT: -- that's pretty detailed about the LIS population versus Part D as a whole.

DR. COOMBS: Okay. Because I can't think that this could be any thicker in terms of a chapter, but maybe just to go over that information for review.

DR. MILLER: I was kind of coming up cold too. But that is right. We have yet another publication, a chapter that's only charts and data tables, and it is in there, right? Right.

DR. CROSSON: Kate.

DR. BAICKER: I think the list of things you've developed for thinking about in March is great, and the thinking about that are out-of-pocket and protection for enrollees, you know I'm a big fan of insurance acting like

insurance for people. And it turns out that 5 percent of a really big number is still a pretty darn big number. So I think that's a wonderful thing to think about as well as proper incentives, even for the LIS beneficiaries to think about tradeoffs in their choice of prescription versus generic that are appropriate for their income, but also preserve some incentive to make high-value choices. So I think all of that is great to think through.

I might add, depending on what the state of the literature is, some discussion about what we know about the relationship between drug spending and non-drug spending, if we see any commensurate reductions in other kinds of spending that offset increases in drug spending or not, how that looks different for standalone Part D plans versus integrated MA-PD plans that have internalized those externalities or not across siloes, I would love to get a more holistic picture of how changes in the -- just like changes between brand names and generics affects our perception, changes between medical and surgical and drug and nondrug treatments should enter into our interpretation of the trend.

So there may not be good available evidence on

that, and that might be the answer, but to the extent that there is, I think that that would be really helpful in our discussion going forward.

DR. CROSSON: My sense of that one -- I may be wrong, but my sense of that one is doing a comprehensive analysis would be difficult, given all the variables at play. It might be, though, possible to look at individual pharmaceuticals that are developed for the treatment of a certain disease. Let's say cystic fibrosis as an example and then use that example to see specifically what that might do for the hospitalization rate for -- I'm making this up, so it's probably not the right example because it's an expensive drug, I know. But pick that type of relatively narrow example and look at that where you can track the drug, the price, the expected costs, which in the case of cystic fibrosis, a lot of that hospitalization cost. Maybe we could find a few examples like that. Does that sound reasonable?

DR. BAICKER: Could I actually --

DR. CROSSON: Yeah, yeah.

DR. BAICKER: So I think examples are always really helpful in illustrating a principle at work. I

think it's pretty hard through example like that to really understand cause and effect. I was imagining more trolling around to see if there have been some good studies with the recently available new data that have at least plausible causal pathways mapped out. Rather than doing your own primary research, I'd just love to get your take on the state-of-the-art about what is known about this from the literature, and to the extent that the literature suggests, hey, there's some offset, then an illustrative example of, for example, we see this happening in these trend always drives the point home. But given the timeline, I was not envisioning -- although if you want to, feel free -- a whole new primary empirical analysis.

DR. CROSSON: Well, the latter part of your comment elicited large smiles at the other end of the table here, so I think you're right. Thank you for that. You're right on target.

DR. SCHMIDT: I think that's because Shinobu spent about a year doing that a few years ago.

DR. CROSSON: Oh, okay.

DR. MILLER: That's the point I wanted to pick up, and I want to take this kind of crazy Kathy Buto idea,

referring back to our own work.

[Laughter.]

DR. MILLER: I don't know what she's thinking, but as long as she's raised it, I'd actually like to incorporate Alice's request for the demographics. And maybe we can say here's a few sentences of what we find, more detail here, and refer to the data book; and to her question, we did a ton of literature review, and then they actually did some primary work themselves, and they actually selected some conditions to look at. Again, by reference, pull that in, and then if there's anything new, just to add to it. So maybe this tradition thing that you guys wanted to get going is starting to happen, but it is a big chapter, and so tons more is going to get pretty weighty. But that's how we'll go at those two things, if you're okay with that.

DR. CROSSON: We could even find a song called "Tradition," don't you think?

DR. MILLER: Well, you know, there's a melody running through my head even as you --

DR. CROSSON: Right. Yes, I'm getting a little loopy, I know.

Jack?

DR. HOADLEY: I have one specific comment on the current chapter in terms of this issue of things. On page 37, there is actually a paragraph that talks about this issue of the LIS, the previous 2012 recommendation, and goes on and talks about the Congress might consider giving the Secretary more flexibility.

And I wonder given what we're anticipating for the June report if we shouldn't -- not make those comments here and sort of save those comments for the discussion along with the other accompanying things that we might address in the June report because I think along with reiterating that we have a previous recommendation, we often do that, but to sort of take the step further that this implies might not belong here.

And I think one of the things that's really exciting about this chapter is that it really does set up what we're talking about, looking at the next couple of months for the June report, and I was at one point trying to list all the pieces of evidence that we had in here that sort of pointed to the issues around both the high-cost enrollees and the high-cost drugs. And I just kind of gave

up because there were too many of them, but between the price index stuff, the level of reinsurance, the table that you looked to a minute ago, I mean, we just have multiple pieces of evidence that sort of join on this point, that three or four years ago, we could sort of say this program is kind of sailing along at reasonably modest growth rates, much lower than anticipated. It was sort of that things were pretty on track, and the last couple of years -- and we always had this concern that there were expensive drugs, and that that patent cliff, the big move that generics was going to run out and that there would be eventually new products coming to market that were important innovations for a wide number of people, there's always been some important new drugs. But for a period of time there, they were mostly for pretty limited numbers of people, and we're now in a new situation here. And that's what you're able to point to with various different displays here, and I think that's really where this menu of things that we were starting to talk about in the fall is well designed.

So that, for example, in a very simplistic way, we can reduce that trend in reinsurance by reducing the rate of reinsurance and, as we've talked about, shifting

more to the plans and less to the federal reinsurance. That, of course, is only an artificial step. The reason we would be doing that is we're trying to change the incentive structure somewhat. It's a means to an end of getting better management of those high-cost enrollees and/or high-cost drugs, and so that's where this goes together.

The formulary sorts of issues we've talked about, I think are ones that -- and that comes under this title of providing plans more flexibility to manage cost, so thinking about that first on the formulary side -- I mean, I think there are steps, although I think here, we're going to be challenged to sort of make sure to do helpful things without doing equal number of harmful things. I mean, there are ways you could increase flexibility for the plans and have some negative effect on access to drugs. We've talked about this before with appeals and exceptions and prior authorizations and things and how to make sure those are done in a way that works to make sure the beneficiaries who need a drug, if you're going to have more prior authorization to control use of an expensive drug.

And we've seen some of this in the hepatitis C world, especially on the Medicaid side, where very tight

prior authorization rules have meant that use of the hep C drug by the Medicaid population has been way lower than a lot of people would like, so I think it's the right area to look at, but I do think we have to be careful about how we sort of structure some of those choices.

So I am interested in ways to think about plan flexibility. We didn't talk about it here in the presentation, or at least very much. The medication therapy management, which has never felt like it works very well -- and various chapters in the past have commented on that -- that is something that in theory ought to be able to help address at least the high-cost enrollee's part, not necessarily the high-cost drug's part.

I think Sue raised the question of biologicals, and with biogenerics or biosimilars, whichever term you like to use, coming on the market already, figuring out how those will be covered, a lot of those are on the Part B side, but there are some that will show up on the Part D side as well, and what tools will plans be able to use to encourage people to shift to those again, again doing it in a way that works well and doesn't lead to other kinds of access problems.

Same thing with the pharmacy networks. I do wonder, the access issues that have been pointed out, CMS indicated that this year, they would review the preferred pharmacy part of the networks more tightly, and they would provide indications to beneficiaries if they were considering one of the plans where access was an issue.

In my looks at the Plan Finder this year, having identified one particular plan sponsor who appears -- who is the preferred pharmacy part of the network is relatively small and doesn't seem to be the one that provides good access. I don't see any indicators on the Plan Finder that sort of flags that, so I'd like to try to find out more about what CMS -- whether CMS followed -- how they followed up on what they said back on the call letter. And before we do things like broaden the authority that I talked about a minute ago for the Secretary to look at things like encouraging LIS beneficiaries to use preferred pharmacies, we've got to make sure those are accessible to that population. And what's accessible on a broad area may not turn out to be available in the particular communities where many low-income folks live. So I think that's going to require a closer look at access to make sure if we're

going to suddenly say -- or we're going to allow the Secretary to say that somebody has to pay more to use a pharmacy that's not -- that doesn't offer the preferred cost sharing, that that's going to cost more to an LIS beneficiary if it turns out that they really don't have one that's easily accessible to them. It's been required, you know, bus rides or whatever to get that, then we're just increasing the cost to that LIS beneficiary. We're not -- or they're going to -- you know, they're either going to pay the cost, or they're going to incur another kind of cost to go get that. So that's where I think -- those are the areas where I think we have to operate cautiously.

Obviously, I've said many times about the issue of increasing out-of-pocket protection of enrollees, the third item on your agenda, and I'm all for that. And I spoke to the fourth one sort of under the other rubric.

I've always been -- I wasn't here when the 2012 recommendation was done. I've always had general support for that concept that there should be ways to encourage more generic use, but I think it has some issues around, and I think we do need to travel carefully on that area. So I'll stop with those.

DR. CROSSON: Thank you, Jack.

All right. Craig, and then we'll go down this way and come back up this way. Sorry.

Mary, were you waiting?

DR. NAYLOR: Yeah. I was going to see --

DR. CROSSON: Now you raise your hand up?

DR. MILLER: She was waiting.

DR. CROSSON: Oh, you wanted to go after Jack?

MS. UCCELLO: I was letting him --

DR. CROSSON: You better. You better.

MS. UCCELLO: I'm going.

DR. MILLER: She's very scrappy.

DR. CROSSON: Right, right.

[Laughter.]

MS. UCCELLO: I was letting him go because we had given him -- we had ceded him.

DR. CROSSON: I didn't know you wanted to go after him.

MS. UCCELLO: I don't care when I go, but I'm doing now.

[Laughter.]

MS. UCCELLO: I think the chapter is great the

way it is, especially if you just add the little references to the stuff we talked about before. That would be great, but I don't think you have to do any big major stuff.

In terms of what we do in the spring, clearly from the findings that are in this chapter as well as things we've done in the past, there is really a need to focus on these high-cost enrollees. And I think the things that are mentioned here in terms of tools to managed care, to manage utilization, to steer people into lower cost drugs all makes sense. But I think we really still need to acknowledge that prices themselves are a really big deal, and we can't lose sight of that.

And in the chapter, there's a little point. It's citing a paper that looked at the costs of hep C and showed that the projected offset, savings offset over 20 years in terms of reduced liver events only offset about 75 percent of the cost of the drug.

And I would argue even if those savings offset 100 percent of the cost of the drug, all of those savings should not accrue to the drug companies. I think some of that savings needs to be shared among the payers, including Medicare, including the consumers.

Now, I acknowledge that there's not necessarily much we can do on the Medicare side in terms of price, but I think the things that we started back in the fall that just talked about the process of drug development and pricing, I think would be helpful. And this is not just a Medicare issue. It's a broader issue than that, and we've acknowledged that. But I think it's something we just kind of need to keep our eyes on.

DR. CROSSON: Thank you.

MS. UCCELLO: Carry on.

[Laughter.]

DR. CROSSON: Okay.

DR. MILLER: Can I ask one thing? And I may have lost a thread in there. So keep your eye on it, but you can't -- but we're not sure we can do -- so, yeah, in amend, where do you --

MS. UCCELLO: Well, I don't know. I think --

DR. MILLER: All right. And that's a perfectly fine answer, but I was -- you know, I often --

MS. UCCELLO: I think -- I know that there were limitations on what Medicare can do about drug pricing.

DR. MILLER: Okay.

MS. UCCELLO: But I don't think that that should necessary limit the things that we look at.

DR. MILLER: Okay. And that is also helpful because often I'm trying to interpret how to actually act on what people are saying, and that last little bit helped.

DR. CROSSON: So, you know, I think that -- and this is simplistic, but what we can do, hopefully, in the end with respect to drug prices is just different from what we can do with respect to all the other areas of payment where we can say pay less, you know, pay a lot less.

At least at the moment, although we could theoretically entertain some innovative notions, at the moment we have to think about it as if we are trying to -- as I think about it, we're trying to restructure the marketplace both in Part B and in Part D. So it's a different set of tools, and I don't know -- although we've just finished talking about a bunch of them, I don't know that we have fully explored all the possibilities or kind of considered which ones are more likely to be effective than others. And that's a lot of the work that we have to do, something like that.

Jack, do you want to comment on that?

DR. HOADLEY: Yeah. On that point in particular, I mean, there are clearly some steps about really getting into the root of crisis that are outside of Medicare. So changing patent law, changing the Hatch-Waxman rules would be pretty clearly not a Medicare policy.

There are other policies that are more direct, and one that's certainly been circulating a lot is the idea of a Part D rebate parallel to the Medicaid rebate. It's usually been focused in terms of doing it for the LIS population because the argument has been capture the savings that would have been captured back when those people recovered under Medicaid.

You could also apply that same kind of a rebate to a broader population. There's nothing that says that Congress could not choose to -- or we could not choose to recommend that a rebate policy be established across the board for all beneficiaries.

There are policies around secretarial negotiation. I mean, there's a lot of arguments why simply changing the current policy that says the Secretary may not negotiate and just changing that policy alone probably doesn't accomplish any real change in pricing, but there

are ways to create some tools for the Secretary to use.

One of them that has been mentioned is to create some kind of an arbitration process for true single-source drugs or some other kinds of things like that, that would at least go after some of those drugs that could be done within the Medicare scope. Those are clearly more controversial items than any of the ones that we have been talking about today, but if there was enough interest around this table to sort of take those stronger approaches, they I think fall clearly within our jurisdiction, and we could take them on.

DR. CROSSON: And I think based on earlier conversations, we have talked about at least commenting, not necessarily folding into recommendations

DR. HOADLEY: Based on earlier conversations, we have talked about at least commenting, not necessarily folding into recommendation, but at least commenting on some of those approaches.

DR. MILLER: You're right. That's at least what you were saying, Cori.

MS. UCCELLO: Yes, and clearly, I should have just gone before Jack.

[Laughter.]

DR. MILLER: It would have helped me immensely, because I -- now I understand what he's saying.

DR. CROSSON: Okay. All right.

Craig.

DR. SAMITT: So, I also think the chapter's perfect as is.

In terms of the March discussion, though, and I've raised this before and I don't know if this is feasible, but when we talk about policy approaches, I see plans and I see beneficiaries. I don't see providers. And, I've asked whether there is some consideration about provider accountability here, as well. And, so, as we look at ACOs and some of the other levers that we're looking at to align with provider around value, why not aligning providers around Part D costs, if not Part B costs, as well, as a subcomponent. So, again, I don't know if there's any feasibility as the ACO world develops, but I would add it as a fifth category, because I'd love to hear more about some options there, as well.

DR. CROSSON: Good point. Good point. Thank you.

All right. Rita, and then I'm going to come back. Rita and Warner, and then we'll come back this way.

DR. REDBERG: So, I want to also say it was a great chapter and I don't have suggestions for change.

But, I would want to get back to some of the things we have talked about before, such as that not all drugs are created equal, and, you know, when we're talking about drugs, and it's certainly striking when you look at the numbers of drugs that Medicare beneficiaries are on now, like four-and-a-half is the average per enrollee, you know, and you think that there tends to be a synergistic increase in the number of drug-drug interactions and harms when you get up to that level of drugs, that some of them are more effective and others. That is in, unfortunately, no way related to price, because supply and demand doesn't really work in the drug market.

And, so, if, you know -- so, some are just not that effective, but some are actually, I think, harmful and still being used, and I thought of it in particular because in the protected drug classes, the three that are very heavily -- influence the trends, antidepressants, antipsychotics, and anticonvulsants, I think likely have

people that would be better off not on some of those drugs.

And I don't know if that can be -- you know, we don't really look at sort of appropriate use or overuse of drugs, but I think that spending on very expensive drugs that are not helping our Medicare beneficiaries is certainly an area where it would be a win-win to reduce it, and I don't know if that fits into the MTMs, which currently aren't that effective, but could be made perhaps more effective.

The other thing I thought about when we're talking about the hep C, and clearly, that big impact -- and it's a big problem, in general, for Medicare, but certainly for the hep C drugs -- you know, a lot of the FDA approvals are based on studies that don't involve Medicare-age beneficiaries, so we really don't know if older people are going to have benefit at all from these drugs.

You know, I think that for Medicare to really behave responsibly, we need to demand to have data in Medicare beneficiaries on which to base these decisions and not think that Medicare beneficiaries are going to be the same as 35 and 40-year-olds that are studied and a lot of the healthy ones where comorbidities have been excluded,

which does not happen for our patients, and that's a big problem and not one we can address on our own, but certainly make it clear and work with other agencies that have jurisdiction.

DR. CROSSON: Warner.

MR. THOMAS: So, I think there's a lot of good information in the chapter. I guess what I would recommend that we consider including is more information around the fact that, you know, we appear to be somewhat hamstrung that we, because we don't, essentially, pay for drugs directly, that we are impacted on how we can impact the pricing of those drugs, and that I think that should be a component of the discussion in the chapter.

If you look at Table 6, you know, some of the largest plans have premium increases of 21 percent, 17 percent, 25 percent. I mean, those are pretty large increases that are directly to the beneficiary. And, you know, obviously some of what drives that is utilization, but probably a large component of that is pricing, as well, and, you know, the single-source component.

So, I just think that -- I understand we're going to take up drug pricing in a broader way in March or April,

but I think to -- I'm just not sure there's enough emphasis in this chapter around the concern of pricing in general as it relates to this program and the impact that it's having on the beneficiary as far as the premium cost.

Now, obviously, they still like the program. It's very attractive to them. It's helpful. But, the premiums are going up pretty substantially. We spent a lot of time this morning talking about beneficiaries and the pricing of drugs and how we can benefit them, and I'm just -- I'm not sure we're capturing the drug cost concern enough in this chapter. So, I think if there were more comments around that, I think it would be helpful, and frankly, I think it's something we struggle with as an industry and as a Commission, is how do we deal with the whole drug pricing component and its impact on benefits and programs like this.

DR. CROSSON: Right. So, I think we did establish a new tradition a little while ago, which is that this kind of status quo chapter could be expanded a little bit along the lines that Warner is talking about, but also along the lines of, at least in a summary way, you know, what we think about this, these trends, and at least just

presaging some of the work that's going to come later. Is that --

DR. MILLER: The other thing that would -- certainly, leaning into saying what we're going to be doing later, no issue at all.

The other thing that I was thinking is whether in the set-up for the chapter we sort of say, look, you know, there was a decision made in legislation to approach Medicare drugs this particular way -- you know, market-based, plans bid, that type of thing -- that has this particular feature. You're not directly purchasing and pricing drugs, which means the tools that you have are a certain type of tools. Or, maybe, this actually does work more towards the end, and then you can lean into the -- what was the word you used? Presage?

DR. CROSSON: Presage.

DR. MILLER: Presage, okay, you know, what we're -- I think that means what we're going to do.

[Laughter.]

DR. MILLER: Then you could lean into that part of the comment, and maybe that gets at some of what Warner is asking there.

MR. THOMAS: I think if it's a status report and we have in our summary that cost trends are increasingly of concern, okay, so how concerned are we about a 20-plus percent increase in beneficiary cost sharing? I mean, to me, that's pretty substantial if you compare it to some of the cost increases we've talked a lot about this morning that were nowhere near that amount. So, it's just -- it's just a comment.

DR. CROSSON: Coming back around, did I see you, Jon? Coming back around this way, and then up to Jon. So, Bill and -- no? Mary, no?

DR. NAYLOR: Great chapter.

DR. CROSSON: Okay. Jon.

DR. CHRISTIANSON: Just in terms of things to focus on, we've talked about this before, but I think this question of whether having the Medicare program be the reinsurer to the extent that it is in this program, it seemed like a good idea at the beginning. We talked before about whether we thought -- you know, there's also implications of pulling back from that in terms of implications for beneficiary premiums and cost sharing and so forth. But, I think we need to take a good look at

that, because conceptually to me, it no longer makes sense to have as much of the reinsurance fall to the government as currently exists in this program.

DR. CROSSON: Jack.

DR. HOADLEY: I was thinking, with the comments that Cori made and also some of Warner's comments, I mean, the first bullet on this agenda is stronger incentives for plans to control spending of high-cost enrollees. When I started my comments, I also sort of made a reference to high-cost drugs, and maybe what we really need is that that is a bullet, too, that it's stronger methods to address the high-cost drugs. We've already established, I think, in the good work that Shinobu and Rachel have done, that a lot of the high-cost enrollees are there not because they're using high-cost drugs but because they're using many lower-cost drugs. There are some people, and you're seeing a growth in the number of people who are using high-cost drugs. So, really, they are two separate kinds of pieces of the issue.

I mean, I also wanted to reinforce something Rita said in terms of this, and I think you've done this before and I just can't remember if it's something you do in the

data book, but, you know, sort of the share of enrollees, not just -- you talked about the average of four drugs per person, but the share of enrollees who are using, say, ten or more drugs, and I don't remember what kind of number that is, but it's not tiny, as I recall.

And I even heard an anecdote recently of somebody whose parent was taking ten drugs. They contacted the plan, hoping to get a comprehensive medication review, and were told they weren't eligible for their MPM program, which is -- could possibly just have been error, but nonetheless, that's what they got told. So, there's not only somebody who has four, which seems like a lot, but the ones who are ten.

But, that's a very separate and different focus than the high-cost drugs and what are the tools, whether it's anticipating the biologicals and the biogenerics, biosimilars, but also just the sort of single-sourced high-priced drugs, and we really should make sure we're addressing each of those sort of as separable issues. And maybe when we sort of have a repeat of this slide coming up in the next meeting or something like it, that would be my suggestion to break out.

MS. BUTO: Just to continue on Jack's point, and that would be across B and D, because, obviously, there are more tools potentially available for Part B, and D is, I think, another kettle of fish.

DR. CROSSON: Okay. This is very good input. Rachel and Shinobu, thank you much for the chapter. I hope you have gotten some good ideas here, and we also have gotten a good sense of priorities for the spring.

So, I think we're finished with our agenda for the day and now we have an opportunity for public comments. And if there are any individuals who wish to make a comment, please come to the microphone so we can see how many people we have.

I'll just make a couple of comments here, which we make each time, and then I'll add one. We invite you to make these comments. We listen carefully. This is a useful tool to us. However, from the perspective of -- from your perspective, it's important to know this is not the only or the best way to provide input. There are both interactive communications mechanisms with the Commission and -- I mean, with the staff, and then also through the staff to the Commissioners, as well as in-person meetings

with Mark and his staff as you need that, before we get to the end of issues and particularly before we get to voting.

The other comment I'd like to make is that it has been the tradition here at the Commission for these public comment periods to be focused on the issues of that morning or afternoon and not, you know, the next day or in the morning or the afternoon. So if you have a comment on the issues we tackled this afternoon, we would invite you to make those comments.

We'll ask you to keep your comments to two minutes, and when this light comes back on, that's an indication that the two minutes has expired.

Please give us your name and your affiliation, if there is one, and proceed.

MR. KATHRINS: Thank you. My name is Richard Kathrins. I'm the president and CEO of Bacharach Institute for Rehabilitation, a nonprofit rehab hospital in New Jersey. I also in a voluntary capacity serve as the vice chair of the American Medical Rehab Providers Association, AMRPA, the national trade association representing 500 rehab facilities and units.

AMRPA respects the work of the Commission and

appreciates the opportunity to provide public comment, both written and oral. We're concerned that MedPAC's faulty assumptions underlying their December analysis and today's discussion could lead to recommendations that are poorly targeted at the problems that they seek to address.

First, we are concerned that stratifying the IRF sector based on Medicare profitability places scrutiny on providers that have found ways to find efficient resource utilization through economies of scale or other means, and the analysis does not show profitability that is a static factor over time and thus may draw influences that are linked to permanent aspects of the sector and should not serve as a Medicare policy.

Second, AMRPA is troubled by the presumption that margins are due to improper coding and patient selection. MedPAC presumes that more profitable IRFs are selecting fewer patients with specific conditions, such as strokes with paralysis rather than the inverse. They have overlooked a multitude of other factors driving case mix such as clinical expertise, regional availability, and referral patterns.

In addition, we do not believe that the

hospital's DRG can draw apples-to-apples comparison between functional, cognitive, and medical status of the patient as they move from the acute-care hospital to the post-acute-care level. There are no functional assessments done in the hospital setting under the DRG program.

Some of our members are troubled by the discussion describing the outlier payments as a program to reallocate payments to low-margin providers. Outlier payments are a critical component of the payment system that allow IRFs to treat highly complex patients that are not a policy tool to redistribute funds within the sector.

Thank you very much for your time.

DR. CROSSON: Thank you.

MR. BAIRD: Hello. My name is Andrew Baird. I am the director of government affairs for Health South, and in addition to the prior commenter's points, which were cited by my colleague Justin Hunter earlier this afternoon in a report that was submitted to the Commission, which I encourage a review and assessment, I would like to make one point about CMS' comments on the outlier issue in terms of its use and its policy.

It is worth noting that CMS has always had under

existing law the authority to raise the outlier percentage from its current 3 percent mark up to 5 percent, but yet it has never adjusted its current 3 percent mark.

Indeed, in the FY2012 final for the IRF PPS -- that's our payment system -- CMS reiterated a previously stated policy view about the size of the outlier pool, saying, and I quote, "The outlier policy of 3 percent of total estimated payments optimizes the extent to which we can encourage facilities to continue to take patients that are likely to have unusually high costs while still also providing adequate payment for all other cases."

It is further noteworthy that every year since that final rule in 2012, CMS has lowered the outlier threshold percentage by reducing the fixed loss amount, as was discussed briefly today, by nearly 19 percent over those five years in order to maintain that 3 percent pool, meaning that for each year the previous year's threshold was too high and there were not enough cases to account for that full 3 percent pool.

So just some facts from CMS. Thank you for your time and consideration.

DR. CROSSON: Thank you.

Seeing no one else at the microphone, we are adjourned for the day, and we will reconvene tomorrow at 8:30.

[Whereupon, at 4:08 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, January 15, 2016.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 15, 2016
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, FAAN, RN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
CORI UCCELLO, FSA, MAAA, MPP

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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Well, good morning, everybody. Welcome back to MedPAC. Welcome to our observers as well.

We have two agenda items today. The first one is an update on our continuing work on the potential for a unified payment system in the area of post-acute care, and Carol Carter is going to take us through that work.

DR. CARTER: Good morning, everybody. Before I get started, I wanted to thank Doug Wissoker and Bowen Garrett, who are both here from the Urban Institute. Their work has been top-shelf, and they are really fantastic colleagues, so I wanted to thank them.

The IMPACT Act of 2014 requires the Commission to consider the design of a prospective payment system spanning the four post-acute-care settings -- home health, SNFs, IRFs, and LTCHs. Currently, Medicare pays for PAC services using separate payment systems for each setting. As a result, though many of the patients treated in different settings are similar, Medicare's payments can differ considerably. Further, the Commission has been critical of the home health and SNF payment systems because

they encourage providers to furnish therapy that is unrelated to a patient's care needs. A unified payment system would span the four settings and correct these shortcomings, basing payments on patient characteristics and not the site of care.

The first of the two mandated reports is due at the end of June, and it must recommend features of a unified payment system and, to the extent feasible, estimate the impacts of moving to such a system. A second report, due much later -- probably around June 2023 -- must propose a prototype design.

This is the third session considering the design, testing, and impacts of a PAC PPS. In September, we outlined an approach to the mandate and reviewed preliminary results using stays in CMS' post-acute-care payment reform demonstration, or PAC-PRD. The results were promising, and we concluded that a unified payment system looked feasible.

In November, we confirmed our preliminary results for an expanded set of patient groups, some of which you suggested. We discussed companion policies that could be implemented at the same time to dampen the volume

incentives that would remain in a prospective payment system, such as a readmission policy, a value-based purchasing program, and the use of a third-party benefit manager. We also discussed waiving setting-specific regulations under a unified PPS. We noted that in the long term, Medicare needs to adopt payment reforms that encourage an efficient, coordinated approach across episodes of care.

Today we present our work modeling payments for all 2013 post-acute stays under a unified payment system. The results suggest the need for certain payment adjusters and not so much for others. We provide rough estimates of the impacts on payments. In March, we will explore the need for an adjuster for low-volume, isolated providers and look at a prototype outlier policy. We will also discuss different ways to think about establishing the aggregate level of payments. And, finally, in April we will finalize the report.

This slide summarizes the broad approach we're taking to meet the first mandated report. The elements of the mandate are in red, the methodology for each is in yellow, and the purpose of each step is in green. The

mandate has two requirements. It requires us to evaluate and recommend features of a PPS using data from the PAC-PRD data -- and that's the first row -- and then to estimate the impacts -- and that's in the second row.

While the PAC-PRD data has unique strengths, the sample is limited. Therefore, we wanted to estimate the impacts using a larger sample of PAC stays. So we devised a combined methodology to take advantage of the PAC-PRD data while using a larger sample. There is an extensive discussion of the methodology in the paper so I will give only an overview here. Basically, we developed three models, and each one has a specific purpose.

To evaluate and recommend features of a PAC PPS, we first developed a "full model" to predict the costs of stays using patient characteristics and the unique data in the PAC-PRD. And that's the first column. The purpose of this step is to establish the relative costs of stays and test whether a unified payment system is feasible. To estimate the impacts, we needed to build a model without the specially collected information since that information is not available for other stays.

So then we re-estimated the model using the same

PAC stays but using only predictors that are available in administrative data, and we refer to that as the "administrative model." By comparing the accuracy of predicted costs using the full and the administrative models for the same stays, we could evaluate if the administrative model would establish accurate relative costs of stays, and that's in the second column. If the administrative model was accurate, we could use it to estimate the impact of a PAC PPS using 2013 stays, and that's the model in Column 3.

To give you a sense of the difference between the full and administrative models, I've listed the types of factors we've included in the models to predict the relative cost of stays. Age and diagnoses are readily available information and are included in all of the models. The models differ in whether and how well they include information on patient impairments, functional and cognitive status, and routine costs. For example, some impairments and cognitive status could be approximated using diagnosis codes. Others, like functional status, had no equivalent in administrative data, and so they were left out of the administrative models. Both models using the

PAC-PRD stays include the same 6,400 stays, while the administrative model using 2013 data includes 8.9 million stays.

To evaluate the models, we looked at many different patient groups listed on this slide. They are defined in the paper, and we report on 13 clinical groups, a variety of impairment and severity groups, community admissions, and other groups including demographically defined groups, such as the aged and disabled and dual-eligible. We also identified stays that used a lot and little/or no therapy to see how a PAC PPS would affect them.

Our first set of analyses look at whether we can use the administrative model, without the unique PAC-PRD data, to accurately predict the relative costs of stays and estimate the impacts of a PAC PPS.

Using the same PAC-PRD stays, we found that full and administrative models were very similar in accurately predicting the relative cost of stays. The administrative models would establish accurate relative weights for almost all of the patient groups we examined with minor exceptions. Those exceptions, such as patients with high

and low functional status, underscore the importance of collecting patient assessment information for accurately predicting the relative costs for these groups.

The models also explained similar (and high) shares of the variation in the costs of stays. The accuracy of the administrative models confirmed our plan to use them to roughly estimate the impacts of a unified PPS using 2013 PAC stays. Our results also suggest that while data on functional status do not substantially improve our ability to predict the relative costs of stays in aggregate or for most groups, the data were important for predicting the relative costs of the functional status groups.

Now we turn to the results using the 2013 data using the administrative model. We first examine how well that model predicted the relative costs of stays using a very large sample of stays.

We found that patient characteristics could establish accurate relative costs of stays in aggregate and across most of the patient groups. The details of the results are in the paper. The results held for almost all of the clinical groups we examined, the frailty groups, two of the medically complex groups, community admissions, and

the demographic groups. For most rural groups, our results suggest that there would be no need for a broad rural adjustment, but the result for frontier providers suggested there might be a possible need for an adjustment for them, and I'll come back to that in a minute. For stays treated in teaching IRFs, the model was pretty accurate in establishing the relative costs, so it didn't look like a separate teaching adjustment would be needed. It appears that a robust risk adjustment method could accurately predict the costs of these stays.

There were a handful of groups where the average predicted costs deviated from the average actual costs, and those fall into broad categories -- those where the results were expected and illustrate the objectives of a unified PPS, and those that suggest the need for a payment adjustment or warrant further study. On this slide, we identify the therapy and setting results that we expected from a unified PPS. For these groups, providers' current therapy practices, current PPS shortcomings, and the cost structures of high-cost settings explain the results, and the findings do not suggest a need for payment adjustments. For example, stays with low therapy costs were likely to be

medically complex and their predicted costs were higher than their actual costs. Conversely, stays with high therapy costs were likely to include services that were unrelated to the patients' care needs, and, therefore, the predicted costs were lower than their actual costs. We want a unified PPS to correct the existing PPS incentives to furnish unnecessary therapy, not replicate them.

For stays treated in IRFs and LTCHs, many of the types of stays treated in these high-cost settings are also treated in lower-cost settings. Therefore, the predicted costs for these settings will be lower than their actual costs because of the averaging that's going on. The objective of a PAC PPS is to establish a uniform payment across settings, so this is also an expected finding. A transition would give LTCHs and IRFs time to adjust their costs to payments under a unified payment system.

Now let's look at the results that may warrant a payment adjustment or further study. First, the results for very short stays uniformly suggested the need for a short-stay policy to prevent large overpayments that would result from assuming a stay of average duration. And although we did not specifically analyze outlier stays, a

stay-based payment system should also have a high-cost outlier policy to protect providers from large losses and help ensure beneficiary access to care. We plan to present information about an illustrative outlier policy in March.

Two other groups may warrant further study. The results for the frontier providers indicated that these providers may lack of economies of scale due to their low volume. We will present more information on this in March also.

Another group was one that Alice suggested, and those were extremely sick patients that were defined as patients with severity illness level 4, on dialysis, with severe wounds, and sufficiently sick that they were not discharged home to home health care. Our results indicate that developing a good risk adjustment will be critical to ensuring access for these patients. Otherwise, providers may avoid admitting these patients. An outlier policy would augment payments when the costs of stays are exceptionally high.

Now we turn to the estimates of the impacts. Because our task is to examine the feasibility of a unified payment system, we estimated aggregate payments under a

unified payment system at the same level of payments as current law. Our estimates do not reflect policy changes since 2013, such as the recently enacted LTCH policies. Our estimates also do not assume any changes in provider behavior. For example, between now and when a PAC PPS is implemented, the patient mix in LTCHs is likely to change, but we have not factored these into our estimates. The estimated impacts should be considered as directional and relative, rather than point estimates.

Our first analysis of impacts looks at how the relative profitability of stays will change under a PAC PPS by comparing the ratio of payments to costs, and I've listed several groups that illustrate the results for almost all of the groups. In the first column, you will see the ratios under current payments, and they range from 1.03 to 1.28. The variation in the ratios reflects the mix of settings where the stays are treated, the high level of payments particularly in home health and SNFs, and the biases of both of those payment systems that favor rehabilitation care over treating medically complex patients. For example, the ratio for orthopedic medical groups -- and that would include patients like hip fracture

-- their ratio was 1.28.

In the second column are the ratios under a PAC PPS. You can see that the range is narrowed considerably, from a low of 1.15 to 1.2, suggesting that the relative profitability of groups would become more uniform under a PAC PPS. Providers, therefore, will not have strong incentives to selectively admit some patients over others or to favor rehabilitation care over treating medically complex cases.

Two groups that deviate from this pattern were the therapy groups I previously talked about and the extremely sick group. Because extremely sick patients are also treated in SNFs and IRFs, the average PAC payment would be lowered by this mix of settings. Although the average payment for this group would just about cover the average costs of these stays, the ratio for that group is lower compared to the average for the other groups. This result reinforces the need to have an adequate risk adjustment method. The other key takeaway from this slide is the overall level of payments. We estimate that aggregate payments were 18 percent higher than costs, and next month we'll lay out different ways one might think

about establishing a level of payment.

A second impact analysis looks at the shifts in payments under a unified payment system. Compared with current policy, a unified PPS will shift payments across stays, increasing payments for some groups and decreasing them for others. Payments will increase for many of the medically complex and patient impairment and severity groups. Payments will decrease for clinical groups where rehabilitation therapy is a key component of care and that provision of therapy was not related to patient characteristics.

A unified PPS will also shift payments from high-cost settings to low-cost settings and from high-cost providers to low-cost providers. Payments to SNFs, hospital-based, and nonprofit facilities will increase because a PAC PPS that bases payments on patient characteristics would consider the medical complexity of patients often treated there.

Payments are estimated to decrease for IRFs, LTCHs, freestanding, and for-profit providers for two reasons. First, payments will decrease for stays with therapy services that are unrelated to patient

characteristics. And, second, many of the types of patients treated in IRFs and LTCHs are also treated in lower-cost settings. Within LTCHs, we also looked separately at stays that meet the LTCH-qualifying criteria, and the payment reductions for those stays would be smaller than the reductions for LTCHs overall.

To summarize, a PAC PPS is estimated to shift payments from rehabilitation care to medical care, and to narrow the profitability by type of stay. This will decrease the incentive to selectively admit certain types of patients over others. A PAC PPS will raise payments to providers that treat medically complex patients and lower payments to providers whose costs and service mix are unrelated to care needs and where lower-cost settings treat the same types of patients.

These results are expected and reflect the objectives of a unified payment system. A high-cost outlier policy and a short-stay policy will help align payments to providers' costs, and a transition period will give providers time to adjust their costs.

The estimated impacts will create incentives for many providers to change their practices and cost

structures, but the impacts on any given provider could differ from these general trends and will depend on several factors: first, the mix of the patients it treats; the second is the current setting where the patient is treated, that PPS and its design and its incentives; the provider's current practice patterns such as whether it often provides services that are unrelated to care needs; and the provider's ability to match its costs to the payments it will receive under a PAC PPS.

Our results lead us to the following conclusions:

Most importantly, a PAC PPS is feasible and will break down the silos between settings. Payments will be based on patient characteristics and not the setting and would correct some of the shortcomings of the current PPSs. A unified PPS will dampen incentives to selectively admit some types of patients over others.

Our results have many implications for the design of a unified payment system. Administrative data could form the basis of a PAC PPS, but functional assessment data are needed to calibrate payments for certain types of patients. Payments for stays in home health agencies will need to be aligned with the setting's lower costs.

In terms of payment adjustors, our results suggest the need for a short-stay policy to prevent large overpayments. A broad rural adjustment and an IRF teaching adjustment didn't appear to be needed, but low-volume isolated providers may need protection and we'll be coming back to that in March.

In addition, a high-cost outlier policy will help ensure beneficiary access to care and protect providers from large losses. A transition period would give providers time to adjust their costs and protect beneficiary access.

In addition, the risk adjustment factors can be refined over time if there is systematic under- or overpayments that occur. And, as in any payment system, the relative weight should be recalibrated regularly to reflect changes in the relative costs of stays.

And, finally, policymakers need to consider the level of payments.

And with that, I'd be glad to answer any of your questions and look forward to your discussion.

DR. CROSSON: Well, thank you, Carol, for this rather elegant modeling and analysis. I have to admit,

when we first started here, I was kind of scratching my head as to how we were going to get through this rather complicated situation and you've done it excellently.

So, let's take clarifying questions. Mary, and then Kathy.

DR. NAYLOR: So, let me echo Jay's comment. I think that this is really extraordinary, beautiful work, elegantly presented.

So, can you talk a little bit about the patient impairment categories and how they were constructed, page 14-15, because they seem somewhat overlapping, but I was interested in knowing how they were constructed and defined.

DR. CARTER: So, those groups do overlap. We were mostly just trying different definitions to see how different constellations of those qualifications differ, if the model would treat them differently.

So, you're right, these groups do overlap. So, one of the groups is severity of illness four, so we ran everybody through a DRG grouper, even for the home health community admits, and anybody that was assigned to level four severity is in that group.

A different group looks at whether patients had multiple, that is five or more, comorbidities, and, so, obviously, some of those also are severity level four.

The third group was the one that Alice had defined, and that's severity level four, they're on dialysis, and they had severe wounds, and those all overlap.

The impaired cognition group, in the PAC-PRD data, those patients were assessed for their cognitive impairment and so we used that data. When we moved to the administrative model and we didn't have cognitive function, we used ICD-9 codes for dementia and coma and Alzheimer's and things like that. So, we were relying on diagnosis codes. And, it's not a perfect overlap, but we were trying to do the best we could with some proxies.

DR. NAYLOR: One other question around the severely ill -- what is the language -- extremely sick. Obviously, the highest cost group, as evident in your work. What proportion -- and I know I just said and we just --

DR. CARTER: It's less than one percent.

DR. NAYLOR: It's less than one percent. Okay.

DR. CARTER: Yes.

DR. NAYLOR: Thank you.

DR. CHRISTIANSON: Kathy.

MS. BUTO: Carol, this work made me feel that we could move almost immediately to a PAC PPS. It's probably an exaggeration, but I was so impressed with the amount of work and detail that you put into it.

But, I really had a couple of questions about some of the exceptions or the adjustments -- short stay, high cost, and then low volume isolated. Are those kinds of patients or facilities -- I guess these are really facilities with patients that --

DR. CARTER: But, they're really patient groups.

MS. BUTO: They're patient groups.

DR. CARTER: What we're reporting are patient groups.

MS. BUTO: Okay. Are they uniformly evident across provider types, or do you find that, for instance, with IRFs, you have more of certain kinds of patients that fall in one of these categories? Which ones are the short stay? Are they evenly distributed, or are they in certain facilities, that kind of thing?

DR. CARTER: Just to look at the need for an

adjustor, we did look at sort of using the current definitions in law and also just the shortest tenth percentile of the distribution by setting. And the reason we did that is because the stay durations are pretty different across the settings. So, we just wanted to look at the low end of the tail in each of the settings to see whether it would look like a short stay policy would be required.

MS. BUTO: Okay. And, I guess the other question was something you raised in just the set-up, which is how important to proceeding to a unified PPS would be making smoother the conditions of participation? In other words, how much of a barrier or an impediment to a PAC PPS would the current conditions and the differences be?

DR. CARTER: Well, I think something like the 60 percent rule comes straight to mind, where you can't be paying uniform -- trying to move to being agnostic, if you will, about where patients are treated and still require IRFs to have 60 percent of its cases in specific groupings. So, that one is obvious to me. Something like the LTCH length of stay criteria -- if we're going to pay LTCHs kind of regardless of the types of patients that are there, you

would expect -- they might want to take different types of patients and they wouldn't need to stay 25 days. So, those are two examples.

MS. BUTO: What about the three-day prior hospitalization requirement for SNFs?

DR. CARTER: Well, that one's trickier, because that one is sort of a speed bump, if you will, in some ways, for converting long-stay patients to Part A qualified. So, I think we'd need to think a little more carefully about whether to proceed with them.

DR. MILLER: And this, I think, really has implications for the second round, so I'm out of order and Jay just got back to catch me at it.

So, I think one of the implications of Kathy's question to think about as we go forward is this constant tension, and I'm going to use your inlier, as I think you asked about. I mean, in a sense, what you want is a payment system where you look across the broad distribution and you're doing a pretty good job of capturing everybody. You have an outlier for those and an inlier, where you say this is it for everybody. To the extent that you have the need or the temptation to go in and do it by setting,

you're going back to rebuilding, and that's going to be a constant tension throughout this, and this is why in some ways transitions and how fast we're ready to move on this, I think, come into play.

But, that's really a second round kind of discussion, but your question, I think, goes right to it.

MR. ARMSTRONG: So, first, I do just want to say I can't remember feeling so excited about something I really understood so little about --

[Laughter.]

MR. ARMSTRONG: But the prospect of being able to really make this work after the debates and the whining we've done about silos and post-acute for seven years is incredibly exciting to me, even for nine o'clock in the morning on the East Coast.

[Laughter.]

MR. ARMSTRONG: And, Mark, just to your point, this may be a second round or a next month kind of a question, but so much of post-acute care, when managed really well, within the context now of what hopefully will be a prospective payment, actually moves between these different settings, and you kind of want it to move between

these different settings. So, how would this kind of a payment model accommodate that?

DR. CARTER: I think I heard your question correctly, which is does it encourage or discourage movement across the settings. So, this doesn't really do much for that. This is just trying to get pricing uniform across the settings, and that's why in November we did spend some time talking about the preference for bundled payments to try to really discourage, you know, patients moving between settings unnecessarily, so that would put a provider at risk for an episode of care and then we're sort of agnostic about how they move or even stay in place and transition between different levels. So, it doesn't really get at what you're talking about.

MR. ARMSTRONG: So, on down the road, though, there will be some, I'm sure, administrative issues we'll have to raise, like who gets the payment and how does the --

DR. CARTER: Unbundled payments.

MR. ARMSTRONG: Yeah.

DR. CARTER: Yes, of course. And we did talk in November, because of the continued incentive for volume, we

talked about the companion policies, like readmission policies or, you know, Medicare spending per beneficiary. So, we are holding -- yes, we're going to pay you on your PPS rate, but we're looking at how much spending you're generating downstream.

DR. MILLER: [Off microphone.] The only other thing I would say is I don't think that this necessarily gets in the way of that and, in some ways, is a step towards it.

DR. CARTER: Oh, I think, definitely.

DR. MILLER: But we tried to bring out in November that you guys -- we didn't use the term whining, but the notion of when are we going to get to a bundle, that kind of payment. I think this takes you a little ways down the road on the uniformity, but it doesn't get you to --

DR. CARTER: Yeah.

DR. MILLER: -- right, as she said.

DR. NERENZ: This is really excellent. Thank you. It's hard enough to do this well in one defined setting when you have some grasp of how the underlying phenomenon are working. To do it across settings is really

hard and it's done very well. Thank you.

Clarifying question. Slide 13, please. In the right-hand column, at a glance, it looks like this is set up to illustrate an 18 percent positive margin. I understand it's an illustration. I understand also things are never that simple in practice. But, my question is, the model presumably has two main components when used in practice. It would have relative weights for the groups, but also, then, a multiplying factor that would turn the weights into dollars. Is that a fair assumption?

DR. CARTER: Yes.

DR. NERENZ: Okay. So, this 1.18 actually could be adjusted up or down depending on that second factor --

DR. CARTER: Yes.

DR. NERENZ: -- and we could recommend about that, Congress could act, CMS could decide. So, the 1.18 isn't kind of an inevitable set in stone forever --

DR. CARTER: That's just the level of payments.

DR. NERENZ: Thank you.

DR. CARTER: Yes. And, it's not a margin. I do want to point that out. That's just ratio, yeah.

DR. MILLER: And you used the term

"illustration." I mean, this is set to be budget neutral with the dollars that are --

DR. CARTER: Yeah. It's not an illustration. This is fact. Yeah.

DR. MILLER: You threw that in, but I didn't know whether you meant it the way you meant.

DR. NERENZ: Well, I guess I was just saying that if this model were implemented in practice and we sat around looking at it two years from now, five years from now, it wouldn't have to always be 1.18. It could be --

DR. CARTER: Oh, and of course, it wouldn't be --

DR. NERENZ: Right.

DR. CARTER: -- because we, by the time this gets implemented, will have had many years of sequestration --

DR. NERENZ: Okay. That --

DR. CARTER: -- and productivity -- anyway, so that number has already changed.

DR. CROSSON: This is the good news? Is this the good news?

[Laughter.]

DR. CROSSON: Clarifying questions, others. Warner.

MR. THOMAS: Just on the same chart, on page 13. So, for the four areas, do we know the aggregate, or what are the aggregate dollars in these four buckets, roughly? Do we know the total dollars?

DR. CARTER: Oh, $60 billion.

DR. MILLER: [Off microphone.]

MR. THOMAS: Sixty, $70 billion?

DR. MILLER: [Off microphone.]

MR. THOMAS: Yeah.

DR. CARTER: Yeah, oh yeah. It's 65, something like that.

MR. THOMAS: Okay. And just so I can understand the comments you just made about profitability, so, the 1.18, if I'm understanding this, so you're saying that's just a -- that's a factor. How does that relate to profitability? So, if we looked at the profitability on the payment updates we do for each of these various areas, is there any way to equate those --

DR. CARTER: Well, so, this is payments divided by costs.

MR. THOMAS: Right.

DR. CARTER: When we calculate our margins, we

take payments minus costs and divide by payments. So, basically, we're saying what's the margin as a ratio of the spending. So, all of these numbers would be a little lower once you divide through by payments.

DR. MILLER: [Off microphone.] For the four sectors that we went through, they range from about seven to 12, 13, somewhere in there?

DR. CARTER: In this year, maybe a little higher, yeah.

MR. THOMAS: And, has there been any thought, or will there be work either done now or in the future about, you know, to the extent that there's the ability to consolidate some of these services, it's more than likely that you'll be able to run these facilities at a potentially higher occupancy, you'll be able to run them in larger types of organizations. So, you would think on a unit basis you'd be able to have a better cost structure. Is there any thought about that?

DR. CARTER: I agree with that. I do think it's one of the reasons why we saw for the frontier hospitals, which are smaller, they don't have the same economies of scale. But, we haven't thought about, so how would these

cost structures change and could we model that. We haven't done that.

MR. THOMAS: Because, I know when we've looked at payment updates in the past, that smaller -- usually, smaller facilities have a lower profit margin, probably because they have a higher cost structure, given the overall fixed costs.

DR. CARTER: Right. I mean, the one thing that the Commission has consistently looked at is it's not just small, but you should be isolated, because we do have this pattern of providers being very close to each other --

MR. THOMAS: Right.

DR. CARTER: -- and both being small and both having poor financial performance. So, I think it's the combination of being small and isolated that we would be worried about.

MR. THOMAS: Thank you.

DR. CROSSON: Okay. Seeing no more questions, we'll proceed to the next round. What I'd like to do, Mary is going to lead off, but Mary, before that, I'd like Mark to just remind us what we're doing here, the timing of this, how we're going to use this information, et cetera.

DR. MILLER: Okay. So, one thing I think I would say is there's sort of a three-part process to this, and just to remind everybody -- I'm pretty sure Carol said all this, but this is a mandated report requested by Congress. It's due in June. We're doing this and we're doing it now and we're doing it as rapidly as we are because we're under a very clear legislated deadline.

But, there's sort of a three-part dance to this. We do this report. Then the Secretary collects the new functional status information and creates a system, you know, her version of the system, or whoever is Secretary, and then we come in behind that and do another report.

So, the way I'm thinking about this report is we would put out something in June, and some of these statements towards the end are some of the kinds of statements, some are more conclusionary statements, but imagine a report at the end that goes, look, you should think about models -- and I may get some of this wrong, Carol, but for non-therapy ancillaries and routine care, and you have to think about how home health sits in the middle of that, and you want to consider an inlier, an outlier, adjustments of these types, low volume, that type

of thing.

And, so, in a sense, what we're saying to the Secretary in the report in June is when you step out with the real data and start to construct this, this is what our research would suggest you should take into consideration for the purposes of constructing the model, or constructing the system, and that would be the nature of the report that we would put together in June.

Is that what you were looking for?

DR. CROSSON: That was -- I think that was elegant, elegant, too.

MS. BUTO: [Off microphone.] Can I ask one quick question about that? The work that was done before, that we talked about, I think, in September, or November, I'm not sure when it was, where we looked at the differences in costs between home health and all the institutional providers and the need for the non-therapy adjustment, whatever that's called, ancillary adjustment, is that going to be in the June report, as well?

DR. MILLER: [Off microphone.] Think of each of those in the material as all put into the -- oh, sorry -- all put into the June report, and so you'll have all the

analytics in there, and then at the end -- what I see at the end, or at the beginning, whichever way you want to think about Executive Summary, is a series of statements that says, this is what we're seeing as the shape of this thing. And even though the work that Carol has done with Urban Institute folks, there is a model, but we wouldn't view that as the model that ultimately gets implemented. The Secretary will construct one, and then we'll -- with more detailed data, and then we'll come behind that and comment a second time.

Is that your question?

MS. BUTO: Yes, that was my question.

DR. MILLER: Carol, that was on --

DR. CARTER: Yeah, that's good.

DR. CROSSON: So I think what we're looking for then here is do people generally -- because you can see the direction this is going. Do people generally agree with the conclusions from the model itself, the conclusions from the model? Are there other things that we might want to add, change emphasis, that sort of thing?

So, Mary, you can start off.

DR. NAYLOR: So I want to join Scott in saying

how excited I am again about this great work with you and your Urban colleagues.

And to build on Mark's comment, this piece, this section, this third section and the evolution of this work highlighted for me some additional opportunities. I don't know if you want them or not at this point, but more than ever, the focus on a post-acute unified payment system has caused me to look at the community population in home health as a big outlier in this in framing the design and wondered whether or not as you think about home health and think about the recommendations for design that we really consider just including post-acute, someone who has just had a hospitalization, because that gives you common ground among all of the people.

So it either is a sensitivity approach, which is to say we're including and not including how with this change, so I don't know if you want to consider that, but it really --

DR. CARTER: Well, we did analyze them separately.

DR. NAYLOR: Oh, you did.

DR. CARTER: We did, yes.

DR. NAYLOR: Okay.

DR. CARTER: But that's different than excluding them from the model and rerunning everything.

DR. NAYLOR: Well, if we present alternatives, one might be that we present an alternative -- or that would present the design as it is with all in, but then say a consideration going forward is to think about a very different population than -- in terms of needs, in terms of cost.

DR. CARTER: Right.

DR. NAYLOR: So it's just a thought. I mean, it came out multiple times in your work here.

DR. CARTER: So you're not suggesting changing the home health benefit, but just saying we might pay for it differently.

DR. NAYLOR: Yeah.

DR. CARTER: Okay.

DR. NAYLOR: You might pay for this group differently than this unified, and that way, everyone that we're considering has in common that they have had an immediate hospitalization prior to the post-acute services.

And here is where I totally agree. The

functional status data absolutely is critical in this design, and I would suggest it be for all patients because this is a core outcome of post-acute care, and so not just subgroups.

I also really liked the attention that you paid and the critical need for accurate prediction of what routine care, especially nursing care, needs to be. This is really now the highlight, centerpiece of caring for medically complex people, and there's actually some work that I'll send to you that's been done in helping to pull this out.

On the issue of -- and so I'm really looking at this more as a clinician. On the issue of cognitive impairment, I would encourage the use of proxy, meaning the diagnosis, but I would also really acknowledge the limitations of that. Most people do not have a diagnosis of dementia and yet they might have severe, moderate -- or they might have moderate to severe impairment or mild impairment or delirium, much of which is then recognized and yet in this population is really important. So I think it's a good beginning.

In the model itself, I think helping to

understand the categorization and the overlap of impairment and severity just -- you have it all, but fleshing that out more in the report, I think would be great.

And the last thing was the variation in stay cost, 57 to 60 percent administrative full model, but then you talked about differences in specific groups. I think it would just be helpful to know which clinical groups are the 22 percent versus 60 percent, but really just --

Oh, one last thing I want to say is, in all of our efforts to make sure that we really focus on the medically complex as a target population in the post-acute benefit, I guess one area that we just will want to make sure, that for people whose patients' characteristics and needs really require the therapy, how to make sure we adequately provide appropriate levels of rehabilitation therapy, when that is aligned with their goal, so just some conversation about that, but really terrific work. Thank you.

DR. CROSSON: Okay. I have Kate, then Herb, Kathy, Craig, and Warner. Who did I miss?

DR. BAICKER: So this is a really great analysis, and I thought the way you outlined what the steps were and

the goal of each step was really helpful in helping walk us through it, and the shrinking of the variance in those ratios is pretty impressive. And that seems like exactly what we want the model to be able to do, and it seems like it's accomplishing that goal.

Some of the issues that you've brought to the surface that I think would be great to signal as where we're going in the long run once the better data are available are some of the outlier payments and short-stay adjustments and things like that are necessary now with the data that we have and may be necessary in the long run, but ideally, we minimize those exceptions.

As more data, richer data comes in with the more granular information that you're expecting in the next wave, one of the things that would be great to do with that data is try not to have the kinds of payment cliffs that we're always trying to avoid in other settings. From what you've presented, it seems clear that they would be needed in the interim period, but to signal with the richer data, we hope to be able to accomplish a model that captures most of that stuff would be great.

And then modeling things based on what people are

actually spending now seems again necessary with the data on hand. In the long run, I would love to move towards a model that produces the cost of efficient delivery for this group of people, and that may mean very different payment structures and cost structures than exist today because what we see today is the product of the siloed funny payment system that we have today. So, again, I don't think there is a way to get around that in the short run, and it's nothing one can fix in June. But one of the goals of incorporating more information and richer data would be to move towards a model where the payments are based on what we think efficient delivery is for the patient with those given conditions, not based on how the costs are allocated today.

So those are just thoughts about some of the verbiage that might be in the report signaling where we think things should go.

As far as the analysis that has been done with the data that's available, I think it's done a great job of shrinking variation in payment to cost that was not helpful for patients or the system.

DR. MILLER: You have made the efficient provider

or efficient point a number of times and the difficult that we have working with the current data. That decidedly feels like something at the conclusion of the -- right. That's what you're saying.

DR. BAICKER: Yes.

DR. CROSSON: Herb.

MR. KUHN: I, too, want to join the others in my compliments to both you and the folks at Urban. This was really well put together, a great read, and I appreciate what you've all done there.

Although when I read the first part of it, I had to smile when it said that the Secretary's report is not due until 2022, and I kept thinking, "I'll be on Medicare when this thing is" -- when the next report comes in this area, so maybe I'll be able to use this new payment system when I get my knee replaced somewhere down the road.

DR. CROSSON: Could I just point out that that is not the end of the world?

[Laughter.]

MR. KUHN: So a couple of observations here and a couple thoughts on additional information. One, I like where this is going, and I like the fact that truly,

hopefully, we'll be in a position where we'll base payment based on the patient's characteristics and not about therapy services that are needed. So I think that is extraordinarily helpful.

Also, I like kind of where this is going directionally because it seems like the money truly begins to follow the patient where they need to be and now would hopefully trigger payment based on the right place for the right characteristics of that patient as we go forward, so I like to follow the patient area out there.

The modeling on the PAC-PRD and the administrative data, that crosswalk you did, I thought was brilliant. I liked that very much, and particularly when you look at the PAC-PRD that had low participation and maybe was even self-selected of those that were in it, the fact that you were able to model over to the administrative data, the high correlation I thought was really terrific because you showed here, and it's talked about in the paper.

The functional status area, there is some differentiation there, but I think that continued work can be done in that area.

I did note in that area, though, in the paper, you talked about on page 33 -- and I think also Mary raised this as well about routine costs, and a lot of that will be nursing. I guess I wrote a note in the margin on the paper when I saw that about the differential rates that will be out there, whether it's high nursing, low nursing, just the complication of the difficulty of collecting that data. I don't know if we need to chase that down in this report now. That's something maybe for future years, but I do wonder about how easy it is or how difficult it is to collect that data since it's not available through the administrative data. I might be overblowing that, but it's just an observation I made on that as I was looking at it.

The other thing -- and picking it up a little bit, which also has been said here -- is I keep thinking about this, and as we move forward, how do we avoid the perpetuation of the silo-based care? So we get a payment out there, and there's this ongoing talk and some innovation going on out there on what is known as these continuing care hospitals and trying to get a unified payment model, by normalizing the payments in a way that get rid of the siloes, but really kind of an entity that

can cover all these different services for the patients, and they can move the payment around.

So, as we kind of move these forward, a little bit what Kate kind of picked up on, could there be some conversation about maybe what these new innovations of these continuing care hospitals or whatever they're being referred to, how this model could maybe help incent those kind of changes in new facilities or new ways of delivering care as we go forward?

And then finally, one additional issue that wasn't in the paper, but I was thinking about it -- and maybe I'm totally off on this, but I was just trying to think through -- the impact this might have on wage indexes as we go forward. And the only reason I raise that, as I recall somewhere in the wage index, that if you have higher nursing costs than perhaps others, there is kind of a ratio or a cap on nursing costs somewhere in there in the wage index calculation. And maybe people can correct me if I'm wrong, but as we change the model, as we may be move to more nursing costs -- so maybe you've got 85 percent RNs to LPNs or something like that -- there's a cap that's put in place. I just don't want to see you in a -- and like I

said, I could be wrong here, but I don't want to be in a position where you've got new payments coming through the front door, but payments going out the back door, because this triggers a change in -- or a wage index activity out there. It would just be worth looking at to make sure there is no impact there at all.

DR. MILLER: For myself, I'm not intuitively immediately getting the issue, but we'll look at it.

MR. KUHN: Yeah, it would be worth looking at.

DR. CARTER: Yeah. I mean, the labor shares obviously differ a little bit by setting, but I'm not aware of what you're talking about, sort of the caps on the nursing.

MR. KUHN: Yeah. And I'll go back and do some -- I just, you know, as I was reading --

DR. MILLER: We'll get on it.

MR. KUHN: Yeah. I was just looking at the paper, and I was just thinking about that.

And then, finally, thanks for identifying the outlier issue. I noticed that as I was reading, and I think we'll bring that up at the next meeting. And I appreciate you working on that too.

DR. CROSSON: Okay. Kathy?

MS. BUTO: So this work made me feel as if going to separate revised PPS approaches for SNFs and IRFs and even home health would be a distraction. In other words, if the model can be developed, it would be better to move directly and skip over those steps. I'm afraid that if they agency gets caught up in revising those individual siloed PPSs that this will never happen. That's one of my fears. So let me just put that out there. I don't know how that would -- I don't think that's to be reflected in this report, and it may turn out that we run into a bump that we're not aware of today. But it's just the thought I had.

The other thought is related to what other people have said, and that is -- and this, I think -- if we can capture in the report would be good -- is some mention of this issue, the conditions of participation or the standards that these different entities are being held to and maybe even a suggestion that some review needs to be made of whether eventually we're talking about institutional, non-institutional. And if the payment rates then suggest some specialization like those that specialize

in really the high-cost cases, risk adjustment and other things should be able to address that. But at the moment, I don't see a great justification for continuing the individual categories of institutional providers, if this model can prove to be really robust.

But I just want to mention that I think the individual PPS refinements could be a distraction and actually slow the progress of moving to something like this. Again, I don't know that we want to say that at this point, but it's a concern I have about going forward.

DR. CARTER: So I just wanted to say one thing about that, which is they could be a good stepping stone because the patient characteristic-based PPSs that we have recommended for SNF and home health are exactly like this, and so if those providers can use the revised PPSs as transition times to change their cost structures, be less emphasized on rehabilitation care and more emphasis on medically complex, that's exactly what this would do. So it could set them up to change their behavior and practices in ways early and ahead of what they would be expected to do with the unified.

MS. BUTO: Right.

DR. CARTER: So that's the other version of --

MS. BUTO: I know where you're -- and I agree with that. It's just that I don't think it would be early. In other words, I think it would take a while to get to that state, implement it, and it would actually end up -- even though that's a better state to be in, to move to another PAC-PPS, I think it would delay getting there is all. You might get there in a better place, but I think it's really a balancing act of how much change can these providers go through.

DR. CROSSON: Kathy, let me just ask you a question, and maybe this is an answer I should know. Just in terms of the terminology you were using about revising the PPS and the complexity involved, just from your experience at CMS, does that also include the terminology we also use, "rebasing"? In other words, to what extend do we use "rebasing" here as simply saying reduce the level of payments, and would that involve as much complexity as you're saying?

MS. BUTO: Well, reducing the level of payments doesn't involve as much complexity, but I think in SNF PPS in particular, I'm thinking the change from the weight

that's given to therapy services, rehab, and so on. The changes that -- you know, having more of a focus on what the patient needs is more than just rebasing or taking money out of the system. It is going to mean actually revising the way that PPS is implemented.

DR. CROSSON: Right. I understand that, but if what you are proposing is actually a fundamental issue here -- and it may well be -- it doesn't necessarily mean that between now and 2022 or whatever, there could be no action taken on some of these areas where we see a need for reduction in payment.

MS. BUTO: Right. I mean, I think the way to think about this is it generally takes about three years to get a PPS system vetted, mounted, and then another several years to actually get it under way in a way that the data are reliable. Maybe that's sped up. I don't know, but it takes a while. It would take probably 5 years just to do that.

It's 2016. That brings us to 2021, even if it were done today, which it's not going to be. So all I'm saying is then to turn around and then in another couple of years ask providers to undergo another set of changes, it's

a lot of change, and it depends on where we think we want to go.

So I'm just saying it's something to think about. We're not there yet. The model isn't ready, et cetera, but I just wonder about that interim step and whether it might delay ultimately getting --

DR. CROSSON: Craig.

DR. SAMITT: Carol, thank you. This is awesome. I don't think I've ever seen Scott so excited before, so --

[Laughter.]

DR. SAMITT: I really appreciate it.

My question is about sort of unintended consequences or reactions. So, on Slide 16, you talk about the estimated impacts, but I am curious to see if you thought through playing out the cards. So this goes into place. How do the providers react? What actually happens, and are there any potential things that we should take into consideration that would make the model stronger or the program stronger? Because we believe if we do X that Y will happen, which could negatively affect quality or access or beneficiaries or result in gaming and so on and so forth. Have you modeled that out or thought that

through in terms of what the response would be by the industry if this were put in place?

DR. CARTER: We haven't modeled it. We have thought a little bit about how providers would change -- would be encouraged or have the incentive to change their mix of patients.

So, for example, SNFs might take medically complex, more medically complex cases. LTCHs might take a broader range. IRFs might take a broader range. So I do think that the mix of patients that you would see in providers could be broader, but they would need to change their cost structures because the costs in the different settings are pretty different, and so that -- both of those things are going to change. The costs need to change, and the mix of patients need to change.

I mean, some things like in the SNFs, we know that for-profit facilities tend to have longer stays, and so they get more affected by a stay-based payment system than non-profits. So having their lengths of stay start to look like other providers is a change that we would expect.

DR. SAMITT: And those are the exact things that I am thinking about.

But, for example, a couple that -- one that you pointed out, that SNFs may take more medically complex patients, I guess we would need some reassurances that they would have the capacity to serve those patients --

DR. CARTER: Right.

DR. SAMITT: -- and that we wouldn't see an erosion of outcomes or quality, and so I think we need to take those things into consideration.

I also don't know when someone asked about the inter-facility transfer or -- does this create any exposure for under a single PPS to encourage sort of readmission or transfer to another facility, and have we thought that through, and how do we factor that into the consideration of the model as well?

DR. MILLER: I guess what I was going to follow up on, the beneficiary side and then the side that you're -- you know, exposure side that you're talking about there. We have some thinking, and it's hard to keep all of this in your head because this is one of these things where we have to do this by June, and so once a month, we're showing up and you guys have to cast your mind back several months.

We talked a little -- one thing to keep in mind

about the new functional status data is it will both feed into the payment system and how you adjust the payment, but it will also be used for quality performance so you can look at somebody's functional status on admission and discharge and figure out how somebody is doing. And then the second thing on the exposure thing, we did, I think -- it didn't just happen in my head, right? We did do some discussion about looking at the aggregate population base around this to see whether there is an inducement of episodes -- or admissions and that type of thing. I thought we did talk about that.

DR. CARTER: Well, we talked about companion policies and readmission policies as one way of trying to dampen kind of patients being prematurely discharged to either another setting and then getting readmitted or being readmitted to the hospital. You know, so we did have a session trying to think a little bit about some of those incentives, and Kathy had asked -- and we had included, I think, in the November presentation a discussion of the range of the quality measures because of how important it is to monitor quality and outcomes as this is going on, and the report will certainly have a section on that.

DR. SAMITT: Thank you.

MR. THOMAS: So I think this is information that's very helpful. I think directionally it's excellent.

The couple of comments I would make as you continue to look at this is, you know, we keep talking about the SNF model and the rehab model, and I think we have to kind of just think about it's the post-acute model, and that, you know, kind of just like we're thinking about in the acute-care hospital. You have different levels of patients in an acute-care hospital. And I think if we moved to a model that we just have one payment but we still think of, well, we're going to have rehab, we're going to have skilled nursing, I think it's going to -- it could be a challenge to implement that versus can you have a facility that gets a payment that obviously is risk-adjusted based upon the type of care for that patient.

So that may be a nuance, and maybe I'm not totally understanding, you know, what is presented. But the regulatory issues that go along with being in each one of those different areas is really limiting, and I would really encourage in the future work to look at those regulatory issues, because I think it's at the end of the

day we want the patient to be in the right setting where they can be cared for appropriately, and it's my impression or experience that sometimes the regulatory limitations or -- just regulatory limitations or regulatory components limit that or make that problematic.

So I'm not sitting here telling you I have the answer at all, but I do know that that is a real challenge for providers to figure out, you know, who qualifies for which area and what's the duration of the stay and, you know, versus if you think about we just need the person when they're being discharged from an acute-care hospital to get into the right setting where they can get the right, appropriate level of care. And I think coming back to you, to the extent we have more of these facilities that are a little larger, they're going to be more capable. They're going to be able to handle a more intense type of patient. And I think that will ultimately have a better outcome because we're going to have more clinicians there that are kind of surrounding that patient and not have it bifurcate into a bunch of different subspecialty areas that are kind of just geared towards a specific type of patient.

DR. HALL: I'll just add my kudos to everyone

else's. I think this is very important work, and it proves a couple of things. One is that sometimes when we complain that systems are too complex to change, if we just try, maybe we can work something out. I think you've demonstrated that admirably.

The other is that we're talking a lot about function, and if we did some kind of Google search of the use of function in all of our reports, I would predict that the term "function" wasn't used very much seven or eight years ago, but now increasingly so, thanks to Mary and others who have been goading us on in this direction. But it really is the basis -- and when we talk about outcomes and assessing quality of care, it's the one parameter that puts it all together in a way that we now know is reproducible and, most importantly, is very, very important to the Medicare recipient and their family. So this is a huge shift in our thinking, and it couldn't come too soon, and I think it's wonderful.

A couple of people have mentioned as we went around that while there are silos, sometimes those silos serve a specific function in that there are specialized needs that people have. For example, if I'm hospitalized

as a Medicare patient because I've had a respiratory ailment, and I'm sent to a nursing home because I'll get rehabilitated for a period of time, that's one entity. But maybe the next-door neighbor who has the same thing, has decubiti ulcers, has big sores, gaping sores that are infected and need specialized care, maybe someone will need some respiratory support periodically. Maybe someone needs something as simple as IVs. Or maybe somebody says, "My family would like to be close to me," or, "I'd like to stay in a system where the same doctors will take are of me." And that's a problem, as two or three people have pointed out. But maybe it's an opportunity to let the providers have an opportunity to suggest the changes, because for every different health system, this conglomerate of services that are not -- it's very easy to define what the P&L is on each of these services. Why not let them come up with innovative solutions? I don't think we have to dictate -- one of our problems in long-term care is we dictated things, and sometimes they're 45, 50 years old, and they're not very good paradigms anymore.

So I think this is exciting not only for solving or starting to solve a payment problem, but may really be

an enormous impetus to change how we measure health care for Medicare recipients overall, and that's an incredible advance. So I'm excited, too, Scott.

MS. THOMPSON: Carol, this is excellent. I join everyone else, as enthusiastically as Scott. And on behalf of those providers out in the frontier, thank you for recognizing the unique situations and those low numbers.

I can't firmly state enough how difficult it is in the frontier many times to find placement for these folks. I mean, these services and these locations are very small, and they often are running with waiting lists of patients to get in. So, you know, again, thank you for recognizing that piece.

But I can't also help but think about how providers must be beginning to think about consolidating these services under one entity and, you know, managing cost structure, and in that I'm concerned with those unintended consequences, that there may be some aspects we need to think about, that there may be some elements of these certain types of patients to care for that would still be more desirable than those with long-term events, tough long-term head injuries that will ultimately result

in a decrease of access for the patient. So I worry a little bit about that, but I call that out. And I wonder -- and I really hadn't thought about this until Warner talked about it, and he brought that out several months ago. When you run a hospital, if you're going to be a licensed hospital, you have to have an emergency room.

Now, if we didn't have to have an emergency room, P&L in hospitals would look a lot different in many cases. And I would think if we're thinking ahead in terms of how this is structured, that there would be some requirements that all of those services be available and offered as we consolidate and take these silos apart.

So my thoughts, but thank you. I think this is extraordinary work. I'm really excited about it.

DR. CARTER: Could I just say, to kind of remind you about in November, when we were talking about conditions of participation, one idea -- and it's just an idea -- is to have conditions, sort of a base level of conditions that all providers would meet, and then have separate conditions for patient groups. So if you wanted to have ventilator care, you needed to meet those requirements, you know, have the skill and the staffing and

the equipment. And if you wanted to take care of wound care, you needed to have adequate staffing, trained staffing.

So it would start to move conditions of participation towards what are the types of patients I want to treat and are capable of treating and gear our conditions that way. Does that make sense to you?

MS. THOMPSON: Yep.

DR. CARTER: That's what I was hearing.

DR. MILLER: Can I ask one thing on yours? So I followed the thread of all of your comments, I think, for the most part, but then just right at the end, it sounded like you said given, you know, the change and the need for consolidation, you might need to have a full range of services. And then what I was wondering, given your opening comments on frontier, do you think if that was a requirement -- and I'm not sure you were saying that, but if it were a requirement, would they be able to do that in the frontier?

MS. THOMPSON: They could and they would because the cost structure would go down. Bigger numbers, bigger denominator.

DR. CROSSON: The cost structure would go down as a consequence of consolidation.

MS. THOMPSON: Correct.

MS. UCCELLO: So I just wanted to join the chorus praising this fabulous work. But, also, I just wanted to make sure that people didn't leave here with the impression that we wanted to back off of any of the recommendations we made yesterday in terms of revising the PPS for some of these post-acute services and the rebasing.

I think, you know, 2025 is still an awfully long time, and I think that people with complex needs, they need places where they can go where their needs can be met. And I think, if anything, I think we need to highlight the urgency of doing the things that we recommended yesterday as opposed to just letting them go by the wayside. And I want to echo what Carol said about doing those kinds of things sooner will help facilitate the movement toward this more unified system.

DR. HOADLEY: You know, I was wondering, from Kathy's comments earlier and your responses and Cori's comments just now, I mean, the dates that we're obviously triggering on are the ones that were put in the statute.

But is there a more structural reason why things have to happen on this particular pace that was set up in the statute in terms of 2022 and 2023? Is that just how much time it's likely to take to take all these intermediate steps? Or could this actually happen much earlier if there was a compelling reason to do so?

DR. CARTER: Well, the functional status data isn't being required to be collected until '18, and so you could move sooner, but we've seen from our results that in aggregate, the results look pretty good, but for the functional status groups, they don't look so good. And so that would be a reason to wait for those data.

That said, the administrative model without it, you know, looked reasonable, and then the question is: Well, how bad was it, I guess, for the functional groups to delay implementation? And that's something we could talk about.

DR. HOADLEY: So in thinking about transitions -- and I gather transitioning is not really part of what we need to talk about in this particular report?

DR. CARTER: We could. We have said we think a transition is decidedly important.

DR. HOADLEY: Right. So, I mean, talking about transition in -- there's the obvious things you say about transition in terms of just making things happen on a gradual basis so there's not too much disruption. But I'm thinking about from Kathy's comments, Cori's comments, maybe talking about some bigger think version of transition and whether it would make sense rather than update some of the systems like SNF to do an administrative version of this model as a transition much sooner or whether that's not smart, but we could do an updated SNF. I mean, I remember, you know, years ago the physician payment transition. There were a whole lot of intermediate steps that allowed the original adoption of the fee schedule to operate, you know, to come in in a smooth way. And are there particular considerations, is there anything we would do different about rethinking, say, a SNF PPS in the interim to smooth the transition towards where we're thinking this would go? And even if we don't have concrete steps but even just to think about it that way, whether the preferences of sort of moving more forward on an administrative consolidated PAC faster versus figuring out a way to transition some of the existing systems, the same

as we've already thought about or a little bit differently in order to get to this point as efficiently and as smoothly as possible.

DR. CARTER: So the SNF PPS that we've recommended is very similar to this, but the difference is that it considers the MDS function data. And as we've seen, functional status is important, and ability to swallow, and there's some very specific things about post-acute care that are captured in the assessment that are folded into our redesign, that if you went to an administrative model, you'd have proxies for some of them but not all of them. So that would be the tradeoff.

DR. HOADLEY: So maybe even just articulating some of those tradeoffs as part of the report discussion --

DR. CARTER: Okay.

DR. HOADLEY: -- would help, and then, you know, we obviously don't stop when we submit this report in June. We continue talking about SNFs, you know, either within the silos or across, whether it's the bundling discussions or just the routine update discussions, and then we could follow up on those in whatever ways we see fit, you know, over the next cycle.

DR. MILLER: And I think I see [off microphone] how you're bringing this together, and I think Carol's comment that in a sense conceptually, what we're saying in the SNF and the home health redesign is conceptually what we're doing here. And I think there's real truth to that. And I think I see your point. I'm just saying this mostly for my mental health, as you could say -- you know, you could start transitioning earlier on this less complete administrative model to moving in the right direction. You'd probably have to have transitions and let's just say bigger -- just for illustration, bigger outlier policies, and then have those collapse as more detailed data comes in and you build the system.

In this whole exchange of our recommendations on SNF as separate from the big thing, I think the important thing to take out of it is we're saying to the industry it's changing, you know, and if there's real resistance to going to the unified PPS, which there is, you know, it's one way or the other, this is the direction Medicare seems to be going, either by silo or across silos. And so I think the timing continues to be a real issue, and the burden on the agency a very important point. But the

signal of this is where it's going one way or the other I think actually complements it.

MS. BUTO: Mark, can I just ask you a question? Remind us how much of the change we're recommending for SNF requires -- and maybe Carol -- can the agency go ahead and do? Wasn't there a considerable amount --

DR. CARTER: They don't have the authority for an outlier policy, but otherwise they do.

MS. BUTO: They can move ahead.

DR. CARTER: Yeah.

MS. BUTO: Okay. It's just that they haven't moved ahead, and it's been a number of years, I think, that we've recommended they move.

DR. MILLER: I don't want to speak for CMS, but just for a moment, I think if they were here -- and, Carol, keep track of this. I think what they would say is, you know, we made changes in certain weights and we adjusted things, and directionally they were, you know, what you guys were saying. Carol then went back a year or so ago and sort of said, well, but comprehensively, when you look across that, how close are you getting to that? And we still think there's a big --

DR. CARTER: It got worse.

DR. MILLER: It got worse.

DR. CARTER: Yeah.

DR. MILLER: So that would be a big gap. But I'm trying to be a little more politic.

DR. CARTER: All right.

DR. MILLER: So, you know, I think they haven't done what we've asked them to do. I think if they were here they would say, yeah, but we tried to do some things. And I think Carol would say, yeah, but you actually didn't get there, and maybe even went backwards a little.

MS. BUTO: And my point was just that if we're going to sort of more fully discuss this transition, so to speak, as Jack was suggesting, I think it would be good to point out where CMS could move ahead on certain important elements right away and not have to wait for more authority and so on and so forth, because, you know, nothing's happening this year authority-wise.

DR. HOADLEY: Further talks is that notion of sending the signals to the industry and figuring out a way to make that start happening sooner.

DR. CROSSON: Okay. Excellent discussion.

Seeing no more comments, thank you again, Carol. And we'll move on to our final presentation.

We're going to hold for a minute or two while I think there's some more people coming in.

[Pause.]

DR. CROSSON: Okay. It's time for our last presentation. We are going to pick up again and begin in more depth our analysis of the payment models that were brought forward in the MACRA legislation, specifically but not totally focusing on alternative payment models. So we've got David Glass and Kate Bloniarz. Did I mess that up? Close enough? Close enough for a chairman. Okay.

[Laughter.]

DR. CROSSON: Kate, are you going to begin?

MS. BLONIARZ: Yes. So, as Jay mentioned, as we discussed last in October, Medicare's payments to physicians and other health professionals are now governed by a set of provisions enacted in the Medicare Access and CHIP Reauthorization Act, or MACRA. So we just continued discussing today the set of provisions pertaining to alternative payment models, or APMs.

I will recap the relevant provisions, including a

timeline, and will discuss potential incentives under the APM provisions and the merit-based incentive payment system, or MIPS.

David will then present draft principles for your discussion and some key implementation issues.

On this slide, we wanted to put down the key definitions from the statute. I won't read it aloud, but it is on the screen.

The first is the definition of alternative payment model, which we refer to "model" in this presentation.

Second is eligible alternative payment entity, which we refer to as "entity."

And finally, qualifying APM participants, which we refer to as participants.

Here is an example of how this work. Let's posit that Pioneer ACOs meet the eligible APM criteria. The Pioneer ACO demonstration would be the model. A specific ACO, like Partners, would be the entity. And the clinicians who are part of the ACO, like Atrius in Boston, would be the entity, and the clinicians who are part of the ACO could be the participants. When David talks about draft

principles, it will generally be in reference to the APM entity, but the principles also implicate the payment models themselves because the model sets the rules under which the entity operates.

The APM provisions are as follows. Clinicians who are qualifying participants in an eligible APM entity will receive a 5 percent incentive payment for each year that they qualify between 2019 and 2024. They will also receive a higher update from 2026 on.

To quality, clinicians must have a specified share of fee-for-service revenue, or beneficiaries, in an eligible alternative payment model entity to qualify for the incentive payment and higher update. The thresholds are set in statute and start at 25 percent in 2019, rising to 75 percent by 2023.

In general, clinicians will be participating in APMs or subject to MIPS.

The MIPS is a system to assess performance for clinicians who are not receiving the APM payment. The MIPS will be an individual- or group-level payment adjustment for clinicians based on their performance in four areas: quality, resource use, clinical practice improvement

activities, and meaningful use of electronic health records.

The MIPS starts in 2019 and is permanent. CMS may use the current quality measurement systems in MIPS, like those that form the basis of the current value modifier.

The basic MIPS adjustments are budget neutral, and the maximum downward adjustment is set in statute, at 4 percent in 2019 rising to 9 percent by 2022. The maximum upward adjustment could be scaled up beyond these limits. There's also $500 million a year for exceptional performance for five years in addition to the basic budget-neutral adjustments.

I'll turn to the first of two items you asked about last time, an illustrative timeline. CMS has not issued rulemaking yet, but conceptually, certain things need to happen to meet the statutory deadlines.

In 2016, we expect a proposed and final rule on both APMs and MIPs.

During 2017, APMs will need to be defined, and APM entities will likely need to be certified or approved.

Then 2018 could be the measurement period for

assessing whether clinicians are qualifying participants. Then the APM incentive payment will be paid in 2019.

When CMS has implemented other value-based purchasing programs for clinicians, they generally start two years ahead of the implementation year. The first year CMS sets regulatory requirements, the second year the clinicians report the appropriate information to Medicare, and the third year the payment adjustment would apply.

You had also asked us to consider the relative incentives that a clinician would face, from joining an APM entity versus staying in fee-for-service and being subject to the MIPS. At this point, what we can give you is quite speculative. We had to make some heroic assumptions because none of the policies have been set.

For example, with respect to the APM provisions, we don't know how CMS will define being at risk, for what spending, and we don't know how many clinicians will participate in these models.

On the MIPS side, we don't know what measures would be in MIPS, much less the distribution of clinician performance on these unknown measures. So we made policy assumptions regarding the APM provisions as well as

assumptions about the potential range of performance.

And finally, we have some illustrative figures for average clinician revenue and spending per beneficiary.

Starting with APMs, the qualifying participant would receive the 5 percent incentive payment automatically, which totals 3,750 in the first line. The shared savings or losses experienced by the entity, on the next line, could be much higher, from 36,000 to minus $36,000 in this example.

But remember that this is only if the APM entity performs 5 percent above or below expected performance, and is responsible for total A and B spending. Actual experience to date in the ACO program is lower than this. For example, it was around 1 to 2 percent.

Moving to MIPS, our illustrative example for MIPS also uses a 5 percent range of performance, and when applied to the professional services revenue, the range is 3,750 to minus 3,750. There's also additional funding for exceptional performance, as I mentioned before, 500 million per year from 2019 to 2024. So, in total, the illustrative range is from $7,500 to minus 3,750 in our example.

I want to also point out that the basic MIPS

adjustments are scaled to be budget neutral, so the potential upside could be higher than what we've shown here. But how likely is it that clinicians subject to the MIPS would see large bonuses? And I'm going to say it doesn't seem particularly likely.

We can't estimate what the MIPs performance results will be, but the experience with other individual or group-level assessment of clinician performance generally finds that most clinicians cannot be easily differentiated from average.

For example, the value modifier results for 2015, which in Medicare applies to large groups of 100 clinicians or more, found that 80 percent could not be differentiated from average, and they received no adjustment. That's the green bar on the right side. Ten percent of the groups were assessed to be of high performance. That's the turquoise bar at the very top. But none scored high enough to receive the maximum adjustment, and 10 percent of the groups were low performance, receiving a penalty. That's the purple bar.

So to summarize all the moving parts, the only certainty is the 5 percent incentive payment that

qualifying participants would receive. The potential shared savings and losses for the APM entity could be significant, but on the other hand, actual ACO performance has been in the range of 1 to 2 percent.

With respect to the MIPs, there is theoretically the opportunity for increases or decreases, but CMS's experience to date with the value modifier has had most groups getting no adjustment.

The risk and reward through the APM provisions is greater than MIPS, but this is dependent on two key definitions. First is the level of risk; and second, what spending the APM entity is responsible for.

Finally, as MIPS has not yet been defined, it's difficult to assess the potential risk or reward.

So I am going to turn it to David, who will take you through some draft principles.

MR. GLASS: Thank you, Kate.

Here are the principles we drew out from your discussions in October. We will discuss these in the next two slides. For simplicity, we will use the term "entity" as short and for an eligible alternative payment entity made up of qualifying participants.

The first three principles follow for making bonuses contingent on performance.

The first, you discussed at some length in October. The basic principle, what you seem to be gravitating toward, is that incentive payment should only be paid to participants based on performance; that is, the clinician's incentive should depend on the success of the entity in which they participate. This principle follows from wanting to protect the Medicare Trust Fund and taxpayers and encourage meaningful delivery system reform. The basic argument is that to protect the trust fund, we want to make sure Medicare gets something for the incentive payment rather than just paying for clinicians being an entity. In addition, if we want the delivery system to change, there has to be sufficient incentive to make the effort to do so. Making bonuses contingent on performance is one way of doing that.

The second principle, that the entity have a sufficient number of beneficiaries to detect changes in spending and quality follows if the entity is at risk. For the entity to take on risk, it will have to be confident that its performance results are reliable. It will not

want to take on risk for random fluctuations. The number of beneficiaries in the entity will need to be sufficient for results to be statistically reliable.

The Commission has also stated the desire to move towards quality outcome measures that are meaningful to the beneficiaries, such as rates of potentially preventable hospital admissions and readmissions. These also require a sufficient population to be measured reliably.

The third principle, that an entity be at risk for total Part A and Part B spending follows if the goal is to encourage care coordination and delivery system reform. If the entity were at risk for just its own billing, the results would be counterproductive for two reasons. First, the entity would have no reason to reduce spending outside the entity; for example, there would be no incentive to reduce hospital readmissions. Second, the 5 percent incentive is an add-on to fee-for-service billing. So if its own billing goes up, but the entity's revenue and incentive payments both go up, this could be a particular problem if the risk were lower than 5 percent.

Now, by implication, if the entity is at risk for Part A and B spending, the design of the model itself will

have to require that. Some models, such as medical homes, may not contemplate that now but could be redesigned to do so in the future.

These three principles related to administration, and again, these are phrased in terms of the APM entity, but the alternative payment models themselves must permit the actions.

The first is that the entity have the ability to the shared savings with beneficiaries. To engage beneficiaries and give them some reason to further the goals of care coordination and use the entity's providers, for example, the entity should have some latitude to share in any savings with the beneficiary. This might take the form of reduced cost sharing for using the entity's clinicians. The Commission has supported this principle for ACOs.

The second principle is that the entity be given relief from regulations designed to deter unnecessary volume and spending. If entities are at risk for total spending, they will already have an incentive not to ramp up volume unnecessarily. For example, regulations requiring a three-day inpatient stay before a SNF stay

could be a way of allowing a more innovative use of SNFs. This principle follows only if the entity is at a two-sided risk for performance.

And the last principle is that there be a single entity to assume risk. This would allow entities to set their own rules on how to divide up savings and losses and enable them to innovate based on local conditions rather than CMS deciding who gets a share of savings or loss and how much. A single entity would also supply administration for CMS. It would, for example, have a single place to go to collect losses rather than trying to collect from individual clinicians.

So taken together, these principles build on one another. Regulatory relief, for example, only follows if the APM is at risk for total spending and is accountable for a sufficient population. Having regulatory relief will allow the entity to be more innovative and provide better care coordination, and this in turn will enable better performance.

With these principles in mind, we can think about some of the issues that will arise in the implementation of the APM provisions.

The first issue is the definition of risk beyond a nominal amount. The statute specifies that entities be at risk beyond a nominal amount but does not specify how much that is. So CMS will have to do so in regulation, and it will likely comment on that regulation, so we wanted to understand what your thoughts are on this issue.

On the one hand, one could define risk beyond a nominal amount as being the investment risk; that is, the cost of setting up and running an entity. This would limit the risk for clinicians forming an entity to the amount they put into it and not expose them to the risk of medical cost. It could also limit possible rewards to the 5 percent incentive, unless CMS also wanted to create a one-sided shared savings sort of arrangement.

The negative is that risk may be insufficient to motivate clinician improvement and counter fee-for-service volume incentives. For example, if the investment was minimal and the reward is 5 percent of fee-for-service billings, why would participants do anything to limit their fee-for-service billings or coordinate care? Doing nothing would cost little, still get the 5 percent reward, and remove them from MIPS reporting and possibly MIPS

reductions.

On the other hand, risk could be defined as the difference between expected and actual spending. This is a classic definition of two-sided risk. The pro in this case is that this level of risk could motivate system transformation. The entity would have a powerful incentive to make changes and invest in care coordination. The possible reward could be larger. It would also allow CMS to waive some regulations, as we've discussed, and allow for more innovation.

The con for this definition is that it would expose clinicians to more risk and perhaps make them reluctant to form entities.

Our draft principles would tend toward defining risk as actual versus expected spending, meaning reward of spending is less than expected and loss of spending is more than expected. This risk could be limited a number of ways, through caps on individual spending or risk corridors, as long as it is a function of total fee-for-service spending. Again, to ensure the difference is meaningful, the APM would need to be of sufficient size.

The second issue is beneficiary attestation or

attribution. The entity to be accountable for a population, that population has to be attached to the entity in some way. We consider two generic forms, attestation and attribution. By attestation, we mean that the beneficiaries identity who they consider to be their primary clinician. After they do that, they would be part of the population for the entity the clinician participates in. The concept is that identifying one's clinician does not require knowing if that clinician is in an entity or that the entity exists. It, thus, presents a lower bar than enrollment in an entity, which would require that the identity identify itself to the beneficiary and that the beneficiary know what the entity was and want to be in it.

Because the beneficiary would have to identify his or her clinician, the beneficiary would have some engagement with the clinician's practice. However, because the beneficiary has to make an active identification, the number of beneficiaries attached to the entity could be limited, and it might make it difficult for the entity to reach a sufficient size.

Another method of attachment is attribution, as is done in ACOs. In that method, beneficiaries are

passively attributed based on their claims history. This method would not require the beneficiary to make an active choice. The pros and cons here are the flip side of attestation. Because the beneficiaries do not have to make an active choice, it would be easier to achieve a higher number of beneficiaries aligned with the entity. On the con side, there would be even less beneficiary engagement.

Our draft principles would tend toward attribution because it's important to have a sufficient number of beneficiaries to achieve reliable measurement of cost and quality. However, one could combine both methods and allow attestation in addition to attribution. Some limits might be required if it was thought that selection could be a problem. The Pioneer ACO program is experimenting with such a design.

We conclude with a few discussion items.

First, we would be happy to answer any questions about the background material in the paper.

Second, we're interested in your discussion of the comparison of incentives for clinicians choosing between alternative payment model entities and MIPS.

And in anticipation of CMS' upcoming proposed

rule, we are particularly interested in whether there is a consensus on the draft principles and your thoughts on the issues of defining risk and of beneficiary attachment to alternative payment entities.

Thank you, and we look forward to your discussion.

DR. CROSSON: Thank you, David and Kate. We'll take clarifying questions.

DR. COOMBS: So I have a question regarding -- you know, we got very interesting information in one of our sessions -- and maybe it was the Executive Sessions -- regarding the number of beneficiaries in Pioneers and medical shared savings, somewhere around 9 million or so?

MR. GLASS: Yeah, the current estimate CMS just put out for all ACOs and the SRD ACOs and stuff was about 9 million.

DR. COOMBS: So when we talk about risk for spending for A and B, I was just concerned about the whole nature of the leakage question and if we have information comparing those two entities with, like, an estimate of how much -- because if the provider assumes the risk for spending in A and B, there's a component of that that

actually has to do with leakage outside of your purview for which you're still at risk for technically, right?

MR. GLASS: Yeah. Of course, most of the ACOs are Medicare shared savings program, MSSP ACOs, in one-sided risk arrangements.

DR. COOMBS: So do we have any data --

MR. GLASS: So most of them don't have upside and downside risk right now.

DR. COOMBS: Okay. So we don't have any data on the leakage from those systems in terms of how much spend goes outside of the system that --

MR. GLASS: We can look into it. We've heard -- you know, we've interviewed different ACOs, and we have some information on that, but I don't know that we have a good composite number.

DR. COOMBS: That would be important for what's supposed to be a near-perfect system or a better system to look at when we talk about transitioning with the kind of risk that might be attributed to you because of the fact that you have a panel that you have a significant leakage. And so that was one of the questions that I had for --

MR. GLASS: Yeah, so we can look into the leakage

question. And, again, it will depend on the -- you know, do you consider if it's a physician-only ACO and the patient gets hospital coverage -- goes to the hospital someplace, is that leakage or not? So you'd have to think about how --

DR. COOMBS: That was my next question.

MR. GLASS: Oh, okay.

DR. COOMBS: If you look at ACOs, there are ACOs that are physician-only, and they have a relationship with a hospital, and then there's larger integrated systems that they consider the ACO the whole package. So the percentage of the whole package versus the physician ACOs, I think it's an important issue because we're looking at driving the MIPS portion toward -- more the IMPS toward the APMs, and that becomes important because of just the propensity of being able to predict what kind of risk you're going to take, because the infrastructure development, which we can talk about on the second round, that's going to be an important piece of that.

DR. NERENZ: Thanks for the good work on this important set of issues, and I think in this case Congress has given us a very tricky set of semantics to work with,

so I appreciate your definitions, and my guess is we're going to stumble still all the way to the end of our morning discussion. So let me start with that.

On Slide 4, I don't want to pick on Kate because I sympathize here, but on the first bullet, it says "APM participants" but you said "entity participants." And apparently that's an important distinction. And then in the bottom slide, it says "participants and entities," but you said "participants in APMs."

Now, here's my sympathetic question: I guess in this particular issue the distinction doesn't matter, but you can't -- a clinician can't be a participant in a model without being in an entity. Is that a fair assumption?

MS. BLONIARZ: So that's --

DR. NERENZ: It's the only way it can be done, right?

MS. BLONIARZ: That's just an error in the last bullet. It should say "will be qualifying participants in" --

MR. GLASS: APM [off microphone].

MS. BLONIARZ: Yeah, alternative payment entities or subject to MIPS. This is also not like a strict line.

There's actually a little -- it's in general. That's how I would say it.

DR. NERENZ: But the thing I -- I wanted actually to get you off the hook here. There is no way that you can be in a model without being in an entity. Is that correct?

MS. BLONIARZ: Yes, that's right.

DR. NERENZ: Okay. So if we just focus on saying who's in an entity, we're on solid ground?

MS. BLONIARZ: Yes.

DR. NERENZ: In subsequent discussion.

MS. BLONIARZ: Yes.

DR. NERENZ: Okay. All right. So --

MS. BLONIARZ: I'm just hedging because I want to give leeway for CMS on rulemaking, but that is how it looks like the language is drafted.

DR. NERENZ: Okay. I just can't imagine on the ground how anything other than that could be true, but I -- okay.

DR. CROSSON: David, let me just comment. I agree with you from a rational point of view. Having read the law, though, one cannot extract that principle from what's written.

DR. NERENZ: Yes. That's why I said, I've read the law also, and it's semantically tricky. So I'm just trying to figure out where's our solid ground where we can have discussion and where is it -- okay.

Then in that same vein, the third bullet -- the same slide, third bullet, here's the Bill Clinton question. What does "in" mean?

[Laughter.]

DR. NERENZ: Because the problem being that in most of these models, particularly the ACO models, the payment to clinicians is pure straight line fee-for-service, and I guess just as a ground-setting question, can you tell us, does that have finite meaning? Or are we to debate that meaning?

MS. BLONIARZ: I wouldn't think it would be worth spending time trying to figure out what the meaning is. I think the relevant portion is back on Slide 3 where it says the revenue "were attributed to such services furnished under this part through an eligible alternative payment entity." And, again, this is subject to rulemaking. CMS will have to say what that means to them.

DR. NERENZ: Now, is that in our scope of

discussion this morning? Because now we just beg the question what does "through" mean.

MR. GLASS: And I think we talked about --

DR. NERENZ: But these are serious because this is -- this is what the law says, that you're in the APM if such-and-such occurs, and I'm just trying to figure out, is that what we're supposed to be talking about this morning, what these words should mean? Or --

DR. CROSSON: David, my sense is this: I think for the reasons that you said, David, you know, when you go through the law, in some parts of it it's very hard to figure out how they fit together, right? I think my guess is -- and I suspect there are people from CMS here at the moment -- CMS also is trying to work that through and then come up with a set of rules that both comport with the law and make sense from the perspective of moving this initiative ahead.

Our sense here is we could spend a lot of time, I think, trying to interpret what we think the legislation says, but I think our general sense should be -- and probably hopefully what would be more helpful to CMS in this regard, would be to say what we think makes sense in

terms of how this works, even if some of that, you know, rubs up against various interpretations of what the language is in the legislation.

DR. NERENZ: Then last clarifying question, I promise. Slide 14, the principles here suggest to me principles for new APMs or at least significantly revised, because these features are not currently true in general of either ACOs or medical homes or other things.

MR. GLASS: Yeah, I think that's correct.

DR. NERENZ: I just want to clarify again scope of our discussion, because I thought we were talking about sort of how do we logically connect current APMs to this eligibility, but this seems to be more about either new APMs or revised APMs. So how do you want us to think about this bit?

MR. GLASS: So this is more of a -- given the principles in the earlier slides where you have APMs that are a two-sided risk and for A and B and that sort of thing, these follow from those. So the entities should be given regulatory relief follows off of an APM at two-sided risk for all A and B spending. So these would be principles that we think would show up given what we've

laid out already.

DR. NERENZ: Okay, but, again, to clarify, are we to be talking about whether we like these principles as characteristics of yet-to-be-developed APMs?

MR. GLASS: All APMs are yet to be developed because there's no rules yet saying what an APM is.

DR. NERENZ: Well, but the MSSP exists. It's up and running right now.

MR. GLASS: Right

DR. NERENZ: And it does not have these features.

MR. GLASS: That's correct -- well, certain pieces of the MSSP would, the Track 2 and Track 3.

DR. CROSSON: Right, but --

DR. NERENZ: Shared savings to beneficiaries, is there?

MR. GLASS: Not yet.

DR. CROSSON: But if you remember how it's worded, if I remember this properly, in the legislation it does list existing payment models such as the payment models for various types of ACOs. But then at the end, it says "and other models to be developed."

MS. BLONIARZ: I guess I would say that maybe,

you know, for your discussion, when these incentive payments kick in in 2019, do you as the Commission want to have these principles apply to all APMs that qualify participants for the incentive payment? You could say yes or you could say no. You could say that's something that's aspirational or something in the future. But right now the state of play is some of the models have some features of this; none of them have all of them.

DR. MILLER: And just one other thing, because I hate to wade in in conversations like this. The other thing, sort of tossing out the notion that there are APMs out there now, but there has been no determination of which of those is eligible.

DR. NERENZ: I don't want to belabor this, but that's -- again, I'm just trying to know the focus of our discussion, because I thought largely what we were being asked to do here is to figure out the connection between current APMs and eligibility for the APM incentive system. This is saying, you know, something -- well, it seems to be saying something different, that we're saying how should APMs evolve or what new APMs should come up, and that's just a different discussion from saying how should the

current ones be linked to the incentive.

DR. MILLER: I don't agree and in the following way: I think there probably -- and I don't feel like I have a real strong handle on all these definitional issues, David. You know, we've had huge internal conversations. I'm surprised no one has resigned yet.

I think we're contemplating both of those things. There has to be -- okay. And I just want to say it out loud, and this is mainly for myself, then, if you're retired -- I mean, if you're find. But CMS has to figure out of whatever's out there is going to be eligible, and if anything new shows up, it's going to have to figure out if those are eligible. And I would go back to Jay's principles that I think the most useful thing you as a Commission can do is articulate -- and this is going to be complicated in and of itself, the vision you have for these things. And I thought he put it well. If it rubs up against either the regulations or the models, you know, then we'll have to deal with that. But I think it would help -- because I think the environment right now is incredibly unclear, and to the extent that any group of people can go, well, here is a path or a vision, that will

help to gel; even if people go, no, I disagree, at least they'll have a common point that they'll be talking about.

DR. NERENZ: And that's fine. If you say both these are fair game this morning, that's fine. Absolutely fine.

DR. CROSSON: This is indeed, David, the essence of our opportunity, I think.

DR. SAMITT: So thank you. It's my turn to be excited. This stuff is awesome.

[Laughter.]

DR. MILLER: This is really worrisome.

DR. SAMITT: Sorry.

[Laughter.]

DR. SAMITT: Right. Slide 4 again, if I may. Can you help me understand sort of the 5 percent additional payment for the revenue allocation? Let's go to your attestation versus attribution. If it's an attestation model and the APM beneficiaries are attested, is my 5 percent on the number of attesting beneficiaries? Or is it all of the members, patients that I care for, beneficiaries that I care for under Medicare?

MS. BLONIARZ: The way that it works is there's a

determination of whether a clinician has a certain share of their revenue in an eligible alternative payment entity -- that's like 25 percent in 2019 -- then if you meet that bar, you get 5 percent add-on on your billing for all of your patients. Your total Medicare revenue.

DR. SAMITT: Whether they are attested --

MS. BLONIARZ: Whether they are attested to you or not.

DR. SAMITT: If you go with an attestation model, it really doesn't matter.

MS. BLONIARZ: That's right. That's right.

DR. SAMITT: Okay. That's helpful. Then my second question also on this slide, why would we not consider MA revenues as counting toward sort of the percentage threshold? If you're in Atrius and you're taking, you know, capitated payments from an MA plan, why would that also not be counted toward whether you're an APM entity or not?

MS. BLONIARZ: So the very simple answer is that this is -- the way the law is written, it's only fee-for-service. The fee-for-service, your numerator is fee-for-service, your denominator is fee-for-service. MA plays no

role.

The nuance is that in later years -- so I think starting in 2021 -- there is an all-payer calculation versus a Medicare fee-for-service calculation. And in that calculation, MA could count as an alternative payment model to the extent that CMS determines that the type of arrangement between the MA plan and the clinician is like the eligible APM definition.

DR. SAMITT: And there's no flexibility in that regard because it's written in the law that way.

MS. BLONIARZ: That's right. The one other thing I will say is that MA -- the integration of MA into APMs or vice versa, CMS is supposed to do a study that I believe is due at the end of this year to figure out, you know, how they could be incorporated. So both the drafters and CMS are well aware of kind of these questions.

DR. SAMITT: Thank you.

DR. MILLER: Kate, should we do the -- MA gets paid by fee-for-service, and if people are in -- getting the adjustment in fee-for-service indirectly, it starts to get -- we should do that little patter, just to make it more complicated.

MS. BLONIARZ: Yeah. So the other thing I'll say is the MA benchmarks are based on fee-for-service. So to the extent that there are 5 percent incentive payments going out, you know, through the fee-for-service system, that will be in the MA benchmarks, kind of whatever the ambient level of, you know, APM participation is. So the money kind of flows through the fee-for-service benchmarks for MA. But that will take a little while to show up.

MR. GLASS: That's a slightly different question.

DR. SAMITT: So that's a revenue stream issue, but it's not whether I qualify as an APM --

MR. GLASS: Correct.

DR. REDBERG: Thank you for this very excellent chapter. We clearly have some interesting and important work, along with others, ahead. Just on the heroic assumptions, as you're willing to make some, on Slide 5, do you have a definition for "exceptional performance"?

MS. BLONIARZ: No. I think there's something in the law that says, you know, what groups it can apply to, but I think it just says -- you know what? Let me get back to you.

MR. GLASS: But that would probably be in

regulation. They'd have to define what that means.

DR. REDBERG: Okay. And we have no kind of hints about that? We're not going to make any heroic --

MR. GLASS: No, we're not going to.

DR. REDBERG: Okay.

DR. CROSSON: Scott.

MR. ARMSTRONG: Actually, Craig asked the very question I was going to ask, but I would make note that I've rarely seen Craig so excited.

[Laughter.]

DR. CROSSON: No comment. Jack.

DR. HOADLEY: So, my question's a little bit parallel to the questions you've had so far, but slightly different. On Slide 6, I'm looking at the time line and trying to understand sort of where our engagement is, and I'm particularly taking note that the proposed rule is listed here as spring, which isn't very far away, and so it sounds like what you're really doing -- and you've got to tell me if I'm understanding this right -- is trying to get sort of our thinking that will then allow you guys to write comments on the proposed rule, and then presumably later steps, but that actually could happen even almost before we

meet again, or at most -- and this would be separate -- I mean, we would presumably -- would we be doing this in a report chapter, as well, to sort of lay out where we stand, but the action step is more comments on the regs?

DR. MILLER: So, and we were talking about this this morning, so we were just waiting for who was going to ask, and we have a couple -- well, we've got some Bingo cards and so we're --

[Laughter.]

DR. MILLER: So, here's the way to think about it. For those of you who were around for the ACO process, think of that process. What the Commission did in ACO, and one of the services, I think, it provided at the time was everybody was using that term and nobody was 100 percent sure what it was, and so we wrote some stuff about what it would mean and then we wrote a letter before the regulations came out, sort of in principle, here's how we're thinking about things, and the regulations came out. And some of that first step stuff I mentioned, that went into chapters. Then we wrote a letter and then the regs came out. Then we wrote another letter, and I think there might have even been one beyond that. Maybe not, but I

can't remember.

But, my basic point to you is this. We're trying to get your thinking, as gelled as possible -- and it's going to be -- it's all going to be imperfect because this is a very new and unclear area -- which we can use to -- in comment letters. I see this also occurring in the chapter, just because of, like, some of the discussion here. What are we talking about? What are the three principles? Can we say anything about the relative incentives, that type of thing.

I see this still heading to a chapter somewhere, and at the same time having material from you guys to use in comment. We will be out of sync, because the regulatory process doesn't schedule around our meetings, and so we'll have to just kind of use what we have at any point in time, tell you guys what's going on. But I would see institutionalizing this in a chapter someplace so that it doesn't just become a letter phenomenon. Sorry.

MS. BLONIARZ: I wanted to get back to Rita. Exceptional performance in the statute actually has a definition. It's the top 25th percentile above the mean performance. So, that's who that additional funds are

available for.

DR. CROSSON: Bill Gradison.

MR. GRADISON: I have several questions. The language of the statute appears to indicate that if you have the required percentage of your professional service income from an eligible APM, you're in the program. So, the risk that is involved has to be the risk that you incur by being in that particular APM, in that entity.

Wouldn't that suggest that it has to be at least five percent, and probably more than five percent, because if it's four percent, why not go into it? The worst you can do is lose four and gain one. And, I just wonder, am I missing something? I'm not trying to judge what they're going to do, but am I missing something in terms of the moving parts?

MR. GLASS: Well, I think you're correct for the professional revenue part. If the -- so, the five percent refers to the clinicians' fee-for-service revenue.

MR. GRADISON: Yes.

MR. GLASS: You have to be careful, because sometimes people are also thinking about A and B risk, right, and then five percent of A and B risk would be a

much larger number than five percent of the professional services risk. So, depending on what the four percent you were talking about, you're absolutely correct. If it's four percent --

MR. GRADISON: It would be felt --

MR. GLASS: If it's its own, yeah, the person's own billing staff.

MR. GRADISON: In general, my understanding of medical homes -- and I know the definitions are not precise -- is that their focus is on primary care, not specialists. I don't mean they couldn't be eligible, but not specialists. If this is correct, what role might specialists -- would it work for a specialist to be part of a medical home type of APM, since it would be presumably very difficult for them to get up to 25 percent initially and then much higher from a particular medical home?

I have a related question in a second, but I'm going to try -- I'm really focused here now on primary versus specialists and the relative appeal or lack of appeal of even participating in these. I can see it, just thinking about it, more for a PCP than I can for certain kinds of specialists and I just wonder if you have any

thoughts about that.

MS. BLONIARZ: So, for the medical home provision, you know, there is a special provision in law that means that the risk above a nominal amount wouldn't apply if there's a medical home model that has been expanded by CMS. That actually hasn't happened, so at this point, it's academic to kind of talk about whether that would be an eligible APM. But, I think the -- I mean, the point is, sure, that medical homes would have -- you know, might have a -- might lean more towards primary care. I know in some of the models there is this concept of the medical neighborhood, which incorporates specialty care, as well. But, each of the models is going to be relatively attractive or not to different types of providers.

MR. GRADISON: Well, maybe let me pursue it this way. Do I understand that a PCP can only participate in one particular model in terms of, in other words, a 25 or 50 or 75 percent, or can a person be in multiple?

MS. BLONIARZ: A person -- a clinician can be in multiple models. I mean, CMS in its administration of the models does sometimes have rules on overlap, both for clinicians and for beneficiaries, but they've set out their

own rules on how that works. And there's nothing in this law that prevents a clinician from being in multiple models.

MR. GRADISON: And this is a final thing. With regard -- and I'm just using ACOs as an example. In a two-sided ACO, how long after the end of a calendar year is a determination made about whether there are savings or not savings and how they are distributed?

MR. GLASS: I think it's, like, six months after the end of the year.

MR. GRADISON: The reason I mention that is we've got a situation here where I'm a provider. I join one or more of these. I immediately get the five percent. But I presume that if, at the end of the day, when the numbers are totaled up, particularly with regard to the -- let's say I don't hit the -- I'm 24 percent. Is there a take-back? wouldn't there have to be a take-back, because you didn't qualify in the end. You didn't know you didn't qualify until the end of the year, but you were getting paid in anticipating of hitting the 25 percent, right?

MR. GLASS: No. I think the pay is actually --

MS. BLONIARZ: Yeah.

MR. GLASS: You get it this year looking at last year's --

MR. GRADISON: Oh --

MR. GLASS: -- situation.

MR. GRADISON: Oh. The first year, then, that doesn't work.

MS. BLONIARZ: So, the --

MR. GLASS: Right. So, 2019 is the first year, so 2018 would be --

MS. BLONIARZ: And I think that's why we think 2018 is probably going to be a key year for assessing whether clinicians meet the 25 percent threshold.

MR. GRADISON: Thank you. That's very helpful.

DR. CROSSON: Bill, let me just add one thing. You know, in addition to the issue you brought up about medical homes, there is an issue that I think many specialty physicians have with respect to the whole ACO movement in a sense that not all, but many ACOs are primary care Accountable Care Organizations. There are some that are multi-specialty. But, I think there is a sense in the specialty community that, you know, as this moves forward, maybe there is not a space or a natural obvious space for

specialty physicians with respect to alternative payment models.

So, my understanding, and the common belief, at least, is that that was the reason in the law why this new commission, I think it's Physician Payment Advisory Commission, was created. And while I assume that commission can do what it feels like, I think that a lot of the energy behind that and within that commission is going to be focused on this issue.

MR. GRADISON: That's helpful. Then my concern is not misplaced about the relative incentives of PCPs versus certain kinds of specialty. Thank you.

DR. MILLER: [Off microphone.] I also think a question for this Commission is, you know, at the extreme, what are you trying to do with this? So, in some ways, at least your initial comments and discussion were sort of, you know, it should be about A-B. It should be about a population type of thing around the patient.

And then to the extent that -- let's just for the moment use an ACO as the example as at least something identifiable out on the environment -- if an ACO came together, even in a multi-specialty type of thing, but

said, you know, I don't necessarily need every specialist in the community, I'm going to focus in on certain specialists, is that an outcome that is a problem or not? And I think that's a principle you as a Commission will have to think about.

MR. GRADISON: I think that there's a larger, in my view, a larger aspect of this, too. There may be parts of the country where you just can't get any of these started, because -- certain states come to my mind, just by the virtue of the geography of them and, frankly, the hostility to managed care and some of these entities, as well. So, I can certainly envision, from the point of view of a physician, let's say, that would like to participate, that, first of all, they've got to make sure there's a group. Yeah, you could say, well, they've got to form one, but that's not the easiest thing in the world to do. But, first, there may not be one, or there may be well one or more and their panels are already filled.

So, the sense that this is a true choice, I can choose whether I want to be in one of these or go under the MIPS, may in practice not really turn out to be, in many cases, a true choice, because you may not have the opening

or the option, at least in the short run, to participate in an APM.

DR. CROSSON: Rita. No, not Rita? I had Rita. Did I miss anybody? Alice.

DR. COOMBS: I just had one question, Jay. Thinking about the specialists, there are large, large groups of different specialties that actually dominate geographic regions, and it might be problematic when we think about these principles to exclude the fact that some large groups might want to consider themselves an APM and not be primary care-based. And I'm wondering if it would be important for us to consider these principles with that in mind.

Some areas I'm thinking of are ENT in the Northeast Corridor, also nephrology, for which that impacts beneficiary access. Many of the ACOs might not include a nephrologist and they may have large groups in certain areas, or they may have limited workforce whereby the pulmonologists come together in a certain state or a certain region. And I'm wondering if we are thinking about -- when we think about those principles, are we applying those to if they're not primary care-based.

DR. CROSSON: That's a very excellent question, and I think it gets -- it will get into our discussion, which will begin today but will go on, about this set of principles that Kate and David have brought forward.

For example, if, in fact, we do believe, as Mark said, that the right direction here eventually is for assumption for -- here we go -- alternative payment models to be constructed in such a way that they incent entities to accept long-term population-based risk for Parts A and Part B, at least, it does raise the question of how a single specialty group of orthopedists or whatever can manage population risk over time, because as you are quite aware, they're seeing patients for a relatively narrow slice of the care of those patients over time.

Now, they could become incorporated, either formally or informally, into some other entity that is capable of accepting that risk, or, essentially -- and this is, I think, my guess is, one of the issues that this other commission is looking at -- be carved out into a separate set of constructions about alternative payment models. But, that's yet to be determined and is still work to be done and may in the end not be possible.

DR. MILLER: [Off microphone.] And just think of the complication those kinds of things create. If you're saying, I really want you to take accountability for A, B, you know, for the whole perspective -- and I should probably stop saying A, B, and eventually have got to start talking about drugs, too -- then there's a slice of this experience, somebody, you know, has a cancer episode or has a surgical episode or something, and then that's pulled out and dealt with under a different model, are you going to adjust the overall model, because at that point, then, how you're rewarding and penalizing becomes influenced by what happened in the other episode if you leave it in. But if you take it out, you have a huge administrative complexity of trying to attribute between things, and I would feel very sorry for the CMS folks trying to work through that. And that's a very difficult complication that comes.

DR. CROSSON: I'd just like the record to show that I did not say Part D. You said it. I just said, at least Part A and Part B.

MR. GLASS: Actually, one example, Alice, at the moment is the ESRD ACOs, which are, you know, nephrologists and the dialysis centers, and they are taking

responsibility for all A and B spending.

DR. CROSSON: Clarifying questions. Kathy.

MS. BUTO: I was just going to comment on that point that you and Mark just made, that why not have specialty-based APMs, because, you know, say a cardiology-pulmonology-hematology kind of practice, or dealing with people of primary cardiac issues but also ongoing management that involves obviously primary care, but those physicians are capable of that. The same thing for diabetes. If you really want to do chronic care management, sort of an endocrinology-based sort of practice. I don't actually think that necessarily is a bad thing, so -- and, obviously, they'll define it, but I can imagine those kinds of practices getting together and springing up and doing better continuity of care.

DR. CROSSON: Yeah. And, I don't disagree with you. A lot of it depends -- we're getting into definitions again -- by what you mean by an alternative payment model. Bundled payments, for example, and bundled payments could be condition-based, which would in many cases relate to a certain specialty, that's an alternative payment model, and an entity could be created to qualify for an alternative

payment model.

So, you know, even with the existing models that we have, but I think we also have -- and this is part of where we need to go -- we also have this kind of, and David called it aspirational kind of idea here, that maybe some of these models are transitional, and ultimately -- because that, for example, doesn't get you to full care coordination, right -- maybe these are important and time limited, but we still have this other question and set of principles to answer.

DR. MILLER: [Off microphone.] And the only other thing I would say to that is I didn't mean to imply that there were, earlier in my examples, only models that would then not necessarily contemplate all of the specialists.

To Alice's point and to David's response, well, by the way, the nephrologists, in a sense, or ESRD, have agreed to take risk for A-B, or at least A-B -- new vocabulary --

[Laughter.]

DR. MILLER: -- and if your example was -- if the Commission came to a principle of, well, we kind of want

comprehensive, and your example was, and the cardiologist says, yeah, I'll do that, my patient has a congestive heart failure, it kind of defines their medical experience and I want to take, you know, the risk for -- then maybe that fits right into the principles and it's not an issue. I was more worried about the carve-out nature and the complexity that that starts.

DR. CROSSON: Okay. All right. Good. Thanks.

David.

DR. NERENZ: Still clarifying.

On the bottom of page 3, this last discussion prompts this. The language here about participants sounds like this decision is made on the individual clinician basis. So, for example, in a multispecialty group practice, some may qualify and some not; is that correct?

MS. BLONIARZ: That's right. Actually, you know, it's going to depend on how "eligible professional" is defined. I think there's probably -- it may actually trigger off how the provider bills Medicare.

DR. CROSSON: As you say, "eligible professional" is defined as an individual or a group of -- as a professionals or group of professionals.

DR. CROSSON: Thank you. I didn't see language, so I just wanted to clarify.

DR. REDBERG: Jay, you were right. I did have another questions.

[Laughter.]

DR. CROSSON: Well, okay. I think --

DR. REDBERG: It's very tiny.

DR. CROSSON: Warner is giving you the go-ahead.

DR. REDBERG: The covered professional services in participants, I assume that's just Medicare-covered professional services?

MS. BLONIARZ: Yeah. You can just think of that as Medicare Part B billing. That's right.

For the Medicare, there's a Medicare threshold, and then there's this all-payer threshold, but we're just -- right now, we're just talking about the Medicare threshold.

DR. CROSSON: Okay. Warner.

MR. THOMAS: What is the current criteria as far as specialty orientation under the existing MSSP and ACO models? I mean, do they have to be? Can they be single specialty oriented? Do they have to be multispecialty? Is

it silent?

MR. GLASS: Well, on the ACOs, because the attribution is based off of essentially primary care services, it would be odd to have one without lots of primary care physicians because that's how the people end up in these, how the beneficiaries end up in these.

MR. THOMAS: And I guess going into some of the comments on having kind of single specialty orientation, how would you see that working? I mean, could you -- because, essentially, you cannot have a member in more than one mechanism, I wouldn't think.

MS. BLONIARZ: You can. Currently, CMS does have models where beneficiaries are in both. They have some where they are only in one, and I think the shorthand is to think about it that if you're in a model that's taking responsibility for all A and B services for a period of time, generally you can't be in another model that also does that.

MR. THOMAS: Right.

MS. BLONIARZ: So the ESRD ACOs, those beneficiaries can't also be in another ACO-type model.

MR. THOMAS: And is there -- I mean, I guess

somebody could be in, say, a cancer kind of global payment model and then also in an ACO that looked at the global payments for the entire situation.

MS. BLONIARZ: We'd have to look. I mean, CMS has so many models under the CMMI portfolio, and they have rules for every single arrangement, every single combination, and I don't know about the cancer bundle demonstration.

MR. THOMAS: It would seem as though, you know, that most of these are actually built around primary care, though; is that correct?

MR. GLASS: I think the ACOs, you can safely say that.

DR. CROSSON: Currently, they are.

But you point out, Warner, I suspect --

MR. THOMAS: I mean, I'm not advocating going to special specialty because I personally believe a multispecialty approach is a more practical way to handle it. I just think if you're in a situation where you have people in -- I just don't see how you can be in multiple types of entities and really account for this appropriately.

DR. CROSSON: Well, you're right. There are two conundrums here. Can a beneficiary be cared for under more than one alternative payment model? Because it's the beneficiary that then triggers the physician's eligibility for the payment. And can the physician or group of physicians be under more than one alternative payment model and/or working in more than one alternative payment entity? And I think these are some of the conundrums that we currently have as we try to interpret what's in the law.

MR. THOMAS: And just one other question. So I know under many of the current models, it's pretty limiting as to what type of interaction you can have with the patients around the fact that they're in these models, they're not in these models. I mean, do you -- I mean, as you look at these regulations, as we think about going forward, do you see that as being relaxed? Do you see that being that providers should be having it, or is it contemplated in the regulations or in the law that there should be more interaction from a provider perspective to engage patients?

MR. GLASS: I think that goes very much to how you end up defining these things because if there's very

little engagement, it's all passive, then there's probably not going to be much communication. And if you make it more coherent and cohesive over the whole spectrum of services, then you could -- as we say, you could have them. In fact, you can give them incentives for staying within the ACO, for example.

MS. BLONIARZ: And I think it also -- that question also implicates kind of involving beneficiaries more in the APM. Some of the regulations that we were thinking about that could be lucent were things that are designed to combat overuse, so SNF three-day rule and things like that, but there are also regulations about beneficiary inducement. And we just would have to think through what does that mean that an ATM could deal with the beneficiary, what kinds of inducements would we worry about in that situation.

DR. MILLER: Drawing from our older principles on ACOs, which may not be the only model here, what we said was if you're willing to accept two-sided risk, the regulatory burden definitely starts to fall away as much as possible without implicating gaming, and to David's point, just to amplify to make sure that other people didn't miss

it, in that context we also said incentives for engaging the beneficiary, such as forgiving their copayment. So, again, I don't know where you were headed, but some of that has been contemplated, at least previously, and you could import as you see fit.

The other thing, back to your specialty point, you're definitely right that the current circumstances is that enrollment or attribution gets pulled through primary care, and what the specialist said -- and we spoke to this in some of our ACO work -- is they said, "Because I'm not the driver in this ACO, I want to be sure that I can participate in multiple ACOs," and sort of some ways the specialty looked at the environment was "Well, if there's these pods of activity, I'll be working off of them that way." And that's another way you can think about it, or the reverse, which came out of Alice, Kathy kind of set of comments of "Well, I'm a specialist, but I'm willing to take the A/B on," and you could sort of think about those are not necessarily mutually exclusive.

DR. CROSSON: Okay. Now we are going to get into the comments area. We've got Alice and Bill Gradison. Sorry, Craig. All right. Just one second -- are going to

lead off, but I want to make a few comments first.

First, Jack, did we answer this? In terms of the timeline, I think what we're viewing this as continuous. So to the extent that we arrive at some conclusions, then a letter, comment on the draft regulations when they come up, probably continued work in the spring and in the fall as this area evolves.

I think we can tell already from the excitement that exists on the Commission and also the discussion so far that we have both an important issue and an extremely complicated one. I hope that in the end of this process, we can get to the level of clarity that Carol got in her presentation of an equally complicated area.

But I think this is also an important opportunity for this Commission. We have a long history here of working on delivery system and payment reform because we believe -- and if you may remember, we've talked about this in our sessions as late as last July -- that, ultimately, I think we see the success of the Medicare program and improving quality and containing cost tied in with both delivery system and payment reform.

The ACO concept itself came out of deliberations

here at this Commission, well before it was put into legislation. So I think, as Mark said, we have principles that are relevant to ACOs. They may or may not be the same ones that we evolve here in this work, but I think we have an opportunity and an obligation even to try to help at least CMS and potentially down the line even the Congress as it begins to think about maybe the next iteration of this work.

Having said that, there is a little inherent -- there are multiple levels actually of tension within this body of work. One of them, though, I think it's important to keep in mind is, what do we think we want to happen? This is about physician payment for the most part. Do we want to see physician payment evolve over time away from fee-for-service into some other set of models of payment that create incentives for improving quality and managing costs for both the Medicare program and the beneficiaries? And I think the answer is yes.

As it applies to alternative payment models and the creation of alternative payment entities, you have to think about whether or not the best direction is a relatively narrow direction where you end up with a

relatively constrained set of payment entities that are really ready for these payment models and perform well on them and are successful and in fact prove the point, or another potential model -- take the other extreme -- a much broader set of alternative payment models which, to get to Bill Gradison's point earlier, many if not most clinicians could find themselves at least on the first rung of that ladder eventually moving up. And so, as we look back 10 years from now, we say, well, a large majority of American physicians have transformed their practices, and we have transformed the way they're paid, and we have moved large numbers of physicians along this continuum.

Now, I am not saying that we have to choose between the ends of that dichotomy, but I think in formulating our principles, we need to think about that and. as we get into this discussion, decide as a Commission sort of where along that continuum this ought to be directed as opposed to necessarily where the current payment models and organizations are directed or even potentially our interpretation of the intent of this particular piece of legislation. And that's a big bite.

I think something like that should inform our

thinking as we go through this process, which is much more than the next hour here at the meeting, but what I would like to do for the next hour, he says bravely, is to focus on page 12, slide 12, the draft principles, and let's have a discussion, starting with Alice and Bill Gradison, of what we think about these principles. And to the extent that we're going to communicate initially with CMS, which, if any, of these principles should be incorporated into that communication? Okay?

DR. COOMBS: Thank you very much.

And so I'll start with the premise that most care occurs not inside the hospital, even though I'm a hospital-based physician, and I think the goals of physician payments should be centered around maintaining a healthy out-of-the-hospital existence.

So that being said, for APMs, I am thinking about how we can transition or move physicians from the current fee-for-service in a manner that seems almost seamless into APMs. So the incentive is important, but I was thinking about the infrastructure. And this is the same thing that we dealt with, with global payment in Massachusetts, is that a lot of the providers wanted to come together and

form ACOs, but they needed the how-to, and they needed some infrastructure development. How much of that infrastructure is IT? If they're already tied into an IT system, then it makes it very easy for them to transition to an integrated system.

It does make a difference whether a group of physicians are aligned with a robust hospital system and they have to have the IT system that goes with the hospital. Epic, as you know, is coming into our hospital and many of the hospitals in the Northeast. It's quite expensive, and any of the IT systems are expensive. So I think the up-front incentive is important for groups of physicians, especially in certain geographic regions.

In terms of the draft principles, I agree with most of the draft principles. The problem I have is the nominal risk definition, and the nominal risk could be what it takes for the lift to get into the APM, whatever that lift is. So who bears out the nominal risk, and how is it that providers are going to come together so that they can actually say that "I want to be a part of this APM"?

I know that in our state, the one model we had is not one-size-fits-all. So when we do the guiding

principles, I think that one thing that is important is imagine it for a group of seven with the covered lives as defined as much as a group of -- a multispecialty group of 200-plus people or whatever. So that's one of the things that I think is really important is that not to think of this as just the generic group that has every single specialty in it, and that's why I thought about this whole notion of there are other specialties that take over. Especially in nephrology and end-stage renal disease, I think that's really important.

And so the nominal risk has got to be the incentive. Whatever way can be packaged to help the smaller group doctors, I think that's really important.

And then looking at condition-based, possibly condition-based entities that care for patients like emphysema, there is one person I know in New Mexico who has a cancer ACO, and she takes care of all of the issues that pertain to her patients, and she assumes the responsibility for them. And she is in the CMMI project. So I think that it's important to understand that there are innovative ways in which people and certain regions can take care of patients outside of what we normally see in terms of a

primary care-based entity. So I think the geographic differences are really important, and we should take that into consideration as well.

I agree with the draft principles on performance as well.

In terms of assignment attribution and how we go about with attestation, how we count who is under whose purview, when you get to specialty groups, it becomes very difficult I think because there is involvement with other specialists, and I do have a problem in that sometimes in specialty groups, they tend to consult a lot more outside of their purview. And it may be the comfort level with some of the other issues. The dialysis patients are many diabetics and severe hypertensive as well, so they may be more likely to get outside consults. That can be problematic. So those are the issues that I see that are important.

I think going forward, we have to begin to reward high-value, low-cost services, and APM does it, such as end-of-life discussions, shared decision-making around intubations and resuscitation. I will actually on the first day in the ICU actually go to the patient's family.

I will meet them the first time to better understand where's their reference point. The second day, I am coming in talking to them about "These are the things that are going on. You've got five organs that are failing," and the next time I speak with them, we're talking about shared decision-making around end-of-life care, whether or not they would want aggressive measures. And I could very well go seven days without talking to the patient about anything, keeping them on the ventilator, on pressors, and doing everything, but I think this whole notion of putting the time in early to say does this patient want this and talking to them about resuscitative measures, that actually does more -- that has more value to that family, to that patient, and it doesn't get paid for in the sense that you're not putting in a PA line or anything. But the big picture is it's better care, and it probably has more value than some of the things that we do that has more -- we see medical intervention. So I think that the APMs do that, and they should do that. I think that's important.

And then the last thing is the whole notion of virtual APMs. I think there is a role for us to consider virtual in all of the consideration for guiding principles.

I don't see anything that directly -- I mean, maybe someone else does -- that would counter any of that, except the covered lives might be problematic. I think the covered lives, you could aggregate them over geographic regions or over a series of groups.

DR. CROSSON: Thank you, Alice.

I think one of the major takeaways you're saying is you would advocate for broader access for physicians to alternative payment models.

Jon has pointed out to me that I was somewhat cavalier when I said an hour. We have, in fact, by the schedule 15 minutes left, which is going to be inadequate for this discussion. But let's do the best we can.

MR. GRADISON: I can help with the timing since I, as artfully as possible, worked in most of my questions under Round 1.

[Laughter.]

MR. GRADISON: But having said that, I'm struck by the continued dominance of fee-for-service, even as I understand it in entities which themselves are at risk, and I'm talking about ACOs and hospital-employed physicians and a fair amount of managed care, too, as far as I understand

it. Certainly the incentives for volume haven't gone away as new doctors are brought on board by hospitals and work out some kind of a salary arrangement. And the reason I mention this is that the way I view this overall is it's an attempt to sort of jump-start a movement in the direction of risk taking from a group which I don't think is very thrilled about taking financial risk and has shown it by their actual practice in the face of efforts at least to nudge them in this direction.

Having said that, I wish I had a better understanding of the motivation of physicians in terms of what might move them in this direction. The assumption here is that the money will move them. And maybe it's that simple, but I'm not too sure about that.

In terms of the specifics, to be a little more specific -- and I just have one more point -- I think as we move forward in trying to analyze this -- and part of it's in the paper. I'm not saying it hasn't been touched at all. But it's to get a clearer idea of what is the real choice a physician faces. I mean, we've talked about what the APM -- even though we're not, you know, and won't for

some time be real clear what they are, but in general, we have an idea about them. And we have some indication from two-sided ACOs, what they'll probably -- something like what they'll look like. But the MIPS is something else again, and I think that there may be opportunities for further analysis of just what -- and maybe some focus groups or something, or talking to the professional groups that represent various specialties or various parts of medicine to try to get a sense of how will physicians look at the choice which this statute provides between two different mechanisms. It isn't just the APMs.

Now, I think in some of the discussion -- I don't mean our discussion but some of the discussion that I've read about and participate in -- the assumption is, well, you know, only the laggards, the people who stand for the status quo are going to go for the MIPS. I think it's a hell of a lot more complicated than that. And as I pointed out earlier, it may be a challenge to provide enough opportunities in APMs, at least initially, even for those who want to go into it.

So those are my main -- my main thought is I think we need to maybe, if we can, monitor the MIPS -- and

you'll probably do this anyway, but monitor the MIPS part just as closely as we monitor the APM part as the comments come in and draft regulations and all that.

Thank you.

DR. CROSSON: Thank you, Bill. I'm going to ask for -- so aim your comments at those principles, if you can.

DR. SAMITT: Let me talk about principles first. So the last one, an entity must assume risk, I would argue, if the intent here is to really see some significant behavior shifts to value, that it can't just be nominal risk. It needs to be sufficient risk. And so what I'm worried about is that there's the potential here that we're just going to pay 5 percent more for no change, unless the risk is substantive enough to really drive alternative practice linked to alternative payment. So we don't talk a lot about that, and so that would be a piece that I would think should be a principle that we should underscore. We don't talk about amount of risk, but I think it has to be sufficient.

DR. CROSSON: I'm sorry, Craig. But that principle, part of the principle you just elucidated, that

payment is a function of performance, which is different really from what's in the law, is in number one.

DR. SAMITT: Yes.

DR. CROSSON: But the degree of payment is a second issue.

DR. SAMITT: Yes, that's what I'm trying to reference. The second principle a lot of people have referenced. I also agree with a more broader leeway regarding who can accept risk. So, yes, we predominantly focus on primary care, but whether it's ESCOs or whether it's cancer ACO or even the consideration of bundled payment, if there's risk associated with it, it feels to me that we want to move people in the direction of performance-based reimbursement and that we should be free. And so it may challenge the third bullet, that the entity must be at risk for Part A and Part B, because there may be some sub-risk that we think should count toward APM -- again, as long as there is sufficient amount of risk for the entities taking risk. So that would be the second principle that I would underscore.

And then the third is -- it's sort of alluded to, because I would imagine that we're going to see people who

will want to move from MIPS to APMs, that there really needs to be a lot of consistency and measurement expectations, reporting requirements, to sort of allow the freedom to somewhat simply move from one to the other as the organization is climbing a higher run on the ladder.

Just quickly, I believe in the attribution, not the attestation. We've talked about that in prior meetings, I think in other -- as it relates to ACOs.

And then you know where I'll fall out in terms of the definition of risk. I don't think investment risk is sufficient. I think it does need to be the difference between actual and expected spending for the reasons I underscored earlier.

DR. CROSSON: Thank you. Very clear.

MS. BUTO: I think Principle 1, incentive payment for participants only if the entity's successful in controlling cost, improving quality, or both, is a critical principle. And I actually would come down in favor of let's keep the initial round and definition tight, and actually demand a track record before we qualify something as an alternative payment mechanism, because once you open this up, you can't close it down. You cannot walk it back.

And so I would say start with a good track record. We're talking about, you know, paying a lot more money, 5 percent more, and if the definition is too loose and too many entities get into it, you can never walk it back, and you'll be just adding to the expenditures, is my view.

So I would start with -- I don't know what the quality and cost parameters would be, but I would just start with the notion that let's get a good track record and then allow that. Okay, so that's just on the principles.

The second one is the Commission has talked about per beneficiary primary care payments, sort of, if you will, a bundled capitated payment for primary care. And so one of the things I hope is that any alternative payment mechanism definitions that evolve will allow for that kind of arrangement within the entity. We might even want to say you get an extra point if you have some of that kind of risk, back to Craig's point, as opposed to just, you know, are you willing to come up against some kind of a threshold of spending over last year kind of thing.

So I don't know how that would work out, but I just want to make sure that our other interests in

increasing payment and accountability at the level of primary care doesn't get lost in this other calculation and structure and that we allow for that to come into this.

DR. CROSSON: I just want to do a check here because I may have missed something, but I have Rita, Herb, Jack, and Warner. Is that correct? And Mary. Sorry. Did I say anybody who hadn't raised their hand? Jack's looking stunned. Okay.

DR REDBERG: Thanks. First, I want to say now that we're in Round 2 that I'm very excited about this as well.

[Laughter.]

DR. REDBERG: And really because, you know, for many years, many of my colleagues, when we talk about health care, have said that we really need to get rid of fee-for-service to make real progress and improvement in our health system. And, you know, the Secretary's goals and the alternative payment models I think give us that opportunity, because fee-for-service really just rewards high volume, not high value. You know, as we know, we get paid well for doing unnecessary, even harmful procedures, and the same is for doing beneficial and life-saving

procedures. And so I think there's tremendous opportunity here.

I think really since SGR clearly wasn't working, you know, more than 10 years ago, we -- you know, so I don't think that we're rushing. I think this has clearly been a long time in coming, and, therefore, I endorse all of the draft principles and think, you know, this is our time to be bold and try to achieve real system transformation, because we really are at a point when we're all concerned about, you know, the future of Medicare, the solvency of the trust fund, and there's an opportunity, I think, to do really good things for the program and for beneficiaries.

And so I would -- you know, I agree with what Kathy and Craig have already stated in detail. You know, certainly in terms of the risk in excess of a nominal amount, I think we have to go for the difference between actual and expected spending, because to really see a difference we have to put something at risk. You know, I think we could have -- we've learned from what we've done in the past, but we shouldn't repeat those mistakes.

DR. CROSSON: Thank you.

MR. KUHN: So, quickly, just two thoughts.

One, all the principles I think make sense for all the reasons cited, so I won't go through those again. I just wanted to touch base on the broader access issue, and for two reasons. One is when we kind of go through our payment systems, as we did in December and then here, you know, whether we look at MA plans or home health or SNF or others, we talk about how many are in a community. We say 99 percent of the zip codes have access to one, and 95 percent have access to three, or whatever. I really would want us to really bear up on this principle of broader access to make sure that we have the maximum opportunity from the beneficiary side -- because we're really talking about the provider entity, but let's really think pretty hard about the beneficiary side. And then to reinforce that, you know, when you look at the paper and on page 24 where there's the appendix with additional information about various risk models that are out there -- and I don't know if this is all inclusive but, you know, just some rough math there. There's only about 2 million beneficiaries in these entities now.

So if you look at this -- you know, if you really

take the MSSP Track 2 and not all ACOs but just the Track 2, you know, it's a limited set. So I do want us to think a little bit broader.

And then the second thought is, as we move into these entities -- and I don't know if they can be captured in these principles or this is something that's outside them -- is that ultimately there probably will be accrediting organizations that will be looking at these entities and determining whether they meet or not. And there have been times in the past where accrediting agencies have disagreed with CMS and don't accredit an entity, and then it creates problems with getting them in the game, so to speak. So some way to think about harmonization between accrediting agencies and where CMS goes on this I think would be important as part of the principles, too.

DR. CROSSON: Thank you. Those are good and two new perspectives, important perspectives.

DR. HOADLEY: So I want to engage on two of these principles. One is the at-risk aspects, and I mean, I certainly agree that too little risk tends to create situations where there's no real impact on behavior. We've

all seen examples of, you know, physicians are in some situation where they get a bonus, but they don't even know what the bonus relates too. It's too small, it just falls somewhere in the accounting.

The flip side of it is, you know, if more risk is to be assumed and we want to create this with an adequate amount of risk, and especially the downstream risk for a larger set of services like hospitalizations, you know, what's the right set of structuring of that risk? What's the right set of protections that goes with that risk?

One of the things I tried to think about, I think about the discussions many years ago of provider-sponsored organizations who were going to take capitation for everything, and there the enrollees, the beneficiaries, were potentially at significant insurance risk if their coverage suddenly wasn't there anymore if the PSO goes under. I don't think we're in that situation, but I do want us to make sure to think about are there scenarios where the beneficiaries could be harmed, are there situations where the way risk is structured that, you know, you say, okay, at the end of the term you've got to -- you owe a bunch of money back.

There was an alternate model that was discussed in the paper which seemed interesting because it didn't necessarily involve that paying back. It was more advance pay, you know, different kinds of things, and I think maybe looking at some of the models by which risk can be structured so it puts plenty of money on the line but it doesn't do it in a way that's going to get complicated in terms of physicians owing money back and are there then implications for beneficiary services.

The other one I wanted to talk about was the engagement with beneficiaries more generally, and I think, like a couple of others have said, I think, you know, the notion of attribution probably is going to work better than some kind of enrollment or attestation model. We've had that discussion around the ACOs. You know, how do you educate beneficiaries to make them understand what this thing is?

On the other hand, if you really want to engage the beneficiaries, we are going to have to think about educating a beneficiary. This is not going to be obvious to a beneficiary what this is about. You know, there's a discussion in the paper about opt-outs. We've seen in some

of the dual demos, you know, very high levels of opt-out. You know, normally we thought opt-out is a way most people get engaged. It's a lot harder to get people to opt in than opt out. But there was a lot of opt-out in the dual demos, sometimes for confusion, sometimes provider-driven. So I think, you know, figuring out how to educate the beneficiaries on what these will mean for them -- and I don't -- you know, I would have a tough time right now sort of walking down that logic, but I haven't spent a lot of time thinking about it. But how do you explain to them -- I mean, we can do it in broad generalities. This is about, you know, aligning your care better and thinking about the whole course of care and not just about individual services. But what is it really going to mean to you? You know, what does it mean in terms of if we're going to engage with some kind of financial incentives? You know, what would those be? How do you make sure to understand them? What does it to cost sharing that's based on a percentage of fees if there's bonuses or reductions? Does that somehow adjust cost sharing? I think there's just a bunch of issues; we need to make sure we think of them.

DR. CROSSON: Thank you, Jack. Again, important

beneficiary perspective to take in.

MR. THOMAS: So I'll preface my first comment with I understand this is very complicated, but I think one of our first principles should be to try to simplify this, because it's very complicated for providers to try to understand what path to take and how to play in these situations. So I understand that's probably heroic, to use your term, a heroic effort. But I think it's an important one from a principle perspective because we want providers to engage in this, and I think there's a lot of aversion because folks don't understand it and they're not sure kind of where to play and where not to play. So I would use that as the first one.

The second piece -- and I agree with Craig, I think there has to be a significant amount of risk here in order to earn the dollars. With that being said, I think we also need to be thoughtful about what is the path to that. You know, if you think about things today, you probably have maybe 25 to 30 percent of providers that are trying to lean in and work on these new payment systems, and they'll continue to go down this road. The question is: How do we get the next 30 percent to opt in? And if

there's not some sort of path or transition, if they just have to step in day one and take, you know, significant downside risk, they're probably not going to play, even with the 5 percent.

So I would encourage us to be thoughtful about how do we move the 25 to 30 percent kind of into the downside risk and how do we get the next group to play, understanding that, you know, if they ultimately want the 5 percent, they've got to have the risk.

The final piece, and maybe it's under the regulatory relief component, but this idea of being able to engage with the beneficiary in an appropriate way and to have the right dialogue with them around things like -- I know this may be a bad thing, but health risk assessments and having the right interaction around preventative types of measures is, I think, a really important component to make sure that we can generate the savings opportunities. And if there's not the right interaction with beneficiaries, that's going to be a challenge. So I appreciate the opportunity.

DR. CROSSON: Thank you. Good points as well.

On this, David?

DR. NERENZ: I think as we go forward -- and I agree with those points -- it's going to be important to clarify are we talking about the entity having risk or the provider having risk. That's not the same thing, because you can be a provider and you can be part of an entity but you have no risk whatsoever. So I think we just need to be clear as a group as this goes forward which one of those two things do we want to require.

DR. CROSSON: Warner, do you want to comment?

MR. THOMAS: Yeah. David, I think that's a good point. I guess the mental model I have on this is you likely have -- I mean, if you have an entity that has risk, say that they have a negative pool of $1 million, that's going to somehow -- that entity has to decide how that's going to get pushed down to the providers, whether it be hospitals or physicians, and maybe that is guidance that should be in here, but I think that's probably what ends up happening, is you're going to have an entity that takes whatever upside or downside, and there's going to have to be a distribution mechanism with that entity as to how they play.

DR. NERENZ: Well, just to sharpen the point a little bit, I agree, but since this is only about physicians, you can have a hospital-led ACO, the hospital can be the at-risk entity, the physicians can sign contracts that do not put them under any risk. They get the 5 percent. They themselves bear no risk. We just have to decide. Is that okay or not okay?

DR. CROSSON: I completely agree with both of you that, A, it's complicated, but B, Warner's point is that if, in fact, most of this five percent is going to flow through the entity, then, in fact, you know, unless the entity has got somewhere else to come up with the money, if there's a downside, or another place to come up with the money to pay the individual eligible professionals, it pretty much should line up that the entity that's bearing risk will transfer that risk more or less one-to-one to the eligible professionals. But, as you say, David, it depends a lot on the nature of that entity and the governance process and the role of physicians, particularly with respect to hospitals.

DR. NERENZ: I assume that the five percent we're talking about here flows directly from CMS to the

providers. It has nothing to do with the entity.

MR. GLASS: Yes, the five percent does, yes.

DR. NERENZ: As written in -- as the law states now, I mean --

MR. GLASS: Yes.

DR. CROSSON: But, the eligibility -- here's the question. But, the eligibility for the five percent, we are positing, should be a focus of whether or not the entity actually meets the performance standards or goals in terms of quality and cost.

MR. GLASS: Just different point.

DR. CROSSON: And, Mary.

DR. NAYLOR: So, David, it's not only about physicians.

[Laughter.]

DR. NAYLOR: Someday, I'll become excited when we all get that.

[Laughter.]

DR. NERENZ: I'm sorry.

DR. NAYLOR: No, no, no, it's to all of us.

I want to build on Kathy's point and wonder whether or not a principle, since the selection of the

models is going to be so important, whether or not there should be a principle that there is a strong, rigorous evidence base in the selection at least of the initial models that are going to be part of this, that enable the creation of the entities.

On beneficiaries, first of all, I support these principles, but I wonder if even the language should be changed to suggest that beneficiaries should participate, not can, to be aligned with our principles as a Commission that beneficiaries are a central focal point of these changes. And, I would really encourage thinking about spending -- defining quality in the context of, on the second one, quality as defined by those performance metrics that matter to the beneficiaries. As we think about specialists and all of the other models, we really need to be putting the attention on care continuity, coordination, the things that matter to a beneficiary.

So, those are my recommendations.

DR. CROSSON: Thank you. Excellent point again.

So, thank you to the Commissioners for helping me, helping us catch up a little more closely to what we're trying to do on the schedule.

This is not the beginning but the, you know, the beginning of an intense discussion in detail and not the end, and so we're going to be spending, I would guess, the better part of a year working on this, hopefully in cooperation with CMS and others who are working on these issues.

David and Kate, thanks very much. Excellent presentation and discussion.

I think our discussion is concluded and we are now ready for public comment. If there are any individuals in the audience who wish to make comments, please come to the microphone.

[Pause.]

DR. CROSSON: I see none, so we are adjourned -- whoa, whoa, somebody had trouble getting out. Sorry.

MS. LEE: Hi. My name is Teresa Lee with the Alliance for Home Health Quality and Innovation. I want to thank the Commission and the staff for some really interesting presentations.

I found today's discussions both around post-acute care payment reform and this discussion around alternative payment models to be fascinating, and just a

couple of observations.

The first is that I find myself thinking in the context of post-acute care payment reform about the significance of home health care in the context of the post-acute care continuum, and it sort of intersects in a way with what you've been talking about related to alternative payment models in that CMS has been very interested in bundled payment approaches, not the least of which is comprehensive care for joint replacement. And in a recent JAMA piece, Patrick Conway and his colleagues at CMMI pointed to the fact that home health care is an important strategy in terms of modifying clinically appropriate and cost effective placement of patients towards home health care.

So, I just wanted to point out that in that context, in the context of payment reform for post-acute care writ large, it would be great to see the Commission recognize the importance of home health care and that while there may be concerns about cost overall in the health care system, home health care occupies a really important place, and that if we're going to be shifting patients towards the home, towards the community, and potentially towards home

health care, it will be important to make investments to better enable coordination of care, which can be costly and may be something that's being taken up in greater measure in years past 2013, which is the year that we're using for modeling.

So, I'd like the Commission to consider the fact that we need to invest dollars into coordination of care, including the need to invest in things like discharge planning, which CMS is addressing now in the context of conditions of participation.

In addition, post-acute care providers were left out of the high-tech meaningful use payments, so if we're going to be able to better coordinate care, we need to be able to make investments in things like HIT. Many providers are already doing that, but we're still a long ways off.

So, I thank this Commission for the opportunity to provide a public comment.

DR. CROSSON: Thank you very much.

I did not do my introductory comments. I see another speaker. Identify yourself, please, and then limit yourself to two minutes. Thank you.

MS. BRENNAN: Sure. Hi. My name is Allison Brennan. I'm with the National Association of ACOs.

And, one of the speakers made the comment that we've seen about 20 to 30 percent of providers kind of lean in to alternative payment models and pursue going down that path of moving away from fee-for-service. And I guess the comment I would have is just that if you do really narrowly define what would qualify as an eligible APM, if 28 of that 30 percent are excluded, I feel like a lot of people who have really embraced this in recent years are going to feel like they've kind of had the rug pulled out from under them. You know, they've pursued all these things, and then if they aren't eligible would be kind of thrown into the MIPS side of things. So, I definitely encourage you to take a broad approach to kind of recognize the work that a lot of providers have done to pursue alternative payment models to date.

And then the other comment that I would just make is the complexity of this, I think, is really overwhelming, as we've all discussed. But, thinking about being a provider who has to make a decision and kind of sees that fork in the road, is it going to be a true fork in the road

where they pursue one thing or not, or are they going to go down one path only to find out that they got 24 percent revenue. Now, they're in another bucket and they have been being evaluated under different criteria that they weren't even focused on because they were focused on kind of that path.

So, thank you very much.

DR. CROSSON: Thank you very much.

We are adjourned until the March meeting.

[Whereupon, at 11:43 a.m., the meeting was adjourned.]