2019

A Summary of the Medicare Payment Advisory Commission (MedPAC) Meeting

FROM THE OCTOBER 3-4, 2019 MEDPAC MEETING

PREPARED BY HART HEALTH STRATEGIES, INC.

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Restructuring Medicare Part D

Presentation

Shinobu Suzuki, Rachel Schmidt

In 2016, the Commission recommended major changes to the structure of Part D to address misaligned incentives as reflected in patterns of plan payments and bidding behavior. Since then, changes in law and greater spending for high-priced specialty drugs have led the Commission to begin considering new approaches for restructuring the Part D benefit.

MedPAC staff discussed several potential changes to restructure the Part D benefit and asked Commissioners' to provide guidance:

1) Eliminating the coverage-gap discount that currently applies to enrollees who do not receive the program's low-income subsidy (LIS), which would make plan sponsors responsible for a consistent 75 percent of benefits between the deductible and out-of-pocket (OOP) threshold;
2) Restructuring the catastrophic benefit to include a cap on beneficiaries' OOP spending, a new manufacturers' discount, lower Medicare reinsurance, and higher plan liability; and
3) Equalizing the basic benefit for enrollees with and without the LIS.

MedPAC staff detailed their goals and approach for Part D, which include:

1. Expanding beneficiary access to prescription drug coverage;
2. Using a market-based approach that facilitates a wide choice of plans that are appropriately incentivized and equipped with needed tools to manage benefit spending; and,
3. Encouraging the creation of a new market of stand-alone plans and broad enrollment among beneficiaries through Medicare subsidies, risk sharing and late-enrollment penalties.

MedPAC staff described a drastically changed landscape since the start of the program in 2006 that includes enrollees using more generics, the development of specialty drugs, changes in the Part D benefit design, availability of Medicare reinsurance, and a doubling of spending in the catastrophic phase. In this climate plans have reduced incentives to manage spending and are encouraged to preferentially treat certain drugs (i.e., high-price, high-rebate) on formularies. This has also affected some manufacturers' pricing decisions. As a result, the Commission continues to seek a restructured Part D benefit, building on its past recommendations.

Another challenge is misaligned incentives for non-LIS and LIS (see Slide 6). MedPAC staff reminded the Commissioner's that the 70% manufacturer discount is for brand drugs only, and that rebates average about 30% for brand drugs. MedPAC staff also noted that the coverage-gap discount affects only a small share of specialty-tier drug spending (based on 2018 data), but that the coverage-gap discount is not an effective way to offset rising drug prices and spending.

MedPAC's plan for restructuring Part D would include:

1) **Eliminating the coverage-gap discount such that plan liability would be 75% for all drugs and biologics up to the OOP threshold for non-LIS:** This would remove price distortions between brand and generic drugs, improve formulary incentives, simplify the benefit structure for beneficiaries, and eliminated manufacturers' financial contribution.
2) **Having the same benefit design for LIS and non-LIS enrollees such that plan liability would increase to 75% and LICS (low-income cost sharing) would decrease to 25% for LIS beneficiaries**: This would

improve formulary incentives, but lead to increased Medicare subsidies and beneficiary premiums. However, these would be offset by a decrease in LICS. MedPAC staff believe plans will need more tools to manage LIS benefits.

3) **Applying a new manufacturers' discount in the catastrophic phase of the benefit to both LIS and non-LIS prescriptions, while ensuring the manufacturers' financial contribution is no less than under the coverage-gap discount (currently 70%):** This would offset costs of eliminating the coverage-gap discount given it would apply more directly to high-cost specialty drugs. This would present a new consideration for manufacturers in drug pricing, and could slow price growth for some drugs.
4) **Capping beneficiaries' OOP spending by removing the 5% cost sharing in the catastrophic phase for non-LIS, and replacing LICS with Part D's basic benefit for LIS enrollees:** This would result in more complete insurance protection, albeit with increases in Medicare's premium subsidies and enrollee premiums, but offset by the decrease in LICS.
5) **Increasing plan liability (to 80%) and lowering Medicare reinsurance consistent with the Commission's 2016 recommendations, while retaining risk corridors and recalibrating risk adjusters:** This would improve formulary incentives. Also, large plans would likely need to self-reinsure, while smaller plans would need to purchase private reinsurance. Plans would also need additional flexibility in setting formularies.

MedPAC staff also discussed concerns about Medicare's reinsurance, generally, noting that it is not serving the same role as private reinsurance, which serves to offset unpredictable risk of extremely high claims. MedPAC staff noted that the market is well-established but reinsurance is growing in an unintended direction. In fact, benefits have remained flat, but there has been significant growth in pharmacy. While some Medicare reinsurance may be necessary, the role it plays should be different. MedPAC staff also noted that most Part D spending in the catastrophic phase is predictable.

To ensure successful transition, MedPAC staff would expect the restructuring to be phased-in as plans assume greater risk. Plans would also be afforded more flexibility in formulary management, and risk adjusters would be recalibrated to discourage risk selection by plans. Risk corridors would be maintained, but narrowed initially, while reducing plans' share of risk.

MedPAC staff will provide more information on LIS at the November meeting.

Commission Discussion

Chair Crosson opined that the Commission's efforts to recommend a restructuring of Part D was "a big deal," and likened it to the initial implementation of prescription drug coverage. Other Commissioner's agreed, and also expressed general satisfaction with the restructuring concept presented, which ***Commissioner Buto*** referred to as "elegant." ***Commissioner Pyenson*** also said the increased coverage would provide relief for beneficiaries from what could be unaffordable co-insurance in the catastrophic phase.

However, several Commissioners raised broad concerns about the impact of the restructuring on beneficiaries, as well as how manufacturers and plans might respond. Some of the concerns were: the impact of premium increases on beneficiaries, the potential for plans to risk select, the possibility for higher launch prices, impeded access to biosimilars, and issues associated with formularies and drug substitutions.

MedPAC staff were unable to speculate much on the "behavioral economics," given there are many moving parts and the parameters around the restructuring (e.g., the OOP threshold, etc.) would impact how various stakeholders might react. ***Executive Director Mathews*** said the restructuring aims to have a longitudinal effect, and by changing the incentives, he anticipated a decrease in price growth over time. ***Commissioner Gelb Safran*** encouraged adding some kind of table that lays out the behavioral incentives and unintended consequences for each stakeholder (beneficiaries, manufacturers and plans), which other Commissioners agreed with (***Commissioner Perlin, DeSalvo***).

Despite agreement with eliminating the coverage gap, some commissioners expressed a desire to see a manufacturer discount at each level of the restructure, noting that manufacturers did not have enough "skin-in-the-game" and could react with higher launch prices. They also expressed concern about the generic market, noting current price escalation in some generics (***Commissioners Wang, Buto, Ryu***). ***Chair Crosson*** acknowledged these concerns, but also believed other market forces might limit price increases.

Commissioners also expressed skepticism about plans' management of formularies and substitutions (***Commissioner Perlin, Pyenson***), and it was noted that a better definition may be needed for substitution. MedPAC staff also noted that plans are concerned about having the tools they need to manage formularies, including flexibility with protected class drugs.

Commissioner Pyenson also expressed a number of concerns about the failure of biosimilars to launch in the US, which are widely used elsewhere. Recognizing it was outside the scope of Medicare payment policy, he felt patent law needed to be adjusted and that biosimilars should be considered "originators." ***Commissioner Wang*** agreed that biosimilars were essential to helping curb cost growth.

Vice Chair Ginsburg said we are in a crisis; the private drug plan market has been disarmed and can't do its job. He was also highly supportive of addressing reinsurance, which was echoed by others (***Commissioner Casalino, Grabowski***). With regard to premiums, ***Commissioner Gelb Safran*** recommended the use of a threshold, similar to Massachusetts' use of the state gross domestic product (GDP), on the allowed percent increase from year to year. A commissioner also said plans should be a gatekeeper for new therapies and at what price. ***Commissioner Buto*** also expressed concerns about high cost generics.

Commissioner Grabowski was highly supportive of giving plans tools to help them take on more risk. He and ***Commissioner Wang*** were supportive of improving risk adjusters, to include adding socio-economic status (SES), to guard against risk selection. ***Commissioner DeSalvo*** discussed the use of technology to address some of these challenges, and pointed to the soon-to-be-finalized CMS/ONC interoperability rules.

Commissioner Wang continued pressing her concerns about shifting too much risk to smaller plans. She said reinsurance for drugs is "dollar for dollar" and not sure eliminating it would be a solution. She wants Medicare to have more skin in the game, as well. She urged additional tools for LIS, and said it is inappropriate to assume that LIS could be treated the same as non-LIS, which was supported by ***Commissioner Navathe***.

Commissioner Ryu also noted concentration in the market. He worried that smaller plans will face greater risk, as they may not have the capital to purchase reinsurance and be forced out of the market. He did not want to further concentrate the marketplace.

Next Steps

Recommendations will be presented to the Commission in the Spring for inclusion in the June 2020 Report to the Congress. These will build on the Commissions' 2016 recommendations.

Improving Medicare payment for low-volume and isolated outpatient dialysis facilities

Presentation

Nancy Ray, Andy Johnson

According to ongoing MedPAC staff analysis, dialysis treatment volume is highly correlated with dialysis facilities' costs. Specifically, the greater the facility's service volume, the lower its costs per treatment; while dialysis facilities with low treatment volume have higher adjusted costs per treatment. MedPAC staff also explained that the end-stage renal disease (ESRD) prospective payment system (PPS) includes a payment adjustment for facilities with low treatment volume and a separate adjustment for facilities located in rural locations. They further noted that the low-volume payment adjustment (LVPA) and rural payment adjustment do not focus on protecting isolated facilities critical to beneficiary access, nor do they meet the Commission's principles on rural payment adjustments as outlined in its June 2012 Report to the Congress.

To improve Medicare payment for low-volume and isolated (LVI) outpatient dialysis facilities, MedPAC staff continue to refine its policy option (presented in the Spring of 2019) that would more accurately target LVI facilities. Under this approach, the two current adjustments (LVPA and rural) would be replaced with one adjustment that jointly applies two requirements: 1) the facility must be farther than 5 miles from the nearest facility (regardless of ownership) and 2) the facility must exhibit low volume over three preceding years. This would redistribute some payments from non-isolated and high-volume facilities that may currently receive either the LVPA or rural adjustment. The new LVI payment adjustment would expand the definition of low volume to mitigate the so-called cliff effect, and to account for the higher treatment costs of relatively low-volume facilities.

Commission Discussion

Commissioners were generally concerned with the extreme consolidation in the dialysis market (***Chair Crosson, Commissioner Casalino***), noting there are two big players that don't need to get any bigger. There were also concerns about the availability of quality data for some of the facilities.

Commissioners were also concerned about the 5-mile threshold, which seems arbitrary, and wanted more data on whether this was the right distance. Some worried about access to care/adherence, which could be impacted by the availability of transportation (***Commissioners DeSalvo, Jaffrey***).

Home dialysis was also discussed, and some Commissioners wanted to see movement toward this and other innovative ways to deliver dialysis (e.g., mobile units), especially if will improve quality of life (***Commissioners Jaffrey, DeSalvo, Buto, Gelb Safran, Navathe***). ***Commissioner DeSalvo*** wondered how a mobile unit would impact the 5-mile threshold.

Commissioner Ginsburg asked about facility closures, commercial payments and "upcoding." MedPAC staff noted there were some closures but also some openings. They also said there are commercial

patients but it varies by facility. Finally, upcoding is not generally an issue, but they are looking at patient levels.

Commissioner Ryu asked whether the payment adjustment would be budget neutral, which ***Executive Director Mathews*** replied that it would.

Commissioners Gelb Safran and Casalino wanted to see a smoothing of the incentives and worried about the "three" cliffs. Also, there was a call for improved quality incentives. ***Commissioner Navathe*** was concerned about access to care, but also wanted to ensure there was an appropriate balance between supply and demand. He said it was worth better understanding the dynamic in how patients access dialysis treatment and that new metrics should be developed to measure access. ***Commissioner Casalino*** was also interested in the impact of competition. He worried if there wasn't enough competition, that could be a problem.

Next Steps

In the Spring, MedPAC staff will discuss modeling alternative patient-level payment adjustment factors and revise its ESRD PPS estimation methods.

Updates to the methods used to assess the adequacy of Medicare's payments for physicians and other professional services

Presentation

Brian O'Donnell, Kevin Hayes, and Carolyn San Soucie

As part of MedPAC's annual analysis to determine the adequacy of physician payments under the Medicare Physician Fee Schedule, the MedPAC staff use several proxies to assess beneficiary access to care, including access to primary care physicians. Given past input from commissioners about how MedPAC conducts this assessment, staff presented additional information and changes to how they count "primary care" physicians and how they conduct their volume analyses.

Background

MedPAC's current methodology for assessing physician payment adequacy includes data and information in the following areas:

- *Beneficiary access to care*
- *Quality*
- *Medicare payments and provider costs*

This discussion focused on the *Beneficiary access to care* analysis, which was prompted by commissioner concerns that the methodology for counting the supply of "primary care" physicians could be inaccurate given that it includes physicians enrolled under the "Internal Medicine" specialty but that historically, "Internal Medicine" has also included hospitalists.

Definition of Primary Care

Staff provided a definition and description of the role of hospitalists: physicians whose main focus is "the general medical care of hospitalized patients." Staff observed that hospitalists now play prominent role in

the delivery of inpatient care. Staff listed several factors that are believed to contribute to whether physicians become hospitalists:

- No additional training required beyond IM board certification
- Hospitalists earn approximately $36,000 more on average annually than general primary care (with general primary care earning ~$243,000 and hospitalists earning ~$278,000)
- Preference for hospitalist work schedule, which is typically working consecutive days and then the same number of consecutive days off

As part of its annual analysis, MedPAC tracks the number of physicians that bill the fee schedule, broken into several categories, including "primary care" and "specialist physicians." PCPs are defined as those who have self-designated under: internal Medicine (IM), Family Practice, Geriatrics, and Pediatrics. However, in 2017, Medicare created a voluntary "Hospitalist" designation. *Commissioner Thompson* asked what the "other practitioners" group consisted of; staff responded that physical therapists (PTs) and occupational therapists (OTs) make up the largest portion. *Vice Chair Ginsburg* also noted that just counting the number of available physicians fails to take into account productivity issues (e.g. younger physicians working fewer hours per week than physicians have done in the past), thus creating a need to find other data points to assess access. *Chair Crosson* also added that a national survey could be masking pockets of geographic access issues. *Commissioner Wang* asked whether services provided in urgent care centers (UCCs) would show up in the analyses. Staff replied that it would (and where it showed up would simply depend on whether it was the physician or APRN/PA billing for the service. Staff added that they are able to break out by place-of-service (POS) if need be.

Prior to 2017 (and for those who have not changed their specialty designation), hospitalists are typically counted as "primary care" because of the IM designation. However, there is concern that the services provided by hospitalists are not those commonly thought of as "primary care."

MedPAC staff were able to utilize the new "hospitalist" designation to better understand trends and make estimates prior to the availability of the designation:

- From 2010 to 2017: the number of hospitalists increased from 32,427 to 48,407, steady estimated annual increase of approximately 5.9% per year.
- When you reexamine the number of "primary care" physicians and separate hospitalists from the count of PCP, MedPAC staff estimated that 1 of 5 physicians that they had counted as "primary care" physicians were actually hospitalists.

MedPAC staff then stated, however, that even with this new data , it does not change the Commission's conclusion that beneficiaries maintained adequate access to care (see data points on slide) given that their conclusion was based on its annual beneficiary survey that showed that:

- Medicare beneficiaries are "less likely to wait longer than they wanted for routine care than privately insured
- No large changes in trouble accessing PCPs
- Access to PCPS has remained as good or better than privately insured

However, once excluding estimated number of hospitalists from its calculations, MedPAC staff estimated a slower growth in PCPs than previously believed, thus underscoring the Commission's concern about future supply of PCPs. *Commissioner Gelb Safran* questioned how there can be 20% fewer PCPs than they had been assuming, but that there is no concomitant concern about beneficiary access to primary care services and whether the Commission needs to move beyond survey data to assess "access." This was

echoed by ***Commissioner Ryu***. There was discussion about whether some of what might have been lost by internal medicine physicians practicing as hospitalists was made up by the increase of encounters by APRNs and PAs, but as the Commission and staff have noted in the past, there is no way to tell by enrollment designation whether APRNs or PAs are in the primary care field or a specialty field. ***Vice Chair Ginsburg*** also brought up the increase of services from APRNs and PAs, but given the information that they have, it would be difficult to tell whether this is the system just "making do" or whether it is a move toward more efficiently delivering services. ***Commissioner Casalino*** also noted that with PAs and NPs, a fair amount of what they are provided from a claim perspective will look like physician billing (seemed to be referring to "incident to" billing). ***Commissioner Wang*** also added that this discussion warrants further investigation into how beneficiaries are actually receiving their primary care (if it's true that there is not an access problem, but there are fewer PCPs than estimated). ***Commissioner DeSalvo*** also noted that the Commission should be thinking about whether the way they define "access to care" is correct and that access itself could be a lagging indicator; while "outcomes" might also be a lagging indicator, it could provide better insight. ***Commissioner Grabowski*** suggested the addition of some qualitative work (e.g. focus groups) and audit studies. ***Commissioner Ryu*** also suggested that prior to seeing access problems in Medicare and private insurance, there would likely first be access problems in Medicaid, and staff should examine that as an indicator of whether there were impending Medicare access problems. ***Commissioner Casalino*** agree that the survey could be inadequate and suggested they explore whether they are able to implement something akin to a "secret shopper" program to help provide data on access.

Several Commissioners also asked for additional information about how hospitalists are paid and whether there is data that can be used to justify the "value" (***Commissioner Gelb Safran; Commissioner Buto***). Staff noted that the history of the specialty is rooted in managed care and the implementation of DRGs, and hospitals made the investment that resulted in reduced LOS and increased quality and patient satisfaction. In addition, staff stated that hospitalists are very heavily subsidized by the hospitals where they practice; that is, their salaries are typically in excess of the RVUs the individual hospitalists bill, but the hospital finds value in their services (some from costs savings) that continue to drive hospital investment in them. ***Commissioner DeSalvo*** added that hospitalists also became an important part of the supply and demand equation for academic medical centers (AMCs) when the resident work hour restrictions went into effect. She noted that the National Academy of Medicine (NAM) has assembled a panel on the future of primary care, which could result in useful information in 18-24 months. ***Commissioner Ryu*** also noted that hospitalists are part of a 24/7 staff model which would explain some of the increased compensation relative to office-based primary care counterparts. ***Commissioner Thompson*** agreed that reliance on hospitalists is a supply and demand issue, but that it has also become an expensive element to running a hospital as well as the standard of care; she noted, however, in rural areas where recruitment is difficult, NPs are often having to fill the hospital medicine role and that the need is starting to be met by increased use of telemedicine. ***Commissioner Pyenson*** requested additional information about how the trends in physician employment should affect their thinking on these issues.

Volume Analysis

In addition to addressing how the Commission counts "primary care" physicians, staff presented changes as to how they conduct the volume analysis as part of its review of adequacy of physician payments. Staff cited that MedPAC uses volume as a measure of access to help determined the drivers of increased spending. Typically, the analysis takes into account the "number of services" and "complexity." However, under the current methodology, a shift in the site of service (e.g. from the physician office to an HOPD) would result in RVUs "disappearing" from their volume analysis.

In order to account for this, staff presented two new analyses intended to replace the current volume analysis:

1. Access measure: Encounters with clinicians: This would count "encounters with clinicians" so it is less sensitive to site of service
2. Spending measure: Allowed Charges: This would then be a function of number of services, RVUs, and other factors (e.g. the conversion factor).

In re-examining data from 2013-2017, the staff was able to see the way in which different patterns emerge. For examples, when you examining "encounters with clinicians" stratified by type of physicians, they could see that while there was general "stable access to care," patterns by type of provider shifted: encounters with PCPs fell by 3% per year, but encounters with APRNs and PAs grew by about 13% per year. Similarly with the "allowed charges" metric, there was a 2016 to 2017 growth of 1.6%, but when looking at type of service, staff recognized that growth in imaging was significantly lower (at 0.5%). ***Commissioner Casalino*** noted that this information still does not give them a lot of information about why these trends are happening (for example, with regard to "imaging" increasing the least: is that a lack of supply? Is that physicians getting better at not ordering unnecessary tests?). ***Vice Chair Ginsburg*** also noted that the outcome of the E/M proposals made in the CY 2020 Medicare Physician Fee Schedule proposed rule could change how they view the trends and, if they are finalized for CY 2021, the Commission will need to think about how that affects this discussion.

Commissioner Level of Support

Several Commissioners expressed support for the recommended changes (***Commissioner Thompson***; ***Commissioner Ryu***; ***Commissioner Pyenson***). ***Commissioner Buto*** however expressed concern about merging "hospitalists" with "other specialties"; she believes that it is important to keep them separate in order to track their role in care coordination inside and outside the hospital and that the Commission should not lose them in a lumping with 'other specialties' (which she also stated, "we tend to denigrate"). ***Commissioner Gelb Safran*** agreed that there was an opportunity to integrate what happens to a patient in the hospital back out to the PCP in the community and thinking more about the ability of hospitalists to treat more complex patients and how that fits into the delivery system.

Next Steps

Staff indicated that they will bring back additional information and further developed proposals at the December 2020 MedPAC meeting. In addition, staff mentioned that they will also be covering issues regarding to the physician workforce pipeline at the November meeting.

Population-based outcome measures: Avoidable hospitalizations and emergency department visits

Presentation

Ledia Tabor

Following up on past Commission discussion and priorities, staff reiterated the Commission's goal for quality measurement: to use a small set of population-based outcome, patient experience and value measures that can align incentives across different populations (i.e. MA plans, ACOs and FFS within a defined market).

This discussion focused on two *claims-based* outcome measures, which staff worked to define via a contract with RTI:

- Avoidable hospitalizations (*includes* inpatient admissions *and* observation stays)
- Avoidable emergency department (ED) visits (*excludes* visits that result in an admission or observation stay)

On Slide 3, staff reviewed the rationale for focusing on hospitalizations and ED visits, including the fact that hospitalizations can expose beneficiaries to health risks and that EDs are not ideal of nonurgent conditions or management of chronic conditions. Staff noted that poor performance on these measures can help identify inadequate access to care or poor coordination of care, but also noted that they are aware that not every use can be avoided. Staff reviewed included diagnoses in 2 categories:

1. *Chronic Conditions* including diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, heart failure
2. *Acute Conditions* including, bacterial pneumonia, urinary tract infections, cellulitis, pressure ulcers (and for ED measure also upper respiratory infection/otitis/rhinitis, influenza, and non-specific back pain)

In looking at 2017 claims data under these parameters, staff estimated 4% of Medicare FFS beneficiaries had at least 1 avoidable hospitalization; while 7% of Medicare FFS beneficiaries had an avoidable ED visit. These results are based on a risk-adjustment model that controls for age, sex, and clinical characteristics, but staff noted that the Commission does *not* adjust for social risk factors because it can mask disparities. Staff conducted an analysis of the risk standardized rates under both MedPAC market areas (about 1,200 areas with about 25,000 FFS beneficiaries in each); and Hospital Service Areas (HSAs) (about 3,400 areas with about 10,000 FFF beneficiaries in each). Staff noted that they have not examined the measure in the context of mortality. ***Commissioner Wang*** asked whether this included avoidable *readmissions.* Staff replied that if a beneficiary is readmitted, it is still anchored to the index admission so that the accountable entity would only be "dinged" once.

Staff asked the Commissioners for feedback on potential next steps:

- Analyze high- and low-performing areas to identify factors that affect performance (e.g. rates of primary care clinicians per capita, concentration of ACOs)
- Identify best practices from high performing areas, including areas with higher proportion of patients with social risk factors
- Continue to explore using these measures to compare the quality of care across FFS, ACOs, and MA

Expansion to ACOs and MA. In response to a question from ***Commissioner Ginsburg***, staff noted that it will be heavy lift to use these measures in the ACO and MA programs. In addition, ***Commissioner Jaffrey*** noted that there might be some value in looking at hospital-led ACOs vs. physician-led ACOs to determine whether there are financial motivators that do not drive hospitals to try to avoid these "events." In addition, it will likely be important to look at comparative costs to beneficiaries. ***Commissioner Gelb Safran*** also suggested if maybe they were approaching cross-system measurement from the wrong direction: if MA encounter data is the rate limiting step, should the Commission instead start by considering by what *is* measurable in MA and then look to expand that out to FFS and ACOs (rather than the other direction in which it might be more difficult to replicated in the MA context).

Measure Reliability. In response to a question from ***Commissioner Gelb Safran***, staff stated that they are working off a minimum sample size of 1,000 (although do not yet know if this results in a 0.7 reliability

factor). *Commissioner Casalino* later stated that if it turns out that 1,000 is reliable that this information that MedPAC should consider publishing as it would be very valuable information. In response to a question from *Commissioner Ginsburg*, staff noted that there is no way to tell if a particular encounter resulted because the patient was told by their primary care physician to just go to the emergency department. *Commissioner DeSalvo* also inquired as to whether they might be able to stratify by who is doing the admitting. *Commissioner Navathe* added that in order to build some validity, they could lean on a lesson learned from the work done on the readmissions measure: there, they saw big annual swings in performance on the measure. Here, he suggested the Commission should look at the longitudinal variation and if there is a lot of movement from year to year, it would question the validity of how the measure has been constructed (using a previous MedPAC example of "healthy days at home" as an example).

Measure Function & Accountability. Staff noted that at the outset, they are thinking of this as a surveillance measure. *Commissioner Gelb Safran* stated that the Commission should think through how to eventually make this an accountability measure. *Commissioner DeSalvo* expressed caution on the accountability for fear that if implemented incorrectly it could discourage care coordination. *Commissioner Thompson* inquired about who the accountable party would be for the measures (outside of the ACO context). Staff replied that they could envision this as a component of the population-based measures as part of the Voluntary Value Program (VVP), as part of MedPAC MIPS replacement recommendation. *Commissioner Wang* express caution about rushing to use this to reward and punish providers, noting that housing, food, etc. can impact all of this even if PCP does everything right. Therefore, she believes it is important to look at SES and suggested that staff perhaps look at data by HPSAs to see if that explains some of the variation (if HPSAs are still in fact good representations of lack of providers). Likewise, *Commissioner Perlin* suggested that it is likely that access to Urgent Care Centers also likely contributes to performance on the measures. *Commissioner Buto* expressed skepticism in the measures and rather encouraged moving in the direction of looking at tools that were more condition-specific and were also constructed with "positive" parameters rather than "negative" as these measures are built. *Commissioner Perlin* stated that functional status should probably play a role here as well. *Commissioner Ryu* raised the accountability issue and stated that by virtue of it being a population-based measure it is going to be a statement on the ambulatory environment and infrastructure, which means performance become multi-factorial; given this, he has uncertainty about who should be held responsible. In several instances, *Commissioner Navathe* reminded Commissioners and staff that the measure will never be perfect and that they should maintain focus on the real need for population-based measures that cut across conditions.

Discussion Specific to "Avoidable ED Visits": *Commissioner Gelb Safran* raised the issue of whether staff is able to look through the data to see how often the beneficiary believes it is an emergency and how you parse that out from avoidability.. *Chair Crosson* noted the importance of looking at the presenting complaint rather than the final diagnosis. In this vein, *Commissioner Wang* raised that in the emergency department, there are prudent layperson (PLP) laws that require insurers to cover the service if the patient thought it was an emergency and noted that, therefore, even having the greatest ambulatory care system in the world is not going to avoid that; from a hospital perspective- "avoidable admission" is still technically "medically necessary" is getting paid for. For these reasons, she said they really need to better consider what they mean when they say something is "avoidable" in the emergency department.

"Ambulatory Care Sensitive Conditions": Because of concerns about whether cases are truly "avoidable" there was significant discussion regarding classifying these as "ambulatory care sensitive conditions." *Commissioner Grabowski* also added that it would be worth looking at the specific conditions and whether

they are different across markets. Staff noted that conditions are correlated on a national level. ***Commissioner Navathe*** noted that the nomenclature difference between "avoidable" and "ambulatory care sensitive" can be important. He also noted, that if the measure was properly constructed, would expect the result would be reduced numbers; but in those markets where there is discordant performance on the two measures, there could have a problem. Therefore, one suggestion from ***Commissioner Navathe*** was *to* think of this collectively and unify the two to address the fact that the same infrastructure could push you in different directions on the measures individually (i.e. create an "ambulatory care sensitive events" measure). ***Commissioner Casalino*** later stated that there might be some value in this composite measure (or present the data in all of its variations). ***Commissioner Ryu*** expressed some interest in combining into a single measure, but raised that it then begs the question of "who was in the last position to do something about the 'negative' event?" If it is the "avoidable ED" situation, it was probably the primary care physician; but if it is an "avoidable hospitalization" then it was probably the ED physician. Given that, who do you hold responsible for the combined measure? ***Commissioner DeSalvo*** stated that it could still be valuable if the goal of the measure is to catalyze shared accountability. ***Chair Crosson*** asked that if they were to do this (combining the two), should there be other "events" that should be included.

Analysis of High/Low Performers & Best Practices. ***Commissioner Pyenson*** was not in favor of expending effort on these activities, not because of the underlying metrics that would identify high and low performers, but that whatever is discovered would be difficult to turn into something actionable because it is incredibly hard to figure out how or why particular regions accomplish what they do. He cautioned the Commission that it should not try to "medicalize" population health outcomes since so many health care determinants are not medical.

Aligning Benefits and Cost-Sharing Under a Unified Payment System for Post-Acute Care

Carol Carter and Carolyn San Soucie
Presentation

This session is focused on how to align benefits and cost-sharing across the four post-acute care (PAC) settings. Staff noted that they are looking for input on 3 key design areas.

Staff began by providing background information on PAC, including the context for promoting PAC reform. For example, there are similar patients across settings, yet payment can differ. There is large variation in Medicare per capita spending on PAC that varies more than for other settings. There are setting-specific patient assessments and outcome measures that make it difficult to compare across settings. Providers can vary their payments through coding and the amount of therapy they furnish. And Medicare payments for PAC are high relative to the cost of care.

Staff presented information on the Commission's work on a PAC prospective payment system (PPS), including around a PPS design (payment per stay or HHA episode and payment for sequential stays); implementation issues (payment levels, transition process, and alignment of regulatory requirements); and how to incorporate value-based payment (value-incentive program, including uniform outcome measures). Under a uniform PPS, payments and regulatory requirements would be aligned so that distinctions between settings will become blurred.

Currently, benefits and cost-sharing vary by setting (see Slide 5). Given these differences, beneficiaries may base their decisions for PAC based on cost considerations. With aligned requirements, beneficiaries would have the same benefits and face the same cost sharing, so that financial considerations are removed from beneficiaries' decisions on where to get PAC.

Areas to align benefits include requirements for prior hospital stays for coverage (e.g. as required with SNF) or limits on the number of covered days. To align cost-sharing, an aligned per-stay copayment could be assessed.

- Prior hospital stay requirement:
  - PAC stays with prior hospital stay vary by setting, with only 35 percent of HH stays preceded by a 3-day hospital stay, but 95 percent of SNF stays preceded by a 3-day hospital stay.
  - Adding a prior hospital stay requirement for all settings would affect the majority of home health users, decrease coverage for a minority of IRF and LTCH users, and modestly lower program spending
  - Eliminating the requirement for SNFs would increase coverage for SNF users, but could also induce nursing homes to qualify long-stay residents as Medicare-covered and likely raise program spending substantially
- Covered days:
  - Establishing a uniform limit on covered days would eliminate open-ended coverage for home health and align the current limits for institutional PAC
  - Eliminating existing coverage limits would retain open-ended coverage for home health care and extend coverage for a small number of beneficiaries with long institutional PAC stays
- Cost sharing:
  - Total cost sharing for PAC was $5.2 billion in 2017, with over 92 percent due to SNF stays, which only cover a quarter of PAC stays. Over 75 percent of PAC stays, including all home health stays, do not require any cost sharing. At the 99th percentile, cost sharing was over $11,000 per stay for all PAC services, but cost-sharing varies based on PAC setting. This cost sharing includes costs covered by supplemental coverage.
  - Under a per-stay copayment, beneficiaries would be liable for a copayment for each PAC stay.
  - Copayments could be uniform, which would fully align cost-sharing across PAC settings and reduce beneficiary financial considerations, but would also require home health users to pay a higher share of the total payment.
  - Copayments could be different, with lower copayments for HH and higher copayments for institutional stays. This would reflect the relative difference in payments to providers, and would also encourage use of less costly services.
  - As far as the size of the copayment, it could be set to cover various proportions of PAC costs, for example 5 percent (consistent with previous MedPAC benefit redesign work), 9 percent (consistent with current aggregate PAC cost sharing), or 20 percent (consistent with current Part B cost sharing).

Staff are seeking input from Commissioners on whether a prior hospital stay should be required for some or all PAC stays, whether there should be a uniform limit on covered days, and whether there should be a uniform copayment. Based on feedback on these issues, staff will model illustrative designs in the spring.

Commission Discussion

The Commission discussion addressed the following topics:

- General Considerations for Deliberation on the Setting Benefit and Cost-Sharing Parameters
  - ***Vice Chair Ginsburg*** noted that there is a "vintage" PAC system that has not been changed since the establishment of the Medicare program, but that requires reform. ***Commissioner Grabowski*** agreed with the framework and need for change.
  - ***Commissioner Ginsburg*** raised questions about the extent to which care is interchangeable across facilities and whether referring providers discriminate between different settings based on patient needs. Staff noted that choice of PAC is based on many factors. ***Commissioner Buto*** noted that, where patients' care needs are similar, PAC payments should be similar.
  - ***Commissioner Buto*** noted that the question of lower copays for home health patients is based on whether the institutional provider patients is interchangeable. She indicated that greater information was needed about overlap across settings and also about what types of patients are coming from the community.
  - ***Commissioner Perlin*** expressed the thought that home health is different from other PAC, and that if a patient does not need institutional care, then it is not appropriate to place an individual in an institutional setting. It should not be hardest to use the least expensive setting.
  - ***Commissioner Navathe*** suggested that cost-sharing and other benefit restrictions should consider the value of services, with high-value services resulting in lower cost-sharing and vice versa. When considering value, it greatly depends on clinical scenarios in question, and also how PAC may contribute to use of (or avert use of) hospital services. He noted, however, that given the difficulty of rationalizing value based on different clinical scenarios, we are stuck with thinking about average value.

- Understanding Beneficiary PAC Choices under Current System
  - In response to prompts about how beneficiaries choose PAC settings, staff noted that beneficiaries often want to go home if they can. When they cannot, many other factors are considered – for example, clinical care needs, availability of beds, proximity to family or caregivers. Staff noted that there did not appear to be consensus on which PAC settings patients should be sent.
  - ***Commissioner Jaffery*** asked whether there is price sensitivity in PAC selection. ***Commissioner Grabowski*** described his research that found that beneficiaries without supplemental coverage are hugely responsive to price, while those who have supplemental coverage are less sensitive. Many without supplemental coverage are discharged from the SNF to the home with home health care immediately on day 21, when cost sharing sets in, and there was not an increase in hospitalizations. This suggests that discharges may be overdue.

- Understanding PAC Use in Managed Settings (Accountable Care Organizations and Medicare Advantage)
  - ***Commissioner Jaffery*** asked why there has been limited uptake in use of the 3-day waiver. Staff indicated that some ACOs may see a prior hospital stay as a speed bump, similar to how it is applied in fee-for-service (FFS). Some see it as a way to reinforce that a SNF stay is a post-hospital extended services visit.

- Staff noted that there does appear to be a reduction in SNF length of stay, and also replacement of SNF services with home health services, for ACOs.
- *Commissioner Jaffery* also noted that there was a shift in SNF to home health usage under the Comprehensive Care for Joint Replacement (CJR) model.
- *Commissioner Thompson* noted that her ACO has taken substantial advantage of 3-day waivers, and they have not found an increase in SNF usage. *Vice Chair Ginsburg* noted, however, that the ACO provides a highly managed environment, so it would not be appropriate to extrapolate.
- *Commissioner Thomas* asked how data compare across ACOs and MA plans versus FFS. Staff noted that utilization in managed environments is very different. *Executive Director Jim Mathews* noted that there is currently some work in development about differences in utilization of PAC in FFS versus ACO environments. They hope to roll this work out later in the fall.
- *Commissioner Grabowski* noted that there are some papers that suggest MA PAC utilization is much lower. *Commissioner Wang* agreed.
- *Commissioner Navathe* noted that ACOs use infrastructure in different ways to rationalize PAC use. They also use post-discharge visits to reduce home health.

- Prior Hospital Stay
  - *Commissioner Wang* asked why costs would increase if the 3-day prior hospital stay were eliminated. Staff noted that previous legislation that eliminated the hospital stay led to spending doubling (though some of the spending was attributed to other factors). *Commissioner Casalino* asked for more information about what happened with that prior legislation, and staff agreed to look into this more. Staff also noted that it was expected that many long-term nursing facility patients would qualify based on requirements for either nursing or therapy skilled services; it would be quite easy for nursing home patients to qualify without a prior hospital stay requirement.
  - *Commissioner Casalino* asked whether there were any other reasons not to eliminate the hospital stay requirement besides ease of requalification. Staff noted that some people think of SNF care as post-acute care, i.e. that implies a hospital stay. *Commissioner Buto* agreed with this characterization of SNF care. Staff noted that Commissioners could consider many options for addressing prior hospital stay requirements that would result in more or less alignment from a uniform PAC benefit across settings.
  - *Commissioner DeSalvo* asked whether staff had looked total cost of care for community admissions, including who could have gone to a SNF without a hospitalization (i.e. would there be savings on total cost of care?). Staff said they could think about this question, and Commissioner DeSalvo suggested there might be something that could be learned from ACO work.
  - A few Commissioners expressed concern about eliminating the prior hospital stay requirement for SNFs and support for including a prior hospital stay requirement for institutional PAC (*Grabowski, Buto, Thomas*).
  - A few Commissioners expressed concern about requiring a prior hospital stay for home health services (*Grabowski, Gelb Safran, Thomas*).
  - *Commissioner Grabowski* suggested that, if a prior hospital stay requirement for institutional PAC was not advanced, then a second best option would be to place a requirement for prior hospital stays for institutional PAC care for patients who are long-stay nursing home residents. *Commissioner Pyenson* expressed support for this approach.

Commissioner Casalino also thought this idea was worth looking into, but also noted that an argument could be made that such an approach discriminates against people in SNFs.
    - *Commissioner Grabowski* suggested that there could be some flexibility around what would be required for a prior hospital stay, for example, counting observation days, or changing the requirement for number of days.
    - *Commissioner Perlin* noted that this deserves further study. *Commissioner Jaffery* agreed.
    - *Commissioner Buto* expressed openness to including a prior-hospital stay for home health, in addition to institutional PAC, but she also noted interest in learning more about community-admitted patients. However, she also noted that if a prior hospital stay is added, then it might be necessary to loosen up other requirements such as the home-bound status requirement, noting that the homebound requirement does not speak to whether a patient can rehabilitate in the home.
    - *Commissioner Gelb Safran* noted that she was not sure a prior hospital stay was necessary for institutional PAC.
    - *Commissioner Wang* expressed support for leaving current prior hospitalization requirements in place, but also expressed interest in learning more about community-admitted patients to home health. She also noted that she believes the current system creates an incentive to participate in ACO arrangements.

- Uniform Covered Days
    - *Commissioner Grabowski* indicated that he did not think a day limit is necessary under a stay-based payment model. *Commissioner Buto* agreed.
    - *Commissioner Navathe* suggested that a uniform day limit is not likely to be of value for home health services.
    - *Commissioner Gelb Safran* did not support a uniform limit on covered days, especially for home health, but also suggested that having some kind of cap would be good.
    - *Commissioner Wang* noted that under stay-based payment, there needs to be an outlier for length of stay.
    - *Commissioner Thomas* expressed support for day limits, but suggested putting milestones where additional review and approval would be needed. Having the right review process would be important.
    - *Commissioner Casalino* supported some kind of limit on days.

- Cost Sharing
    - A couple of Commissioners expressed a preference for a set copayment amount, versus a variable percentage cost-sharing (*Gelb Safran, Navathe*).
    - *Commissioner Buto* asked about potentially applying a deductible across all settings, with no requirement for a 3-day hospital stay. Staff noted that they considered a deductible comparable to a per-stay copayment.
    - *Commissioner Grabowski* expressed support for cost-sharing across all four PAC settings.
    - *Commissioner Grabowski* suggested that cost-sharing might be proportional across settings, with a lower cost-sharing requirement for home health, but an amount that represents the same share. He noted that a fixed amount would distort behavior. Commissioner Perlin agreed about a proportional approach. *Commissioner Gelb Safran* also expressed comfort with such an approach.
    - *Commissioner Perlin* did not believe that cost-sharing should discourage home health utilization.

- *Commissioner Navathe* suggested that the value of PAC services vary, such that a uniform copayment does not make sense.
- *Commissioner Jaffery* did not believe that cost-sharing should incent people away from use of home health services, despite moving away from uniformity.
- *Commissioner Buto* noted that there is a contradiction between the goal of a uniform PAC PPS and an underlying theme that cost-sharing should encourage use of home health. She expressed concern about mixed signals that might lead a patient to use home health even when institutional care might be better, but she seemed to conclude that copayments for home health should be lower.
- *Commissioner Gelb Safran* noted that Commissioners are not indifferent about settings, and that it does not make sense to align cost-sharing such that incentives are the same. She also noted that home health feels different, and there are social factors that are at play, so the Commission should think carefully about how far to go in equalizing across settings.
- *Commissioner Wang* also expressed confusion around how to apply cost-sharing for home health, and that she would benefit from understanding more about services provided in the home health setting.
- *Commissioner Ginsburg* noted that she would not put any cost-sharing for patients on home care, for fear that patients would turn it down. She considers home care to be a preventive service. Any barrier to home care may serve as an excuse for foregoing care.
- *Vice Chair Ginsburg* noted that zero cost-sharing leads to fraud, and there has been experience with fraud with home health services. In response, *Commissioner Ginsburg* noted that it has not been patients who have been responsible for fraud.
- *Commissioner Thomas* suggested that uniform cost-sharing could be made based on diagnoses, rather than setting.
- *Commissioner Casalino* noted that a lower copayment for home health might be attractive, but also noted that a stay-based copayment might be problematic for patients who may not need much home health – once a first copayment is made, there is no incentive to stop.

- Supplemental Coverage
  - *Commissioner Ryu* asked about the percentage of aggregate cost-sharing that is covered by supplemental coverage. Staff did not know the answer to this question, but noted that about 80 percent of beneficiaries have supplemental coverage. About a third of supplemental coverage is Medigap, which does usually cover cost-sharing, but little is known about the employer coverage landscape.
  - *Commissioner Grabowski* noted that the role of supplemental coverage in the marketplace needs to be addressed in order to use cost-sharing to encourage appropriate use of PAC. *Vice Chair Ginsburg* also supported this notion.
  - *Commissioner Navathe* suggested looking at use of supplemental coverage by income since supplemental coverage is not uniform across income distribution.

- Additional Issues
  - *Commissioner Jaffrey* noted that eliminating the days limit on SNFs would affect Medicaid spending. Staff agreed but also noted that very few SNF stays exceed benefit limits.
  - *Commissioner Navathe* asked what cost-sharing by PAC setting would look like for dual eligibles. Staff said they could look into this question.

- ***Commissioner Pyenson*** asked whether there had been an examination of hospital-at-home programs, and whether SNF-at-home might be another option. Staff said they could look into this.
- ***Commissioner Gelb Safran*** noted communication challenges with educating beneficiaries on any changes that might be implemented.
- ***Commissioner Ginsburg*** suggested that the term "PAC" was no longer appropriate since she did not think acute care should be central to the delivery of services typically considered PAC. She also thought it could instead be called "community-based care."
- ***Commissioner Thomas*** suggested thinking more about digital and telemedicine when contemplating home health services.
- ***Commissioner Thomas*** expressed interest in looking at acute care costs during the same period as PAC costs to see if there are differences in acute care costs while patients are in different PAC settings.
- ***Commissioner Pyenson*** suggested there was a need for objective utilization criteria for SNF or home health services, to apply a utilization management approach. He noted that a similar approach had been used for certain durable medical equipment. However, ***Commissioner Buto*** noted that utilization management tools are difficult to deploy and very budget dependent, and it would be difficult for CMS to do. ***Chair Crosson*** noted that utilization management would be challenging at the CMS level, but that MA plans and ACOs are applying it successfully.

Policy Option to Modify the Hospice Aggregate Cap

Presentation

Kim Neuman

This session explored a way to modify the hospice aggregate cap as a way to increase equity across providers, increase payment accuracy, and likely generate savings for the Medicare program.

Staff began by providing background on the Medicare hospice benefit, including providing information on services covered, eligibility criteria, total payment, and payment structure (i.e. per diem payments for four levels of care). Staff then discussed concerns about the current hospice payment system, noting that aggregate payments substantially exceed cost[1]; that payments are out of balance by payment level (e.g. routine home care is overpaid and the other levels of care are underpaid); that long stays are more profitable, leading to substantial for-profit entry into the hospice sector; and that margins of hospices that exceed the cap are strong and increasing. Staff noted that CMS' changes to restructure routine home care in 2016 and to rebalance payments for 2020 are improvements, but concerns remain since aggregate payments remain above costs and long stays remain profitable.

Staff then provided details on the hospice aggregate cap, including how the cap is calculated (see Slide 7) and the consequences of exceeding the cap. Staff noted that when the hospice benefit was first established, the cap was added to ensure savings. Staff also provided details on hospice length of stay (see Slide 6), including the median (18 days) and mean (87.8 days) length of stay; notably, 13 percent of decedents' stays were more than 180 days long.

[1] Staff reminded Commissioners that the Commission recommended a 2 percent reduction to the FY 2020 base rate, which was not enacted. Instead, hospices received a 2.6 percent increase to payment rates for 2020.

The hospice cap functions as a mechanism to reduce payments to hospices with long stays and high margins. In 2016, 12.7 percent of hospices exceeded the cap, and overpayments were equivalent to about 1 percent of total hospice payments. Before the return of cap overpayments, above-cap hospices had margins of over 20 percent, and margins remained at almost 13 percent after the return of cap overpayments. Hospices above the cap had substantially longer stays and higher live discharge rates. They were also disproportionately for-profit, freestanding, urban, small, and recent entrants to the Medicare program.

The hospice aggregate cap is not wage-adjusted, resulting in a stricter application in some areas with high wage indices relative to hospices with low wage indices (see Slide 9). As a result, providers with the same utilization in different parts of countries fall on different sides of the cap: about 20 percent of hospices with wage indices above 1.0 exceeded the cap in 2016, versus 9 percent of hospices with wage indices below 1.0.

To address these issues, the Commission could consider a policy that would wage adjust and reduce the cap, in order to improve equity of the cap across providers, improve payment accuracy and reduce overpayments to providers with disproportionately long stays, lessen the attractiveness of the business model focusing on long stays, and generate savings for taxpayers and the Part A trust fund. To understand the effects of such a policy, staff simulated the effects of wage-adjusting and reducing the cap. For the simulation, staff reduced the cap amount by 20 percent (though this was an illustrative reduction, and other amounts could have been considered). They used 2016 data and did not assume any utilization or behavioral changes. They also simulated the effects of CMS' final policies for FY 2020 to rebase payment rates before simulating the effects of the policies to modify the cap.

Overall, under the simulation, the share of hospices exceeding the cap increased (26 percent), but many would have remained substantially under the cap. For example, about half of hospices would have been 41 percent or more below the cap. The table on Slide 13 shows the effects on Medicare payments under the simulation to wage adjust and reduce the cap, including an aggregate reduction of 3.2 percent to Medicare payments across all hospice providers. Overall, hospices with disproportionately long stays and high margins would see a reduction in payments, while other hospices would largely be unaffected. Effects by category of hospice depend on the prevalence of providers in a category with disproportionately long stays, but under the simulation, for-profit and freestanding hospices would experience reduced payments, while nonprofit and hospital-based hospices would see little effect.

Staff noted that under the policy option, beneficiaries would be expected to continue to have good access to hospice care, and, to the extent that some providers have entered the sector to pursue revenue generation strategies focusing on long stays, the policy option could lessen the attractiveness of that business model.

Staff noted that guidance from the Commission was needed regarding whether to develop the option further for potential consideration as a recommendation in December.

Commission Discussion

The Commission discussion addressed the following topics:

- Overall Support for Continuing to Pursue this Policy Option

- Several Commissioners expressed support for continuing to pursue this policy option (*Vice Chair Ginsburg, Grabowski, Thompson, Pyenson, Gelb Safran, Buto, DeSalvo*).
- *Vice Chair Ginsburg* noted that he was particularly influenced by the fact that few hospices exhibit patterns with disproportionately long stays. Lowering the cap would serve the function of reducing abuse.
- *Commissioner Grabowski* stated that wage-adjusting seems like a "no brainer," and *Commissioner Casalino* agreed. *Commissioner Gelb Safran* raised the potential for unintended consequences with respect to setting wages. However, staff clarified that a hospice raising wages would not have an effect on the cap since the hospital wage index is used to adjust payments to hospice providers.
- *Commissioner Pyenson* noted that the reduction to the cap is a more refined policy option that is fairer to the industry than what the Commission has already recommended (i.e. the 2 percent cut to hospices recommended for FY 2020).
- Staff noted that it appears the cap is functioning as more of a payment accuracy tool, homing in on providers with highest margins, rather than as a savings tool.

- <u>Interest in Supporting Expanded Use of Hospice and Palliative Care and Need to Protect Against Unintended Consequences</u>
  - Several Commissioners expressed interest in recognizing the importance of hospice and palliative care and striking a balance with promoting hospice while also addressing bad actors (*Thompson, Gelb Safran, Crosson, DeSalvo, Casalino, DeSalvo*).
  - *Commissioner Casalino* asked about how the reduction to the hospice cap might affect hospices if there were improvement in increasing lengths of stay to a more appropriate duration than the current 18-day median length of stay, noting that it would be good to see more stays of longer length.
  - *Commissioner DeSalvo* expressed concerns about creating such a broad policy that it disincentivizes movement into hospice and palliative care. She indicated that it might be useful to also think about more targeted strategies.
  - *Commissioner Gelb Safran* noted that end-of-life care is one of the most important things the Commission can focus on and that it would be important not to undercut progress in current trends to get patients into hospice sooner.
  - *Chair Crosson* reiterated that the discussion today is consistent with greater utilization of hospice and palliative care and noted that progress in that area needs to happen more quickly.

- <u>Need for Additional Analysis</u>
  - *Commissioner Perlin* expressed the need to have more information on specific outlier hospices with long stays and on their patients before feeling comfortable with the discussed adjustments to the hospice cap.
  - *Commissioner Gelb Safran* suggested that staff could undertake qualitative research, including site visits to hospices (including good actors and bad actors), to develop a better understanding.
  - *Commissioner Navathe* suggested that it would be useful to look at hospices with negative margins, with the idea that this work on the cap might be paired with rebalancing the fee structure.
  - *Commissioner DeSalvo* suggested that it would be useful to look at comparator populations to determine the impact of hospice on total cost of care, including hospice care with long stays. She noted that while there are extra costs with long stays, there are

also benefits as well. Staff noted that it is methodologically tricky, but that available evidence suggests that there are savings for hospice patients in the first month or two right before death, but that when stays are longer, there is a point where savings turn to extra costs.

- Program Integrity Considerations
  - Many Commissioners expressed interest in identifying and dealing with bad actors (*Thompson, Casalino, Gelb Safran*).
  - A couple of Commissioners questioned whether a more targeted approach focused on bad actors would be better than a broad policy that has the potential to affect all hospices (*Gelb Safran, Casalino*). Staff noted that the wage index adjustment would put hospices on equal footing, and that while the change to reduce the hospice cap is a broad payment policy, its effect is targeted on those providers with significantly different distributions in the length of stay for their hospice patients.
  - *Commissioner Thomas* indicated that a broader review of how to deal with bad actors, not just in hospice, might be an area for MedPAC to explore further.

- Characteristics of Hospices that Exceed the Cap
  - *Commissioner Casalino* expressed surprise that hospices that exceed the cap tend to be small. Staff noted that these hospices have different patient mix, and longer stays for each category of patients.
  - *Commissioner Perlin* asked about the location of hospices that exceed the cap. Staff noted that they tend to be more in urban areas, with geographic concentration in some states more than others. Many are along the southern coast.

- Changes in Hospice Diagnoses over Time
  - *Chair Crosson* asked for background on the change in hospice diagnoses over time. Staff noted that there has been a big shift over the last 15 years or more, where hospice patients used to largely be cancer patients, but they have shifted to a majority non-cancer population that is more reflective of the general decedent population. *Chair Crosson* also noted that there is a particular emphasis on patients with chronic neurologic disease, and staff agreed that such patients make up the largest category.
  - *Commissioner Ryu* asked about the drivers in this change in diagnosis. Staff noted that there are many factors, including broader acceptance that hospice is appropriate for a range of patients and that longer stays may be more attractive from a business model perspective.

- Additional Topics
  - *Commissioner Grabowski* noted that live discharges should be monitored.
  - *Commissioner Perlin* suggested that one option to address long stays might be to reclassify patients as home health, to retrospectively address this issue. *Commissioner Gelb Safran* expressed interest in this idea.
  - *Commissioner Perlin* noted that it can be difficult, even for the best physicians, to accurately estimate the length of remaining life.
  - *Commissioner Buto* asked if the policy option could be implemented administratively, but staff indicated that it was not likely since the cap is written into statute.
  - Commissioner Casalino asked if there is information on physician referral patterns, but staff have not looked into this.

- *Commissioner Perlin* asked what the long hospice stays may be substituting for. Staff noted that they have heard anecdotally that the long stays may be replacing long-term care or other services and supports.
- *Commissioner DeSalvo* asked about the clinical services being delivered, including with respect to palliative care. Staff noted that the last time they compared use of services across cap versus non-cap hospices, they did not see much difference.

Public Comment

Annie Acs, National Hospice and Palliative Care Organization (NHPCO). Ms. Acs, the Director of Health Policy and Innovation at NHCPO, made comments on behalf of the organization's President and CEO Edo Banach. NHPCO is the largest membership organization representing the entire spectrum of non-profit and for-profit hospices. As stated today, the original intent of the cap was to establish savings. However, it is not clear if the contemplated changes to the hospice cap would produce savings for Medicare. The vast majority of hospice providers do not exceed the cap limits. NHPCO is concerned about the unintended consequences of the two options (the wage adjustment and cap reduction) on patients, especially for those in underserved areas. We would like to work with MedPAC on the policy to wage adjust the cap and may consider possibly indexing the cap based on quality. Any changes must first be tested to determine the extent to which beneficiary access to high quality care is hindered.

The next meeting will be November 7-8, 2019 at the Ronald Reagan Building and International Trade Center.

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