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

FROM THE NOVEMBER 2-3, 2017 MEDPAC MEETING
PREPARED BY HART HEALTH STRATEGIES, INC.
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Refining an alternative to the Merit-based Incentive Payment System

Presentation
Kate Bloniarz, David Glass

The Commission continued its discussion of the Merit-based Incentive Payment System (MIPS) and the potential policy options to replace this program under consideration. MedPAC has had concerns since the Medicare Access and CHIP Reauthorization Act (MACAR) was signed into law, and notes that CMS also has concerns given its “delay” of full implementation in the first two years (e.g., in year one, CMS established a “Pick Your Pace” reporting strategy to limit the reporting burden and penalty to as few as possible). MedPAC also noted that provider have expressed discontent with the program, among others.

Following up on last month’s discussion, MedPAC staff responded to Commissioner questions about the MIPS replacement – the Voluntary Value Program (VVP) – and questions about VVP’s interaction with Advanced Alternative Payment Models (A-APMs).

Starting with A-APMs, staff noted that CMS has taken favorable action making these more attractive to clinicians. For example, prospectively attributing beneficiaries to ACOs and allowing aggregation of smaller entities to form larger entities, among other things. Staff also said that A-APMs are available for specialists. Specifically, their data show 2/3 of physicians in Medicare Shared Savings Programs (MSSP) are specialists, and that three of seven existing A-APMs focus on conditions managed by specialists (i.e., Comprehensive Care of Joint Replacement, ESRD Seamless Care Organization and Oncology Care Model).

Staff also noted that the VVP would encourage clinicians to form voluntary groups and reward them for population-based outcomes, making them better positioned to join A-APMs since they would be familiar with groups and the associated measurement. Also, the VVP rewards would be limited, where A-APMs would be higher (currently at 5 percent). Essentially, the VVP would serve as an on-ramp to A-APMs.

Regarding the size of the groups being measured under the VVP, staff felt that 10 was reasonable, given experience measuring cost/quality using population-based measures under the now-sunset Value-Based Payment Modifier (VM). Staff did not believe there should be a limitation or cap on the size of a voluntary group, only a minimum. Staff also believe CMS could help provide assistance to clinicians in forming groups (i.e., referral networks). For those clinicians that are unable to find a group to join, CMS could create a fallback group.

Regarding measures, VVP would rely on population-based outcomes, patient experience and cost. And, those measures would be patient-oriented, encourage coordination across providers and time, and promote change in the delivery system. Clinicians would not be responsible for reporting the measures. During the last meeting, several Commissioners expressed that measures would need to be reliable and valid using a defined minimum number of cases; distinguish meaningful differences among voluntary groups; and appropriately risk-adjust. Addressing social risk factors was also raised as an important consideration. Given concerns about attribution, staff noted that single or multiple attribution could be used, and income cases a variety of attribution may be appropriate, but the default would be multiple.

Regarding the 2 percent withhold, staff noted that figure is illustrative; it could be larger or grow over time, but it shouldn’t be more attractive than A-APMs.
Given concerns about the loss of beneficial information collected in MIPS, staff noted that other entities, such as the ACOs, health systems, and even specialty societies, could continue to measure and report individual performance to clinicians or the public, if they so desire. Also, staff noted there are more direct ways of pursuing goals of having clinicians adopt and use electronic health record (EHR) technology. Also, under VVP, CMS would no longer need to certify qualified clinical data registries (QCDRs) and collect data from them. Registries could still be established to inform internal quality improvement.

Staff emphasized that the SGR would not return under the VVP proposal and that all other aspects of MACRA would stay in place; the VVP proposal only impacts MIPS.

Commissioners were then invited to consider the policy option and ask questions in preparation for a draft recommendation next month.

**Commission Discussion**

**Clarifying Questions:** Craig Samitt, MD asked how many specialists were not in ACOs that could be, given the figures presented? Staff were not able to answer the question, but felt as if specialists could easily join ACOs. They also noted that the MSSP program allows specialists to form ACOs, since it is an “any willing provider” program.

Bruce Pyenson asked staff to summarize the top 1-2 differences between MIPS and VVP. Staff described these as 1) all clinicians would be measured on the same set of measures, 2) assessment would only be done at a group level, and 3) clinicians would no longer be reporting data to Medicare.

Dana Gelb Safran asked staff to remind the Commission of the statutory MIPS payment adjustments. Staff provided an overview of these figures, but noted that CMS used its authority in the first two years, which limits the exposure of penalties and shrinks incentive potential significantly. Paul Ginsberg chimed in that the potential for larger rewards in later MIPS years could interfere with movement into A-APMs. He felt that many would stay in MIPS if they performed well, given the significant incentives available and the predictability of the program. He said the predictability of MIPS was a shortcoming of the program that undermines the A-APM track.

**Specialty APMs:** Dr. Samitt urged an acceleration of specialty APMs so that specialists have as much of an opportunity to engage in APMs as primary care physicians (PCPs). This really resonated with him as he felt specialists did not have a “home” under the proposal.

Dr. Jack Hoadley agreed that specialists need more A-APM options, noting that the data for specialists’ participation in ACOs must be for Track 1, which is not an A-APM under MACRA. Dr. Hoadley suggested that regional/national medical societies could potentially make their memberships a group under the VVP. He suggested that staff provide some options like this in the chapter, so the idea of forming VVP groups is less intimidating.

Ms. Dana Gelb Safran, Dr. Brian DeBusk, and Ms. Pat Wang also spoke to the need for specialist APMs. Dr. DeBusk noted he looks forward to the Advanced BPCI models, which are expected soon. Ms. Wang was concerned about holding surgeons accountable for readmissions when there is so much more to why readmissions occur that are unrelated to the surgeon’s performance in the operating room, thus outside the surgeons control.
Ms. Kathy Buto noted that specialty group issues are important, particularly for some specialists, like endocrinologists, who are focused on chronic conditions. She believes they may need to be treated differently under the VVP so they can more easily form A-APMs.

Dr. David Nerenz was surprised by the ACO figures, but noted that while a lot of specialists might be able to join ACOs, they are not likely engaged in any meaningful way.

**Group Size:** Dr. Samitt raised concerns about the size of voluntary groups, noting that 10 is too small, especially for readmissions measures. He said the minimum should be much higher. Ms. Wang agreed that 10 is too small, as did Ms. Safran and Dr. Grabowski. Ms. Safran said you need at least 10K to have stable and reliable information.

**Measures:** Dr. Samitt felt that measurement should be based on local benchmarks to reflect regional differences in care. Dr. Rita Redberg would like to see appropriate use/overutilization measures included.

Ms. Wang said that specialty societies could help with identifying the measures that are appropriate for specialists in a more enhanced VVP. She also expressed concern about risk adjustment.

Ms. Safran spoke in favor of using the current two-year transition period to encourage clinician reporting of CPT Category II codes to help with clinical outcome measures, as well as the use of patient reported outcomes measures (PROMs). She said that you couldn’t pay based on changes in score, but could pay based on adoption. The data from PROMs would be useful in shared decision making in the future (if collected over time). Clinicians would have to do this to earn their exceptional performance bonus.

**Attribution:** Dr. Samitt urged staff to reconsider multiple attribution, which he believes would undermine measurement and accountability, as well as create confusion. He spoke in favor of single attribution.

**Policy Option:** Generally, Dr. Nerenz and Dr. Coombs spoke against the policy option of replacing MIPS with the VVP, while the remaining Commissioners spoke in favor. Dr. Nerenz said there is no good evidence that the VVP will work and worried about the impact on beneficiaries. He also noted the program isn’t voluntary if there is a penalty. He also worried about the cost associated with forming voluntary groups, as well as the “social engineering” aspects. He said you can’t just put a group of physicians together and expect them to just start collaborating; it takes a lot more work. He supports repealing MIPS, but not with VVP, which he noted was essentially the same as an ACO.

Dr. Coombs does not support repeal of MIPS, which she believes, despite the negative aspects, has a lot of good and should not be scrapped yet. Most of the population measures that would be used in VVP do not save lives, but the measures that she and her colleagues are accountable for are under MIPS, do. And, these are what beneficiaries care about, as well as physicians who are trying to improve clinical care. She noted that MIPS may not be driving people into APMs directly, but physician movement into APMs is happening on its own according to a recent report by the Health Care Payment Learning and Action Network (The LAN).

Drs. Samitt and Redberg want to see a change in incentives and a move away from fee-for-service; worries we are not advancing under the current structure. Dr. DeBusk expressed some concern about the VVP becoming a MIPS catch-all, while. Dr. Paul Ginsberg said MIPS is unwieldy. Mr. Pyenson said the vendors will complain they are losing billions they have invested into the system for MIPS.
Ms. Buto and Mr. Warner Thomas encouraged an increase in the VVP withhold, with part of the withhold going to A-APMs. Both also prefer not to have a fallback group. Mr. Thomas also wants doctors to be more proactive, as he feels like most are not organizing because they simply don't want to.

A draft recommendation will be presented in December.

Improving incentives in the emergency department payment systems

Presentation
Jeff Stensland, Zach Gaumer, Brian O'Donnell, Sydney McClendon

The Commission continued its 2016 discussion of rural access to emergency services and its 2017 discussion of urban off-campus emergency departments (ED). Staff noted there is a need to maintain access to ED services in rural areas that cannot support a full-service hospital, but raised concerns about growth in ED visit volume in urban areas and potentially unnecessary growth in higher-cost ED visits relative to lower-cost physician office visits.

Staff showed the disparity in payment rates across Type A (open 24/7) and B (open less than 24/7) hospital EDs, and urgent care/doctor offices for “similar” level 3 ED and E/M services, which ranged from $264 -- $109. Staff also noted there are 580 stand-alone EDs in operation, but only hospital-owned off-campus EDs (OCEDs) can bill Medicare (if considered an off-campus provider-based department).

The Commission has noted an uptick in the number of stand-alone EDs, particularly in urban areas, which has generated concerns. Most of these have opened in high-income areas and have low stand-by costs compared to on-campus EDs, yet their reimbursements are the same. Growth is partially attributed to Section 603 of the Bipartisan Budget Act of 2015 which excepted EDs from off-campus site-neutrality payment rates, which means that OCEDs can bill higher OPPS rates for emergency services and non-emergency services (such as doctor’s office visits, imaging, etc.). As a result, health systems are incented to co-locate physician offices and other ancillary services within OCEDs.

**Addressing Section 603:** MedPAC offered a policy option that would pay physician offices co-located with OCEDs the same rates as off-campus physician offices (and no longer receive facility fees for physician office visits), which would mean lower rates for OCED physician practices, lower beneficiary cost-sharing, and less incentive to build unnecessary OCEDs.

**Addressing urban growth:** MedPAC offered a policy option that would set payments to account for the differences in the resource needs of OCED patients and those of urgent care cents and hospitals on-campus EDs. Type B rates would be paid if the urban OCED was within 20 minutes of an on-campus ED and Type A rates would be paid for more isolate OCEDs. This was determined given stats that more ambulance transports were made to on-campus EDs and walk-ins were predominant at OCEDs. The effect would be moderately lower rates for OCEDs, moderately lower cost-sharing for beneficiaries, and reduced incentive to build EDs when urgent care centers could meet patient needs.

Preserving access to care for beneficiaries in rural areas is also key, but the strategies that have been in place (i.e., making higher payment to rural PPS hospitals and cost-based payments for critical access hospitals CAHs), is increasingly inefficient and does not always preserve the hospital. Staff noted that admissions at CAHs are declining and the cost-based payments do not always preserve access to emergency care in rural areas. For example, 21 CAHs close from 2013 to 2017. Staff question whether the
funds used to preserve these hospitals would been better directed toward the ED to preserve access to emergency services in rural areas.

**Addressing rural access:** MedPAC offered a policy option that would target isolated hospitals (that is, those 35 miles from other hospitals) and provide them Type A outpatient PPS rates per service, and a fixed amount to help fund standby costs (i.e. Medicare provides a fixed amount and the local governments could be required to provide matching funds). This would maintain emergency services access in isolated areas and offset the cost of the additional ED payments with efficiency gains from consolidating inpatient services. Patients with acute needs would shift from low-occupancy to high-occupancy facilities, and post-acute care patients would shift from high-cost CAHs to facilities paid at skilled nursing facility PPS rates, although many patients would be forced to travel for inpatient care. Staff noted that the conversion would be optional for these hospitals, but it provides them with a mechanism for financial viability when inpatient volumes fall below viability levels. Also, the supplemental funds available to the outpatient facility will help with physician recruitment in rural areas. Beneficiaries would have lower coinsurance, as much as 50 percent when site convert from CAH to PPS.

**Commission Discussion**

**Clarifying questions:** Ms. Buto asked if there was any appeal to the idea from small rural hospitals so far and if they’d indicated they would they take it up. Staff conducted site visits and found that those in financial trouble were willing to convert to OCED and be part of another hospital or system. Dr. Miller said that the Kansas Hospital Association said it did modeling to see which ones could do this. Information on the payment model was a key element that was needed, however.

Ms. Amy Bricker asked about the issues with free-standing EDs in Texas. Staff said there has been a huge surge of stand-alone EDs. In 2010, the State decided to start registering these facilities for payment, which created a boom. The hospitals have opened OCEDs and there are also many independently owned. The hospitals can bill Medicare, but not the independents; so, the independents are partnering with hospitals to be able to bill Medicare. The market is saturated in Houston and Dallas. Generally, staff are concerned that the free-standing EDs in urban areas are not meeting access need, whereas the rural free-standing EDs would be.

Dr. Ginsberg was alarmed by data in the chapter, particularly that services are moving out of the urgent care and into the ED. He said that emergency physicians are increasingly employed by contracting groups that teach them how to code, which is a concern. He suggested adding these issues to MedPACs agenda.

Dr. Redberg was also concerned about coding creep, wondering why so many visits were Level 5. Staff responded that ED visits are not time based and the definitions are vague. Dr. Redberg also pointed out that private payers are not paying for certain diagnosis codes in the ED. She said patients should not be sent to the emergency department by their PCP for chest pain, which she said was low-risk. She referred to this as inappropriate triaging. As a cardiologist, she said many patients are referred to her inappropriately. She’d like to see ACOs incented to do a better job with this. She also wanted to see imaging addressed, because there is too much of this happening in the ED unnecessarily.

Ms. Safran worried whether the rural hospitals converting would be able to handle OB care, which staff said most of them were not doing that before.
Support for Policy Options: Chairman Crosson noted that the ED is costing the Medicare program too much, and is looking to the commissioners to provide staff important direction so they can prepare recommendations for the spring.

Dr. Grabowski, Ms. Safran and Ms. Bricker raised concerned about asking rural community governments to come up with matching funds, but were otherwise generally supportive of the policy options. Ms. Safran wants to see telehealth added to the discussion here.

Ms. Wang agreed with the rural option, but was concerned about the urban option because she noted that even in urban areas, you could have a hospital in trouble where the community needs access and the facility is serving a purpose. She urged the commission to consider an urban policy option similar to the rural option for urban hospitals in trouble. She urged the commission to stay away from any approach that seeks to differentiate payment types within the same facility, however.

Mr. Thomas generally supported the of the options, but did note that if there is no PAC provider in town, it could be a challenge. Wanted to see an option for those that convert to be able to revert back, if they wanted to. He also pointed out that, while fee-standing ED proliferation in urban areas may be inappropriate in some cases, if there are 12-14 hour waits in the on-campus ED, having another free-standing ED nearby is a good idea, because an urgent care would not be able to provide the right level of care.

Dr. Samitt is concerned about the policy options. He thinks we need more urgent cares and less EDs. Wondered if certain ED services should be paid differently (i.e., Level 4-5 paid Type B rates and Level 1-3 paid at urgent care rates).

Dr. Coombs, Dr. Hoadley and Dr. Ginsberg were generally supportive of all the policy options.

Public comment
A representative from CAPG spoke against the elimination of MIPS and VVP replacement.

Rebalancing the physician fee schedule towards primary care services

Presentation
Ariel Winter, Kevin Hayes

Staff reviewed prior Commission recommendations to rebalance the fee schedule toward primary care. The five core elements of primary care are accessibility, continuity, comprehensiveness, coordination, and accountability. High-quality care is essential for a well-functioning health care system. Primary care physicians include those in family medicine, internal medicine, geriatrics, and pediatrics (19 percent of professionals who billed Medicare in 2016). Other primary care practitioners include advanced practice registered nurses and physician assistants (21 percent of professionals who billed Medicare in 2016).

There are problems with how the fee schedule pays for primary care. Primary care services are underpriced relative to other services: the time needed for procedures eventually declines due to changes in productivity, clinical practice, and technology, but rates are not updated frequently enough to reflect reductions in time. Primary care services are labor intensive, so time is less likely to decline. Fee-for-service (FFS) payment allows certain specialties to more easily increase the volume of services than primary care clinicians. The fee schedule is not well-designed to support primary care.
The Centers for Medicare and Medicaid Services (CMS) has reviewed potentially mispriced services since 2008 but the fee schedule is still unbalanced. Services that comprise 29 percent of fee schedule spending have not yet been reviewed. Relative value units (RVUs) for clinician work did not decline as much as time estimates, potentially because decreases in time were partially offset by increases in intensity. Staff reviewed the wide income disparity between primary care and radiology/nonsurgical procedural specialties.

Prior incremental efforts to address underpricing of primary care services have not succeeded in rebalancing the fee schedule. The Commission may wish to consider more significant changes. Should Medicare increase payment rates for primary care services provided by all specialties or just primary care clinicians? Should payments also be increased for psychiatric services? How much should payments be increased? Should higher payments be distributed on a per service or per beneficiary basis?

One approach would increase the fee schedule payments for primary care and psychiatric services provided by all specialties. This would be a budget neutral change: higher payments for primary care and psychiatric services would be offset by lower payments for other services. The payment increase would be paid on a per-service basis. Primary care services would include evaluation and management E&M codes for office visits, home visits, visits to patients in long-term care settings, chronic care management, transitional care management, welcome-to-Medicare visits, and annual wellness visits. Psychiatric services would include the same E&M codes as primary care services and psychiatric diagnostic evaluation and psychotherapy. Staff outlined the share of fee schedule payments derived from primary care services in selected specialties.

The second approach presented by staff would increase payments for primary care and psychiatric services provided by certain clinicians. Clinicians would be eligible based on specialty designation (primary care or psychiatry) and their share of payments from primary care and psychiatric services. The rationale for targeting certain specialties: they play a unique role in the delivery system, and have lower compensation than many other specialties. This approach would use the same definitions of primary care and psychiatric services as the first approach. Primary care specialties would include family, internal, geriatric, and pediatric medicine, and advanced practice registered nurses and physician assistants. The payment increase under this approach could be distributed on a service-by-service basis, which would be easier to administer but reward clinicians who provide more discrete primary care visits. The payment increase could also be distributed on a per beneficiary basis, paying clinicians based on the size of their patient panel rather than the number of visits, which could encourage non-face-to-face care coordination. As the size of the payment increases, questions about patient attribution and risk adjustment will arise. The Commission could also consider a mix of both options.

Commission Discussion
Clarifying Questions: In response to a clarifying question, staff explained that take-up for chronic care and transitional management codes is still small, but is growing. Staff confirmed that if actual versus assumed time was corrected for in the fee schedule, you would have a good shot at getting the overall RVU correct. Staff clarified that only a certain set of E&M codes were considered primary care, for the sake of today’s discussion. Distribution according to a per beneficiary basis could be done prospectively or retrospectively, or a combination of the two.
Staff does not believe that a per-beneficiary payment should involve beneficiary cost-sharing.

**The Role of Compensation in Specialty Choice:** Staff clarified that the option of including psychiatry services was presented because psychiatrists derive a lot of their revenue from E&M office visits, and because they are on the lower end of compensation by specialty – though staff acknowledged that there are other issues at play that account for the low participation of psychiatrists in Medicare. The Chairman acknowledged that income is not the only factor accounting for the decision making of medical students – some specialties have gotten easier over time (due to technology, time spent at work, etc.). Staff will provide more details at a later date, but certainly other aspects of medical practice influence specialty choice outside of compensation. Another commissioner requested evidence on whether other non-procedural specialties are having a hard time attracting a workforce.

**Specialty Breakdown:** Within the non-surgical, non-procedural category of specialists, staff guesses there would be a small increase in payment (urology, endocrinology, rheumatology, etc.). Staff can get more dis-aggregated numbers on specialties going forward. Staff will check on whether palliative care is a distinct specialty care in the claims data – if it is not, it would be hard to identify whether or not it should be included within the umbrella of primary care. Staff will drill down and get more information on what else primary care specialties are spending their time on (where is the other share of fee schedule payments coming from?). Dr. Grabowski and another commissioner argued that geriatrics should be targeted as a primary care shortage area as well.

**Mid-Level Practitioners:** A number of commissioners pointed out that the increasing mid-level primary care workforce is going to make a difference on some of these issues, though a primary care shortage remains. The question is whether MedPAC should also try to do something to incentivize workforce shifts. Dr. Samitt believes that MedPAC should attempt to both stabilize primary care payments, and increase the primary care workforce. Ms. Bricker noted that if there is not a payment or workforce issue among mid-level providers, then this work should solely focus on physicians (although she is curious what this would mean from a financial perspective). There was some agreement that excluding mid-level practitioners from this discussion would be fine.

**Compensation for Primary Care Versus E&M:** Dr. Ginsburg was pleased that the distortions in the fee schedule were documented in today’s presentation. We’ve been using the term ‘primary care’ – but all the evidence about primary care is really about E&M...that is what is being distorted. We should be talking in terms of E&M services. There are real problems in the primary care workforce, which would be even more severe without recent growth in nurse practitioners and physician assistants. He is concerned about specialties that don’t have a lot of income from procedures. We need to rebrand this to be about E&M services and those physicians that perform them. We may need to make some decisions based not on data measurement, but on judgments regarding access to care, supply of physicians, etc. There was agreement among commissioners about the need to better analyze the magnitude of fee schedule distortions.

Ms. Buto was not completely comfortable with the approach taken today. She doesn’t think, at its best, that the solution of raising fees gets to the core of the problem with the disparities/distortions. Yes, fees should be adjusted to take into account overpriced procedures in order to value them more accurately. But that is a baby step – the issue is the need to recognize that primary care, or the management of patients by some physicians, is at the core of what the Medicare program does. This is a critical role that needs to be rewarded justly. I don’t think you can just do this for all primary care physicians – you would
need to start in a more targeted way to improve the management of the most difficult patients. She is queasy about assigning an arbitrary increase and taking a decrease from every other physician. She supports the direction of addressing the inequities in the ways fees are computed and updated. She would like to see something that looks more like partial capitation, to highlight the central role of management and primary care. We can find a way to address some of the real inequities in the fee schedule itself, but I hope we go beyond this and look at a more comprehensive approach to raise funding for managing patients to a higher level.

Dr. Nerenz believes that the first approach would be a blunt instrument for addressing the problem presented. He doesn’t believe primary care is the right label for what MedPAC is discussing. Everything included in E&M isn’t necessarily valuable or worth more money. Commissioners should be more nuanced about where the value is within the categories of primary care and E&M. He expressed concern about pay cuts for proceduralists – it will be relatively easier for them to just do more services in response to a rebalancing.

Another commissioner believes that examining specialties that deliver E&M services is a slippery slope. MedPAC should consider whether there is something in research regarding the common definition for what is considered primary care. Dr. Hoadley asked whether there is any data on who beneficiaries regard as their primary doctor – who is playing the primary care role from their perspective?

Dr. Redberg also noted the need to recognize that a lot of specialties can provide important E&M services.

Dr. Coombs noted that requiring a specialist reach a certain benchmark for their E&M service provision could be considered.

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

- Dr. Samitt, Ms. Bricker, Dr. Thomas, Dr. Redberg, and others support the targeted focus on primary care clinicians.
- Other commissioners support the first approach, which would focus on primary care services – it would address the fee schedule distortion and could be implemented faster.

**Should payments also be increased for psychiatric services?**

- Dr. Samitt, Mr. Thomas, Dr. Hoadley, and others agreed, though it remains unclear if this will be enough to attract more psychiatrists to Medicare.
- Another commissioner argued that payments for psychiatrists should not be increased unless there is assurance that it will increase their participation rate in the Medicare program.

**How much should payments be increased?**

- Dr. Samitt believes the increase should start with the lowest threshold.
- A commissioner pointed out that MedPAC should not try to answer this question without tying it to the conversation about the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs).
- Other commissioners, like Dr. Hoadley, were unsure.

**Should higher payments be distributed on a per service or per beneficiary basis?**

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• Dr. Samitt and Dr. Redberg support a per beneficiary approach—in the hopes that accountable care organizations (ACOs) and other efforts will move the system toward more population health. This would also encourage innovation (like in telehealth).
• Another commissioner was indifferent on who payments should be distributed (whichever approach is easier).
• Dr. Hoadley was inclined to support a per-service distribution, while acknowledging that attribution could get complicated (did the patient see a doctor just for that service?).

The Chairman closed by noting that commissioners’ perspectives will be helpful to prioritize the next set of discussions on this issue.

Increasing the equity of payments within each post-acute care setting

Presentation
Carol Carter

MedPAC is pursuing this now to begin to correct biases of current prospective payment systems (PPS) and redistribute and increase the equity of payments, to encourage providers to make the changes needed to be successful under a unified post-acute care (PAC) PPS, and to support recommendations that would better align payments to costs without undesirable impacts.

Payments should be adequate to ensure beneficiary access while protecting taxpayers and long-run sustainability of the program. To improve payment accuracy and equity, payments should be aligned with the cost of treating patients with different care needs.

There are a number of concerns about Medicare’s current PAC payment systems. The level of payments is high. The current PPSs encourage providers to furnish therapy services unrelated to care needs; prefer to treat some types of patients and avoid medically complex patients; extend lengths of stay to avoid short-stay payments, or, in the case of skilled nursing facilities (SNFs), to increase payments; and/or code clinical conditions and frailty to raise payments. Provider financial performance varies widely. There are also more general concerns about PAC—similar patients are treated in home health agencies (HHAs), SNFs, inpatient rehabilitation facilities (IRFs), and long-term care facilities (LTCFs). Separate payment systems establish different payments for similar patients. There is a lack of evidence-based guidelines to base decisions about the need for PAC. Medicare per capita spending varies more for PAC than for any other covered services. These concerns have led Congress to mandate studies of a unified PAC PPS in the Improving Medicare PAC Transformation (IMPACT) Act of 2014.

Staff estimated the impact of a unified PAC PPS using 8.9 million PAC stays in 2013 and other readily available data. The system would redistribute payments across conditions, increasing payments for medically complex care, and decreasing payments for rehabilitation care unrelated to a patient’s condition. The system would narrow the relative profitability across conditions. A unified PAC PPS is feasible, could be implemented sooner than contemplated, and would result in more equitable payments.

Staff reviewed the basic elements of the system. Within each setting, payments would be calculated using a blend of the setting-specific and the unified PAC PPS relative weights. Total payments to each setting would remain at the Commission’s recommended level. Within each setting, the system would begin to redistribute payments across conditions. Blending a PAC PPS and setting-specific relative weights would
change the case-mix adjuster. Within each setting, blended relative weights would shift payments across providers. Payments would increase for nonprofit providers and hospital-based providers. Payments would decrease for for-profit providers and freestanding providers. At current levels, aggregate payments to a setting remain well above the cost of care.

It is possible to increase the equity of payments within each setting before implementing a unified PAC PPS. Redistribution would begin to correct the biases of current PPSs, increase the equity of payments across conditions, give providers more time to adjust to changes needed to be more successful under a PAC PPS, and support recommendations that better align payments to the cost of care. Next month’s update will evaluate the level of payments in each setting, and consider an approach to increase the equity of payments within each setting.

Commission Discussion
Clarifying Questions: Staff clarified that statute requires a unified payment system to be studied, but not actually implemented.

Budget Neutrality: Dr. Grabowski believes the proposal should hold each sector budget neutral. There are going to be winners and losers, but he doesn’t want to shrink the pie. Other commissioners were interested in learning if there were any cases where this proposal would push a sector upwards initially, then downwards dramatically under a unified PPS. This would be a situation to be aware of.

Next Steps: The Chairman has not heard a lot of opposition to this proposal, which could be included as a policy option in the regular update recommendations next year. is there enough support to bring this policy option forward in December and January? Dr. Grabowski, Ms. Buto, Dr. Ginsburg, Dr. Coombs, and Dr. Hoadley strongly support the proposal. It is a step in the right direction. Dr. Grabowski noted that there is both within and across sector distortion in paying for and delivering these services.

Mr. Thomas would like more clarity around the weighting proposal and methodology. As we see more and more care in the hospital being done on an outpatient basis with follow up home care, we need to fund that appropriately (it is probably more intensive home care) so that we continue to see people discharged to home, rather than going to another inpatient setting.

Medicare payment policy for non-competitively bid durable medical equipment, prosthetics, orthotics, and supplies

Presentation
Brian O’Donnell

Staff provided background on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule rates, the competitive bidding program (CBP), and CBP results. Their analysis of non-CBP DMEPOS products’ payment rates focused on the highest-expenditure items because spending is concentrated in those products. They examined non-CBP products for signs of excessive payment rates by comparing Medicare payment rates to private payer rates and examining codes for rapid expenditure growth.

They found that Medicare rates were higher than private payer rates for 9 of 10 items by 18-57 percent. Medicare would have saved approximately $192 million in 2015 if Medicare rates were equal to median private payer rates. Among the top 10 non-CBP DMEPOS products, Medicare expenditures grew 21
percent on average in one year (2014-2015). Rapid growth often occurred over multiple years and continued into 2016.

One policy option to improve payment accuracy would be to encourage CMS to use its current authority to include more products in CBP, and expand the agency’s statutory authority to include other DMEPOS products. Payment rates for certain non-CBP products could be immediately reduced, followed by reduced rates annually until the products are included in CBP or the rate is similar to private payers. Another policy option would be aligning participation and balance billing rules with other Part B services to protect beneficiaries.

Commission Discussion

Clarifying Questions: Staff confirmed that CMS does have the ability to use DME infused drugs (pumps, nebulizer, etc.) in competitive bidding. Staff clarified that the agency does not have the current authority to make adjustments like phasing in the commercial price as an upper limit in Medicare. The fee schedule is the exclusive payment rule for DME not included in the CBP.

General Comments: Dr. DeBusk lead the discussion on this topic. It is good to expose non-CBP items to market forces. Depending on the product, however, the tactics to be used will be different. He did not advocate an overhaul of the CBP, but is in favor of steps to make it more effective. In some of these situations (like bracing), we need to figure out how to reign in some practices (ex. narrow the L code descriptor, look at preauthorization, visit-based encounters, keeping the prescribing and dispensing closer together). CBP is a great program and has been very successful, he would just advocate for making it smarter, and achieving savings through refined billing and coding practices.

Support for the Policy Proposals: Dr. DeBusk is in favor of adding more products to the CBP, but not in favor of reducing rates across the board in a broad, non-specific manner. This could be accomplished once coding changes were put in place. He also supports the proposed beneficiary protections. Dr. Redberg supports the recommendations to move toward increased use of the CBP. She is interested in not just the price of these products, but what beneficiaries are getting for the money. There is very little data on a lot of these devices. She doesn't understand why some things are excluded from CBP in the first place, and supports moving toward value-based process. Dr. Hoadley agreed, and is very much in favor of beneficiary protections. Dr. Grabowski is also in favor of adding more products to the CBP (while seeing it strengthened), in addition to patient protections. Dr. Ginsburg is very much in favor of the policy options, but would also like to discuss refining the auction process. Commissioners were open to other suggestions from Dr. DeBusk to refine short term issues and correct the flaws in the current CBP.

The Chairman asked for more specific input from Dr. DeBusk as MedPAC evolves this policy.

Public Comment

The Alliance of Wound Care Stakeholders suggested that before MedPAC starts thinking about products to add to the CBP, coding needs to align with payment. CMS needs to reform its coding system — the trend is to group disparate products, and instead of giving them a new code, it will give a code that says “any type.” What results is disparate products under one code, all very different, but with one price. She referred commissioners to a 1998 Government Accountability Office (GAO) study on processing claims.
Biosimilars in Medicare Part D

Presentation
Shinobu Suzuki, Rachel Schmidt

Staff provided an overview of biologics (therapies derived from living cells or organisms and manufactured through biological processes) versus biosimilars (follow-on products that are highly similar to – but not exact replicas of – the originator biologics), as well as an overview of how Medicare pays for biologics and biosimilars in Part D and how the Part D benefit is structured. They noted that manufacturers pay 50% of the cost of brand name drugs and biologics in the coverage gap, and that beneficiaries who use high-priced biologics tend to reach the catastrophic phase of coverage, where beneficiaries pay 5 percent cost sharing and Medicare bears most of the cost. Staff also noted that Part D spending for biologics has increased at an average annual rate of 29 percent from 2011 to 2015, and that it has grown as a share of Part D spending, but that the number of prescriptions has not grown as a percentage of total Part D prescriptions. They also noted that over 80 percent of Part D biologic spending and nearly 90 percent of spending growth is attributable to three treatment categories: insulin, inflammatory diseases (e.g. rheumatoid arthritis), and multiple sclerosis. They also noted that prices for these three categories of drugs grew between 16 and 20 percent annually.

Staff noted that the manufacturer coverage gap discounts only apply to originator biologics, which distorts price signals and may affect formulary placement. While plans generally encourage use of lower-priced products, the discrepancy in application of manufacturers to biologics versus biosimilars provides a financial advantage to originator biologics. Similarly, beneficiaries may have higher cost sharing with biosimilars. This is largely attributable to the fact that manufacturer discounts count towards beneficiaries’ out-of-pocket (OOP) spending, which determines when they hit the catastrophic phase of coverage. Beneficiaries who use originator drugs would move more quickly into the catastrophic phase than those who use biosimilars.

Staff introduced a policy option that would apply coverage gap discounts to biosimilars, in order to reduce price distortion and align incentives. Further, consistent with previous recommendations, coverage gap discounts would not be treated as beneficiaries’ OOP costs for the purposes of determining movement into the catastrophic phase.

Staff noted that this option builds off of June 2016 recommendations to:
- Transition Medicare’s reinsurance from 80 percent to 20 percent of catastrophic spending and keep Medicare’s overall subsidy at 74.5 percent through higher capitated payments;
- Exclude manufacturers’ discounts in the coverage gap from enrollees’ “true OOP” spending.
- Eliminate cost sharing above the OOP threshold.

Staff presented the following Chairman’s Draft Recommendation:
- The Congress should change Part D’s coverage-gap discount program to:
  - Require manufacturers of biosimilar products to pay the coverage-gap discount by including biosimilars in the definition of “applicable drugs,” and
  - Exclude biosimilar manufacturers’ discounts in the coverage gap from enrollees’ true OOP spending.
Staff noted that the draft recommendation would lead to the following impacts:
- Better price signals, greater opportunity for biosimilars to be placed on plan formularies
- Relative to current law:
  - Manufacturers would pay larger discounts
  - Medicare would continue to pay 74.5 percent subsidies, but there would be higher plan liability and direct subsidies and lower Medicare reinsurance
  - Enrollees who reach the coverage gap could have higher cost sharing

Further, the Commission’s 2016 recommendations would eliminate cost sharing above the OOP threshold. The value of the hard OOP cap would grow over time, but to the extent that the 2016 recommendations resulted in net savings, there could be consideration of lowering the OOP threshold.

Commission Discussion

Clarifying Questions: Commissioners raised the following clarifying questions.
- Are biosimilars being included on plan formularies? (Buto) There was not enough information since the one example staff could find on this was not technically a biosimilar and it was therefore subject to the discount.
- Are the recommendations on top of the 2016 recommendations? (Hoadley) Chairman Crosson believed these were an extension of 2016 recommendations and hoped that Congress would take them all together.
- Are the manufacturer discounts similar to manufacturer coupons? (Ginsburg) By lowering cost-sharing, there is an effect similar to discounts.
- How are the OOP caps growing and would hard caps help? (Christianson) Benefit parameters grow by average spending in the program, which has historically been lower than the price growth for expensive drugs, so those beneficiaries who take expensive medications get to the catastrophic limit quickly in the year.
- How do pay-for-delay settlements (like the Amgen/AbbVie settlement) factor in? (Bricker) The Medicare Modernization Act established reporting requirements for such settlements, but larger molecule drugs are not subject to this reporting requirement, so FTC is not receiving reports on these types of settlements.
- Would it be helpful to show graphics showing impact for LIS beneficiaries? (Pyenson) Mark Miller mentioned that LIS are not incurring OOP spending, and that they are more concerned with the federal share.
- What would a visual representation of the policy alternative look like? (Wang) Mark Miller mentioned that they struggled with visual representation, and that they sought to provide displays in the slide deck.
- How does the manufacturer discount work operationally, and what was the goal? (Redberg) Staff noted this has changed over time and that Medicare used to front funds but the arrangements are more direct now. Commissioner Pyenson noted that manufacturers have to report liability related to the discounts in their financial statements. Staff noted that the intent of the discounts was to require enrollees to pay less. However, Medicare pays more because beneficiaries get through the coverage gap faster with the discounts counting toward OOP spending.
- Can providers provide rebates/discounts for patients in other areas of Medicare? (Warner) Commissioner Buto noted that doctors have tried to waiver cost sharing requirements, but that that would trigger anti-kickback provisions, so statutory changes would be needed.
Need to Expand Context: Many Commissioners raised the need to expand the context in terms of thinking about Part D spending on drugs and to make sure to keep these topics on the table. Additional topics that were raised for consideration include:
- Barriers to drug entry (FDA approval, interchangeability policies, patent disputes, and state laws that limit automatic substitution of biosimilars) (Hoadley, Bricker, Coombs, Redberg)
  Commissioner Redberg noted that Allergan is attempting to transfer a patent to the Mohawk tribe to extend the patent life.
- Exemption for reporting pay-for-delay settlements like the Amgen/AbbVie settlement, which delays access to the biologic in the United States until 2023, but allows for access in the European Union, and the impact of such settlements on delaying access to biosimilars (Bricker, Thomas, Coombs, Hoadley)
- Broad solutions to address drug affordability and pricing, overall spending, and spending growth (Warner, Wang, Redberg, Crosson)
- Commissioner Pyenson suggested that there could be more opportunity on the Part B side rather than Part D, since there are set structures and processes for federal payment.
- The role of rebate arrangements in increasing drug prices (e.g. the “rebate trap”). (DeBusk, Hoadley) Commissioner DeBusk raised the lawsuit between Pfizer and Johnson and Johnson as an example.

Importance of Adhering to 2016 Recommendations: Several Commissioners noted the importance of placing the new coverage gap discount recommendations in the context of the previous recommendations, particularly with respect to the recommended changes to reinsurance coverage. (Hoadley, Coombs, Buto). Mark Miller mentioned that scoring will be in the context of the 2016 recommendations, and that CBO will not be able to provide scoring of the incremental effect of the new recommendation. Commissioner Wang mentioned that the reinsurance proposal from 2016 is about shifting risk for cost, and Commissioner Coombs indicated that the risk shift would change choices and behaviors of stakeholders. Commissioner Coombs asked if the Commission would consider prioritizing some of the recommendations over others.

Concern about Additional Beneficiary Cost Sharing: A few Commissioners raised potential concerns about higher OOP spending if manufacturer discounts do not count as OOP spending. (Safran, Buto) Staff noted that many beneficiaries would end up with higher cost sharing since they would not reach the catastrophic phase. At the same time, Commissioner Hoadley noted that, while that is true, the people who would benefit under the recommendation to cap OOP spending in the catastrophic phase would be much better off (and have a higher dollar impact), so there is a complicated trade off.

Management of Costs for Sole Source Drugs. Commissioner Wang noted that there is not much management for sole source specialty drugs that are important for patients’ health. Commissioner Bricker mentioned that there is some management, for example priority authorization, and Commissioner Pyenson also mentioned that there is some interchangeability, even if the drugs are not technically interchangeable; he offered insulins and growth hormones as examples. Commissioner Hoadley noted that prior authorization limits access. Both Commissioners Pyenson and Hoadley referenced potential lessons from Europe on how to handle interchangeability/substitution.

Additional Considerations: Commissioners also raised the following considerations:
- The need to track factors that encourage or support clinician acceptance of biosimilars (Wang)
- The potential to look at value-based contracting (Hoadley)
- The potential for MedPAC to comment on FDA policy given the relationship with Medicare coverage (Buto)
- Potential for competitive bidding (Safran)
- Concern about the tone when discussion manufacturers’ motivations, who agreed to discounts to help reduce cost sharing for Part D beneficiaries (Buto)

Mandated Report: Principles for evaluating the expansion of Medicare’s coverage of telehealth services

Presentation
Zach Gaumer, Andrew Johnson, Amy Phillips

Staff noted that today’s discussion covers the third of the three Congressional mandates – to identify ways in which telehealth services covered under private insurance plans might be incorporated into the Medicare fee-for-service (FFS) program (including any recommendations for ways to accomplish this incorporation).

Staff noted that they narrowed the definition of telehealth to include:
- Direct-to-consumer (DTC): patient-initiated telephone or two-way video virtual visits with clinicians from any location
- Provider-to-provider (PTP): a clinician at an originating site – in the presence of a patient – initiating communication with a clinical specialist at a distant site
- Remote patient monitoring (RPM): A patient at home or a facility being monitored by a clinician from a remote location using two-way video or electronic device

Staff noted that their research identified several distinctions between Medicare coverage and private payer coverage, and highlighted a few:
- Payment incentives: Under the Physician Fee Schedule (PFS), taxpayers are not indemnified against volume incentives, whereas commercial plans can use tools to control volume
- Originating sites: Medicare restricts telehealth to rural sites, but commercial plans allow access from a variety of locations, including rural and urban sites, and also patients’ homes
- Cost sharing: Under Medicare, the costs are similar to in-person services, but most beneficiaries are shielded by Medigap, while for commercial plans cost sharing is generally equal to or above in-person services
- Managed care financing: Under Medicare Advantage (MA), benefits are financed from rebates or supplemental premiums, while for commercial plans finance telehealth the same as other benefits
- Testing: Medicare has some testing as part of larger payment models, but for commercial plans, focused testing is common

Staff identified the following principles for evaluating telehealth services under Medicare, noting that services should strike a balance between:
- Access: Expand the availability of services or providers, facilitating more timely delivery of care and increasing convenience
- Quality – improve outcomes, patient experience, or value
- Cost – reduce costs for beneficiaries or the Medicare program
Staff provided four illustrative examples of how to apply principles to the determination of policy changes related to coverage of telehealth services, all of which are expected to increase costs for Medicare:

- **Example 1:** Telestroke expansion to urban sites. This is a limited service that would expand access to neurologists and thereby likely lead to quality improvement. There is low risk of misuse and also the potential for savings from reducing disabilities, but there is also a limited supply of providers.

- **Example 2:** Expansion of telehealth to urban sites and patient homes for patients with certain physical conditions or mobility limitations (e.g. Parkinson’s). The population is relatively limited and the expansion could benefit patient outcomes, but evidence is limited.

- **Example 3:** Expansion of telehealth to urban sites and patient homes for patients accessing mental health services. This could potentially increase access and improve outcomes, but evidence is limited. There is also a limited supply of providers.

- **Example 4:** DTC telehealth services in urban and rural areas, which would expand access but with unclear evidence of quality effects.

These examples go from more to less targeted beneficiary populations, with less evidence of benefits. MedPAC staff noted that cost increases under examples 2-4 could be mitigated by tools such as visit caps or prior authorization. Staff noted that some services may add value greater than their potential costs, while others may be unclear and require testing first.

Staff noted that additional flexibility did not seem necessary in other FFS payment settings since there is already flexibility and services can be provided in provider’s fixed payments. Staff did note that Commissioners were interested in providing additional flexibility to entities bearing risk, such as two-sided ACOs and MA plans. With respect to MA, staff provided two options:

- **Option 1:** Expand telehealth in FFS, in which case benefits would effectively expand to MA. This would essentially be status quo.

- **Option 2:** Allow MA plans to include telehealth services in their basic bid, rather than requiring plans to bid using rebate dollars. Plans would be required to report the telehealth component of their bid separately from other A/B benefits, and would lead to differential benefits under FFS and MA.

Staff noted that, following today’s discussion, a full report would be discussed at the January meeting, and that the Report to Congress is due March 15. The report would follow the structure of the discussions to date.

**Commission Discussion**

**Clarifying Questions:** Commissioners raised the following clarifying questions.

- Do plans have flexibility to substitute other non-covered services for MA benefits if they think that will improve care? (Buto) There is some flexibility, but plans cannot market a telehealth benefit.

- Are there other examples where expansion of telehealth could reduce costs (similar to potential savings for telestroke)? (Grabowski) Staff hadn’t seen any information on other options.

- Would the report include formal recommendations? (Hoadley) The Commission would vote on the entirety of the report. Chairman Crosson noted that whether some options are supported more strongly will depend on the conversation today.
- Where there is a limited supply of providers, is it possible that expansion of telehealth may not increase access? Or that the cost impact may not be as high because increase in telehealth services may be accompanied by decreases in other services? Question raised for consideration. (Ginsburg)
- Is the MA Option 2 required for all MA plans, or optional for plans? (Pyenson). This would be an option for plans who choose to offer telehealth services.

Characterization of Telehealth: A Commissioner raised the question of whether the illustrative examples create a new benefit or just offer the same benefit via a new mechanism (Nerenz), with some agreeing that, for mental health, the service is the same and that telehealth just increases flexibility in the way the service is delivered (Nerenz, Ginsburg, Buto). A couple of Commissioners also noted that the discussion did not seem to make the usual distinction between rural/urban originating sites very clear (Hoadley, Buto).

Support for Limited Testing: A few Commissioners raised support for testing through CMMI rather than broad expansion. (Ginsberg, Grabowski, Coombs, Warner) At the same time, some also seemed to support more aggressive expansion in certain areas.

Consideration of Four Examples as “Illustrative Examples” or Actual Areas for Expansion: Mark Miller raised the point that the four examples are illustrative examples that show where there is more or less evidence that the cost is worth the benefit. Some Commissioners appreciated this approach to considering the examples. (Hoadley, Grabowski). However, Commissioner Buto suggested that the areas identified may not just be illustrative examples, but where – in accordance with the Congressional mandate – commercial plan experience suggests that changes might be incorporated into Medicare.
- Support for FFS Telestroke: Several Commissioners expressed support for expansion of telestroke services (Coombs, Redberg, Thomas, Wang). Commissioner Thomas noted the benefit of local retention of patients.
- Support for FFS Telehealth with Certain Conditions: Commissioner Coombs noted support for telehealth for patients with Parkinson’s.
- Support for FFS Tele-Mental Health: Several Commissioners expressed support for tele-mental health services (Nerenz, Ginburg, Coombs, Redberg, Thomas, DeBusk). Commissioner Wang expressed some reservations about broad coverage in FFS. Commissioner DeBusk noted that support for tele-mental health under FFS would send an aggressive message that the Medicare program is prepared to respond aggressively to fill provider shortages (given 50 percent participation rate by mental health providers in the Medicare program).

Support for Flexibility with Risk Bearing Entities: Several Commissioners noted support for additional flexibility for risk-bearing entities like MA plans and ACOs given volume incentives in FFS. (Grabowski, Safran, Coombs, Redberg, Wang). Commission Wang noted that her interpretation of flexibility is on a person-specific basis, rather than notice of broad availability.
- Support for MA Option 2: A couple of Commissioners express support for Option 2, in particular. (DeBusk, Ginsburg). Commissioner DeBusk noted that providing for MA coverage of telehealth under the second MA option would allow the Medicare program to benefit from telemedicine at an incremental cost since interested plans would likely already be covering services using their rebate dollars, so the “cost” of including telehealth in the base bid would only be the difference between the rebate percentage (e.g. 50, 60, 70 percent) and the 100 percent coverage provided under Option 2. Commissioner Ginsburg noted that MA plans would not have good information about whether telehealth increases or decreases costs for several years.
Additional Considerations: Commissioners also raised the following considerations:

- Telehealth provides value to patients who might be working, and value to employers (Crosson)
- Potential additional flexibility for DTC telehealth services for primary care physicians who might receive a per beneficiary primary care payment, as contemplated by the Commission (Buto)
- Whether broader coverage of telehealth would require CMS to reconsider E/M codes, and whether payments should be adjusted to account for lower practice expense costs (Pyenson)
- Concerns about potential exploitation by telehealth vendors and need to consider prevention (Hoadley, Crosson)
- The benefit of incorporating site visits into research and policy recommendations (Ginsburg)

Closing and Public Comment
Chairman Crosson noted that this is the last meeting for Mark Miller, who will be leaving MedPAC this month. He then opened the floor for public comment, noting that there are many ways to provide comment to MedPAC. Public comments included the following:

- A representative from the American Medical Associated noted the following:
  o Many physicians raised concerns during the Affordable Care Act debate that the new FDA regulatory regime could create confusion about interchangeability.
  o AMA strongly supports efforts to remove perverse incentives to use innovator drugs, but cautions against forced switching.
  o AMA applauds the telehealth structure outlined in today’s discussion, including the three criteria. However, they see a distinction between telehealth and remote patient monitoring (RMP) and they also caution that a telephone call is not telehealth.
  o AMA has supported work on an Interstate Compact that includes 22 states in order to address state licensure issues.
  o Most telehealth does not cross state lines.
  o There is support for three of the examples: tele-mental health, telehealth for complex chronic conditions, and telehealth for specialty areas that are underserved such as neurology.
- A representative from the Alliance for Connected Care noted that remote monitoring is not subject to telehealth restrictions, and suggested that the Commission may need to reexamine the definition of telehealth. She also noted that some RMP is paid (e.g. CMS just unbundled 99091) and that there is voluminous data on RMP, even in the Medicare program. She also recommended that MedPAC consider post-acute care as another example, and noted the 8 codes provided under the Comprehensive Care for Joint Replacement model. She also asked MedPAC to acknowledge coverage of telehealth in the VA, TriCare, and DOD, where savings have been shown.
- A representative from the American College of Medical Genetics and Genomics noted that there is a need for coverage of telehealth for genomic medicine and medical geneticists, who are primarily located in academic medical centers.
- A representative from the University of Virginia Health System expressed thanks to MedPAC staff for conducting a visiting them to inform this work and appreciation for some of the examples used in the discussion. She noted that additional work is needed for substance abuse, that her system has seen savings with RPM, and that in Charlottesville, there is not much MA coverage.
The next meeting will be December 7-8, 2017 at the Ronald Reagan Building and International Trade Center.

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