

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 7, 2019  
9:40 a.m.

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DR. CROSSON: Okay. I think we can sit down and begin.

I would like to begin the meeting, welcome our guests for the morning session. The first topic here is a continued discussion on the part of the Commission on the issue of pharmaceutical costs, and we are going to be talking about - today we are going to be talking about various proposals to try to improve the cost of pharmaceuticals paid under Medicare Part B. And we will begin with Nancy, and, Kim, I guess you are going to start, or Nancy, you are going to start?

MS. RAY: Yes. Good morning. Today we are going to discuss two potential Medicare payment strategies to improve price competition and value for Part B drugs reference pricing and binding arbitration. The idea is that these strategies could build on the Commission's June 2017 recommendations to improve payment for Part B drugs. We anticipate that these topics could be included in a broader June 2019 chapter on drug issues.

First, some background about the topic. Part B

1 drugs include products mostly administered in physician  
2 offices and hospital outpatient departments. The Medicare  
3 program and beneficiaries spent \$32 billion on Part B drugs  
4 in 2017.

5 Spending has been growing rapidly, 9.6 percent  
6 per year on average since 2009. Price growth accounts for  
7 more than half of spending growth, which reflects increases  
8 in the prices of existing drugs and shifts in the mix of  
9 drugs, including the launch of new high-priced drugs.

10 Most Part B drugs are paid at a rate of 106  
11 percent of the average sales price. ASP is the average  
12 price the manufacturer realizes from selling the drug to  
13 most purchasers net of rebates and discounts, with some  
14 exceptions.

15 Due to concern about rising spending growth, high  
16 prices of some Part B drugs, lack of price competition for  
17 some drugs, and provider incentives under this payment  
18 system, the Commission, in June of 2017, recommended  
19 improvements.

20 The Commission's recommendation had three major  
21 components. The first part was improvements to the ASP  
22 payment system. And for example, here the Commission

1 recommended consolidated billing codes for biosimilars and  
2 reference biologics to spur price competition among these  
3 products, and an ASP inflation rebate to address price  
4 growth in the years after a product's launch.

5           The second part of the recommendation called for  
6 development of a voluntary market-based alternative to the  
7 ASP payment system that physicians and hospitals could  
8 choose to enroll in. This alternative, which we referred  
9 to as the drug value program, or DVP, would rely on vendors  
10 to negotiate lower prices using tools including binding  
11 arbitration in certain circumstances.

12           The final part of the recommendation was to  
13 reduce the ASP add-on in the ASP system to encourage DVP  
14 enrollment.

15           We developed the 2017 recommendations as a  
16 package. Subsequently, Commissioners have expressed  
17 interest to do more to influence the price Medicare pays  
18 for drugs. So today, we are going to talk about extracting  
19 some elements of the 2017 recommendation and evaluating  
20 whether to use them more broadly. So first, I'll talk  
21 about reference pricing as a potential strategy to improve  
22 price competition and value among single source drugs with

1 similar health effects. And then Kim will discuss binding  
2 arbitration as a potential strategy to address launch  
3 prices for high cost drugs with limited competition.

4           There is evidence that the ASP construct of  
5 assigning single-source brand drugs and biologics to  
6 separate billing codes does not promote price competition  
7 among therapeutically similar products.

8           There is concern that ASP payment policy does not  
9 consider whether a drug results in better outcomes than its  
10 alternatives.

11 Consequently, there are instances in which a drug's ASP is  
12 higher than its alternatives even though there is no  
13 evidence on whether the product improves outcomes or when  
14 evidence shows it results in similar health effects.

15           The Commission has held that Medicare should pay  
16 similar rates for similar care.

17           Reference pricing might be a tool to apply to  
18 products with similar health effects that could improve  
19 price competition and value for Part B drugs.

20           To spur competition, some payers have adopted  
21 reference pricing policies under which a maximum payment is  
22 established for groups of therapeutically similar drugs.

1 Payment can be set based on the price of the least costly  
2 agent, or some other point along the range of prices within  
3 the drug group. Reference pricing is an extension of the  
4 Commission's standing recommendation to implement  
5 consolidated billing codes for a reference biologic and its  
6 biosimilars.

7           Reference pricing is designed to drive the  
8 patient and physician toward lower priced alternatives.  
9 But under reference pricing, access to higher-cost products  
10 is maintained. If the patient and his/her provider select  
11 a higher-priced treatment, the patient would pay the  
12 difference in higher cost sharing.

13           Our review of the literature suggests that  
14 reference pricing reduces drug prices and lowers payers'  
15 spending.

16           The two approaches to reference pricing vary  
17 based on the source of drug pricing data. Under internal  
18 reference pricing, a payer uses its own pricing data to set  
19 the payment amount for a group of clinically comparable  
20 products based on, for example, the least costly product.  
21 Under international reference pricing, a payer sets the  
22 price it pays for a drug based on the prices used in other

1 countries.

2           Internal reference pricing is an emerging benefit  
3 design among U.S. payers and employers, and we have  
4 provided two examples in your briefing paper.

5           Reference pricing is used more frequently in  
6 other countries, in nearly all European Union member  
7 countries as well as in Australia, Canada, and Japan. We  
8 are happy to answer any questions about the use of  
9 reference pricing in other countries that was included in  
10 your briefing paper.

11           Between 1995 and 2000, Medicare used internal  
12 reference pricing for Part B drugs. Both policies, the  
13 least costly alternative policy and functional equivalence  
14 policies, set the price of drugs with similar health  
15 effects based on the least costly product. Both policies  
16 used existing statutory payment formulas, for example,  
17 setting the price for a group of drugs based on the ASP of  
18 the least costly product. Thus, no additional data  
19 collection was necessary.

20           A beneficiary successfully challenged the use of  
21 a least costly alternative policy in federal court, and the  
22 Secretary withdrew the policies in 2010.

1           These reference pricing policies resulted in  
2 savings for beneficiaries and taxpayers. Moving forward,  
3 to apply reference pricing to Part B drugs, Medicare would  
4 need explicit legislative authority. At present, the  
5 Secretary's lack of flexibility to apply this policy stems  
6 from the statute which requires that biologics and single  
7 source drugs without generic competition be paid based on  
8 their own ASP and not averaged with other drugs.

9           If Medicare was given statutory authority, a  
10 clear and transparent process would be to be developed for  
11 applying reference pricing policies. For example, the  
12 process would need to address how Medicare would define  
13 groups of products that are clinically similar, how the  
14 reference price would be set and updated, how medical  
15 exceptions would be considered, and how frequently policies  
16 would be reviewed. In addition, policymakers would need to  
17 address whether Medigap could apply in instances in which a  
18 higher-cost product is selected by choice, not a medical  
19 exception

20           So looking at the implications of reference  
21 pricing, this policy would spur price competition among  
22 therapeutically similar products, which would lower drug

1 prices and yield substantial savings for beneficiaries and  
2 taxpayers. It would increase economic engagement of all  
3 concerned.

4           On the other hand, some beneficiaries might face  
5 higher cost sharing if they selected a product that was not  
6 set at the reference price , and the design and  
7 implementation of a reference pricing payment policy for  
8 Part B drugs would most likely be complex.

9           MS. NEUMAN: So Nancy just talked about drugs  
10 that have competitors. I'm going to switch gears now and  
11 talk about high-cost products that lack competition.

12           When the Commission designed the DVP, the  
13 Commission included binding arbitration as a tool that  
14 vendors could use to influence prices for costly drugs  
15 within limited alternatives. The inclusion of arbitration  
16 was motivated by recognition that launch prices are  
17 increasing, and that is an issue that is a broad concern  
18 for Medicare, not just specific to the DVP model. So, for  
19 example, under the ASP payment system, Medicare Part B is a  
20 price taker and lacks tools to balance an appropriate  
21 reward for innovation with value and affordability for  
22 beneficiaries and taxpayers.

1           Binding arbitration is a tool that has been used  
2 in other situations to establish health care prices. For  
3 example, some states use binding arbitration to establish  
4 payment amounts for out-of-network bills, and Germany also  
5 uses binding arbitration to establish prices for some  
6 drugs. There may be an opportunity to use binding  
7 arbitration more broadly to address prices for drugs with  
8 limited competition under Medicare fee-for-service.

9           So there could be a couple of benefits to  
10 expanding binding arbitration beyond the DVP. First, since  
11 the DVP was designed to be voluntary, if the DVP is  
12 implemented some providers and spending will remain under  
13 the ASP payment system. Expanding arbitration to high-cost  
14 drugs paid under the ASP system would be a way to get  
15 program wide benefit from arbitration.

16           Second, Part A providers like inpatient hospitals  
17 also furnish some of the same drugs that are paid for under  
18 Part B, and although Part A providers are typically paid  
19 for drugs as part of larger payment bundles, these  
20 providers may have little leverage to influence the prices  
21 of products that lack alternatives. So there could be  
22 benefits to expanding arbitration to Part A providers as

1 well.

2           If binding arbitration were available more  
3 broadly in Medicare fee-for-service there would be several  
4 important structural features for such a system, and today  
5 I am going to walk through an illustrative model how an  
6 arbitration system could be structured.

7           First is type of arbitration. We are focused  
8 today on final offer arbitration, often referred to as  
9 baseball arbitration. In baseball arbitration, two parties  
10 each make an offer and the arbitrator picks one of those  
11 offers. This approach provides an incentive for parties to  
12 make offers that are closer together because of fear that  
13 the arbitrator will choose the other parties offer.

14           Another key issue is who would be the arbitrator  
15 and how would that person or persons be selected. It would  
16 be very important that the arbitrator be neutral without  
17 conflicts of interest. So one way to operationalize this  
18 would be to task a nonpartisan government agency with  
19 selecting a neutral arbitrator or an arbitration panel.

20           Another important design element is when would a  
21 product be eligible for arbitration and how would that  
22 work. So criteria would need to be established for when

1 the Secretary could request arbitration, such as when the  
2 products estimated cost meets a certain criteria or exceeds  
3 a threshold and when the product has limited competition.  
4 When the Secretary requests arbitration, the manufacturer  
5 could be required to enter arbitration and abide by the  
6 arbitrator's decision as a condition of Medicare payment.

7           So let's walk through sort of an example of how  
8 arbitration could work. First there would be a triggering  
9 event. So, for example, a new first-in-class drug comes on  
10 the market that has an estimated cost that exceeds the  
11 specified threshold, and then the Secretary would request  
12 arbitration. And in that situation, then the Secretary and  
13 the manufacturer would each submit an offer price and  
14 supporting materials to the arbitrator.

15           Criteria would exist of the arbitrator to  
16 consider in weighing the two offer prices, and the criteria  
17 could entail things like clinical benefit compared with  
18 existing drug treatments, prices of existing treatments,  
19 whether the drug addresses specific areas of need or rare  
20 conditions, the cost of manufacturing the product and  
21 research and development, and affordability for taxpayers  
22 and beneficiaries. The arbitrator would weigh the offers

1 in light of the criteria and pick one of the offer prices.

2           It is important to note that the arbitration  
3 system just described does not contemplate direct  
4 negotiations between the Secretary and manufacturer. It is  
5 the arbitrator that that would be the final decider on the  
6 price.

7           Once an arbitration price had been determined,  
8 that price would have to be operationalized to affect  
9 Medicare payment, and there are a couple different ways  
10 this could be done.

11           Our slide shows two options, and under Option 1  
12 the Part B drug payment rate would be set at the  
13 arbitration price. And then to ensure that providers could  
14 obtain the drug at that price, manufacturers would be  
15 required to sell the drug to providers for Medicare  
16 patients at a price no higher than the arbitration price.

17           It would be possible, under this option, to  
18 extend this manufacturer requirement to all Medicare  
19 providers, which would mean that Part A providers could  
20 also get the benefit of the arbitration price.

21           A second option would be a manufacturer rebate  
22 for Part B drugs. So here is how that could work.

1 Medicare would continue to pay providers ASP+6  
2 for Part B drugs under this option, and then the  
3 manufacturer would pay Medicare a rebate on the back end  
4 that would achieve a net price equal to the arbitration  
5 price. Different from Option 1, Option 2 would not affect  
6 providers' acquisition prices for drugs.

7 And I would just like to add one additional  
8 point. Whichever approach is taken, once the arbitration  
9 price is in effect, there would need to be a process for  
10 reconsidering the arbitration price after a certain time  
11 period or in certain circumstance, such as if new evidence  
12 came out about the effectiveness of a product.

13 So now turning to the implications of  
14 arbitration, in terms of advantages, binding arbitration is  
15 one of the few practical approaches available to address  
16 the issue of high launch prices for drugs with limited  
17 competition, and it could have the potential to lower Part  
18 B drug payment rates and yield substantial savings for  
19 beneficiaries and taxpayers. Also, depending on how the  
20 policy were operationalized, binding arbitration could also  
21 lower drug prices for Part A providers too.

22 In terms of disadvantages, there would be

1 complexities involved in designing and implementing a  
2 system of binding arbitration, and for binding arbitration  
3 to be effective it would be important to get those design  
4 elements right. Some stakeholders may point to access  
5 concerns, for example, if a manufacturer chose not to  
6 participate in binding arbitration. However, Medicare's  
7 market size and design elements of the arbitration system  
8 would provide strong incentives for a manufacturer to  
9 choose to participate.

10           So to summarize, today we have discussed two  
11 policy options that have the potential to build on the  
12 Commission's 2017 recommendation and apply some of those  
13 elements more broadly.

14           First, reference pricing would focus on drugs  
15 with similar health effects and would improve price  
16 competition and value among these products. The second  
17 policy, binding arbitration focuses on high-cost products  
18 with limited competition and would help address increasing  
19 launch prices for such products. These policies address  
20 different issues and they could be paired together, or they  
21 could be standalone policies.

22           In terms of next steps, it would be helpful to

1 get your feedback on these policy options and whether you  
2 would be interested in having them further developed for  
3 consideration as potential recommendations in the next  
4 cycle.

5 DR. CROSSON: Thank you, Kim and Nancy. We are  
6 now open for clarifying questions. We will start with  
7 Marge.

8 MS. MARJORIE GINSBURG: The ASP+6 sounds like it  
9 has been around for a while. I wonder if you could give me  
10 some clarification about this means, that I think it means.  
11 So if they are selling a drug at \$2,000 per dose, that 6  
12 percent represents the additional payment to the hospital  
13 or the doctor for the acquisition cost, storage cost,  
14 administration cost. Is that what the 6 percent is?

15 And then, if that is what it is, that means that  
16 a drug costing \$10,000 as opposed to \$2,000 gets \$600 for  
17 their labor, as opposed to \$120 if the drug is cheaper. So  
18 the second part of my question is if that is the use of the  
19 6 percent, does it seem like there ought to be some kind of  
20 a sliding scale so that what we are paying for the drug  
21 doesn't get accelerated simply because the drug costs more  
22 than another drug? So it is that 6 percent that I am

1 really question about, about why that doesn't - couldn't  
2 vary according to the price of the drug, the acquisition  
3 cost.

4 MS. NEUMAN: So when Medicare pays a physician or  
5 a hospital for Part B there are two pieces to the payment.  
6 There is the drug payment, which is paid at ASP+6, and then  
7 there is a payment under the physician fee schedule or  
8 outpatient prospective payment system for the act of  
9 administering the drug to the patient.

10 And so we have these two components. So the  
11 labor costs associated with sort of administering it is  
12 covered under those two other systems. There is a question  
13 of what the 6 percent on the drug side was intended for,  
14 and there is no clear information about what was sort of in  
15 the mind of the Congress when that 6 percent was  
16 established, but there are some competing theories.

17 One idea is that because ASP is an average and  
18 some providers are going to pay more and some are going to  
19 pay less, that 6 percent is intended to help cushion the  
20 variation and make it possible for providers that have less  
21 leverage to be able to purchase under the Medicare payment  
22 amount. Others have suggested that perhaps the 6 percent

1 is accounting for some storage or handling costs that are  
2 somehow not picked up in the professional payments paid  
3 under the fee schedules.

4 And so there's not sort of a definitive answer to  
5 what the 6 percent is for.

6 MS. MARJORIE GINSBURG: And have we ever looked  
7 at that and questioned whether this was an appropriate  
8 formula to be using? Or have we just left that alone?

9 MS. NEUMAN: So back in 2015, 2016, we modeled  
10 some policies that took the 6 percent and converted part of  
11 it into a fixed fee, and so we have some work looking at  
12 that. But then in the 2017 recommendation, the Commission  
13 instead sort of moved toward the idea of taking the 6  
14 percent down gradually over time, keeping it as a  
15 percentage but moving it down over time, as a way to incent  
16 providers to choose the DVP and move away from the ASP  
17 system.

18 MS. MARJORIE GINSBURG: It hasn't been moved  
19 forward [off microphone].

20 MS. NEUMAN: Right, there hasn't been action on  
21 that.

22 DR. CROSSON: Jon, Pat, David.

1 DR. PERLIN: First, let me thank you for a very  
2 thoughtful report. I have a question for you. In  
3 practical terms, have you contemplated how it would operate  
4 for a provider purchasing for beneficiaries of multiple  
5 payers? So, for example, whether it's a hospital  
6 outpatient department, a physician's office, or if it were  
7 extended to Part A, under either of these schemes, what  
8 would be the practical effect in terms of purchasing, you  
9 know, Drug X for what you would typically buy en bloc for  
10 efficiency with a particular rate that's under binding  
11 arbitration reference pricing for the Medicare  
12 beneficiaries and, you know, other patients, maybe  
13 commercial or uninsured or what have you? Within that, is  
14 there any fear about a sort of new cross-subsidization or  
15 something of that sort occurring where, while it would  
16 reduce the acquisition costs for Medicare, it wouldn't  
17 necessarily, you know, lower the cost of drug spend for  
18 health care?

19 MS. NEUMAN: So to restate, you're concerned that  
20 if the arbitration price were to be lower, the price to  
21 other payers might increase?

22 DR. PERLIN: That's the fundamental, that, you

1 know, in practical terms, when you're purchasing  
2 pharmaceuticals or any supplies, you're buying for the  
3 aggregate of patients under different payment mechanisms.  
4 I'm just wondering how both operate technically and whether  
5 that dynamic you just suggested would occur.

6 MS. NEUMAN: So, technically speaking, if  
7 Medicare providers could get the drugs at a price no higher  
8 than the arbitration price, then there would need to be  
9 some back-end reconciliations that would happen to, you  
10 know, ensure that the stock that was then administered to  
11 Medicare patients was provided at a price that was no  
12 higher than that ceiling. So there would have to be some  
13 back-end systems.

14 There are some things that work like that today  
15 in other sectors, so technically that would seem to be  
16 possible. We haven't sort of in our formulation of this  
17 event scoped out implications for other payers. We've sort  
18 of been focusing on sort of how the Medicare payment would  
19 work.

20 DR. CROSSON: But, Jon, I think your point is a  
21 valid one, of course, because some of us might believe  
22 that, were this to take place for the Medicare program,

1 then one response from the pharmaceutical industry could be  
2 to increase the price of the drugs to commercial payers.  
3 That's an issue that the Congress would have to take up in  
4 deciding how broad to design such a program.

5 Pat?

6 MS. WANG: My questions have to do with the  
7 options on Slide 15 with binding arbitration, what the  
8 impact is on beneficiary cost sharing under the different  
9 alternatives. In Option 1, which Jonathan was just  
10 discussing, I guess that I'm confused about how it would  
11 work as well, and with that back-end reconciliation, there  
12 are precedents like with 340B where drugs are acquired at,  
13 you know, the same price, and then there's back-end that  
14 reduces the cost to the acquiring provider, but the  
15 beneficiary is still paying at the higher cost-sharing  
16 amount, and it's complex to administer. And I wondered if  
17 you had considered that that's the way that would work, or  
18 maybe there's a more straightforward way. In Option 2, the  
19 impact on the beneficiary would be to be paying cost  
20 sharing based on the higher amount, because that certainly  
21 would be a back-end reconciliation. Is that right?

22 MS. NEUMAN: Right. So on Option 1, if the

1 Medicare payment rate is set at the arbitration price, then  
2 the beneficiary would immediately get the effect of that  
3 lower price in terms of lower cost sharing.

4 In Option 2, with a rebate, there are ways to  
5 structure a rebate to share it with the beneficiary that  
6 could be considered if that was the route you wanted to go.  
7 It's a little bit more complicated, but it's a possibility.

8 DR. CROSSON: David.

9 DR. GRABOWSKI: Thanks.

10 MS. RAY: I'm sorry, excuse me. Just one follow-  
11 up, though. But under Option 2, it would ultimately lower  
12 deductibles in the future. So just -- right? The --

13 MS. NEUMAN: If you didn't find a way to up-front  
14 share the rebate with the beneficiary, then by lowering  
15 program spending, it would effectively lower deductibles in  
16 the long run.

17 MS. WANG: Option 1 from a total savings  
18 perspective, even if the binding arbitration price is  
19 identical in the two scenarios, Option 1 you're also  
20 eliminating the 6 percent add-on. So would that lower --  
21 or would you be?

22 MS. NEUMAN: Under Option 1, you could reduce the

1 6 percent add-on or eliminate it. So you could save, yes.

2 MS. WANG: I didn't see that in here, because I  
3 thought -- I didn't see that, so I thought that the  
4 rationale was that you're not spending any money acquiring  
5 the drug. Somebody else is doing that for you in a sense.  
6 So relative -- that's unclear, but relative program  
7 spending then between the two options is equivalent in your  
8 mind or is --

9 MS. NEUMAN: They could be structured to be  
10 equivalent. It's a policy choice.

11 MS. WANG: Thank you.

12 DR. GRABOWSKI: I wanted to ask you about binding  
13 arbitration. You presented a case in the chapter and in  
14 the presentation today built around the final offer  
15 baseball arbitration model. And, obviously, a big part of  
16 the baseball arbitration model is this negotiation prior to  
17 arbitration. You note in the chapter that I think 95  
18 percent of the baseball arbitration cases are settled  
19 before they ever get to the arbitration, and yet you ruled  
20 that out in the chapter, and I'm just curious. I want to  
21 learn more about that, like why we wouldn't allow sort of  
22 the pre-negotiation, which is a big part of that model. Is

1 there a way to do that? Or is that just further  
2 complicating this?

3 MS. NEUMAN: So in the chapter, we talked about  
4 the idea that there could be pre-launch discussions between  
5 manufacturers and Medicare, sort of sharing information  
6 about what Medicare thinks about when considering  
7 arbitration, if a product meets criteria, and the  
8 manufacturer could share information about their product.  
9 So we sort of thought about it in that kind of approach.

10 There are other ways to do it to allow more  
11 interactions, but we set it up as an initial construct to  
12 be just informal and before --

13 DR. CROSSON: So I want to interject for a  
14 second, because I think this gets a little bit to Jon's  
15 point as well. This is one model of how to do it, and the  
16 model here is that -- let's just imagine Congress sets some  
17 sort of benchmarks for launch prices in this case, or  
18 perhaps even for annual increases. Let's say 5 percent a  
19 year for three years triggers this as well, just for  
20 argument's sake. Congress establishes those benchmarks, a  
21 launch price -- I'm making this up now, a launch price  
22 greater than \$50,000 a year for a patient would be the

1 trigger.

2           In this model, then the Secretary -- and this now  
3 applies to Medicare. The Secretary would be the individual  
4 who would say now it's time for arbitration. That's this  
5 model. There are other models. The other model, for  
6 example, would be that Congress would set the same  
7 benchmarks, but then it would be up to the purchasers, they  
8 would be given the right -- the purchasers. In the case of  
9 Part D, it would be the plans or the PBMs. In the case of  
10 Part A, it would be the hospitals. And in the case of Part  
11 B, it would be the DVP that we have recommended be created.

12           Collectively, they would then say to the  
13 manufacturer, we are now permitted to require binding  
14 arbitration. That model, to get back to Jon's point, could  
15 be extrapolated beyond the Medicare program to include  
16 commercial insurance.

17           Have I confused everybody? Does anybody  
18 understand what I said? Paul?

19           DR. PAUL GINSBURG: Yeah, actually, I think I  
20 understand what you're saying, but one of the things you  
21 said prompted me to bring this up now that I was going to  
22 bring up later. Since we have a -- you know, this is

1 fairly silent about how this relates to our DVP proposal,  
2 and my perspective is that this may be an alternative or it  
3 may be an add-on, and that we should just be very flexible  
4 saying the DVP proposal still stands, but this may be a way  
5 to augment it. And if Congress is not interested in DVP,  
6 they could go with this instead.

7 DR. CROSSON: They could, and just to underscore  
8 what you said, the DVP, this is a tool that the DVP could  
9 use. It's also a tool that could be independent of the DVP  
10 proposal or independent of dealing with Part B  
11 specifically.

12 But I'll just repeat it again. I want to make  
13 the point that this model empowers the Secretary to  
14 trigger, based on Congress' benchmarks, triggers the  
15 Secretary to say now we have to arbitrate. That involves  
16 CMS. There's another model that would say essentially  
17 Congress could empower the purchasers collectively to say  
18 now we're going to arbitrate because you have passed the  
19 trigger point or the benchmark that Congress has  
20 identified.

21 DR. GRABOWSKI: Just to follow up, I was  
22 suggesting a tweak to that first model. I think the

1 Secretary would say binding arbitration, yet you would  
2 allow negotiation leading up to that. Maybe that's  
3 unnecessary, but that's kind of the true final offer  
4 baseball model.

5 DR. CROSSON: And I don't agree with that at all.  
6 I think that would be, of course, incorporated into the  
7 other model I just described, because the marketplace  
8 dynamic then you would argue would be for both parties to  
9 not want to go to binding arbitration, as Kim has pointed  
10 out.

11 DR. GRABOWSKI: Correct.

12 DR. CROSSON: All right. Sorry. Kathy.

13 MS. BUTO: On your point about a broader  
14 application if Congress should, you know, legislate  
15 accordingly, I think there's -- you run into a problem with  
16 the states actually regulate insurance. So I could see  
17 Congress doing something -- Paul and I were talking about  
18 this -- on ERISA plans, but I don't see how Congress could  
19 legislate a process for state-regulated insurance plans. I  
20 just --

21 DR. PAUL GINSBURG: Actually, it can [off  
22 microphone].

1 MS. BUTO: There is a way to do it?

2 DR. PAUL GINSBURG: Yeah, actually I've been over  
3 this in my contacts with the surprise billing work, and  
4 apparently the notion of Congress setting, say, maximum  
5 amounts that providers can charge in fully insured  
6 insurance has been accepted generally in other spheres. So  
7 that it's only when it comes to regulating in the sense  
8 that states can't regulate self-insured plans, but that the  
9 federal government can, or it can relieve states of the  
10 ERISA preemption.

11 MS. Buto: I think this needs to be fleshed out  
12 then because it's a delicate dance for Congress to come,  
13 and even if it's legally okay, and try to impose price  
14 limits at the level of insurance plans.

15 DR. CROSSON: Yeah, okay. Having completely  
16 violated it myself, I just want to make the point that  
17 we're on clarifying questions. Marge, do you want to come  
18 back in? And then we'll come over here.

19 MS. MARJORIE GINSBURG: Yes. Following on this,  
20 I just want to make sure I'm clear. So if a manufacturer  
21 refuses to go to binding arbitration, just says, "No, I'm  
22 not going to participate in this," that means that Medicare

1 will not cover this drug, but other private insurance  
2 companies can still provide it for their members, and then  
3 Medicare beneficiaries are all over us. So I just want to  
4 make sure --

5 DR. CROSSON: So, Marge, Congress would then have  
6 to -- in its consideration of how to craft this  
7 legislation, would have to figure out how to deal with that  
8 circumstance. And there's actually a piece of proposed  
9 legislation already that has a way of thinking about how to  
10 deal with that, but there are many other ways of dealing  
11 with it. But, you know, we would not want to end up with a  
12 system that would deny coverage of single-source effective  
13 medications to Medicare beneficiaries.

14 Bruce?

15 MR. PYENSON: Kim and Nancy, I have a question on  
16 background data that might be more relevant to the  
17 reference pricing issues. I understand average sales price  
18 is an average from the manufacturer. Do we have any source  
19 of insight into what providers are actually paying for the  
20 drugs that they're administering? So, for example,  
21 physicians or hospital outpatient, what their actual  
22 acquisition is? And one of the reasons I'm asking that is

1 that we see -- there must be variability in that, of  
2 course, and that variability presumably could be a source  
3 for insight into a reference price, as well as a potential  
4 better understanding of -- so a related question is: Do we  
5 -- have we ever heard of providers complaining that the  
6 Medicare reimbursement on an ASP basis is actually less  
7 than their acquisition cost?

8 MS. RAY: So I'll take the first part of that  
9 question. In terms of what are providers' acquisition  
10 costs, I think the best information we have for that is  
11 from the OIG that looked at provider acquisition costs for  
12 certain drugs, and I think it was the eye drugs and ESRD  
13 drugs back in the day. So that probably to -- I'm not  
14 aware of more recent data than that, but I can send you  
15 those reports.

16 MS. NEUMAN: And I guess we also have something  
17 that's a little bit more indirect. Back in 2015, I think  
18 it was, we looked at some IMS data on the invoice prices  
19 for Part B drugs for the clinic channel of purchasers, and  
20 those prices don't include off-invoice rebates, so they're  
21 a little bit -- they're not the net price. But we did find  
22 in that work that a large chunk of the invoice prices

1 looked to be at 102 percent of ASP or less. So we could  
2 share that piece with you as well. It has limitations, as  
3 I said.

4 And then you had a second question about feedback  
5 on the ASP payment rates compared to acquisition costs?  
6 And I would say that we do sometimes hear complaints about  
7 particular providers not being able to get a certain  
8 product at the Medicare rate. We don't have a good way to  
9 judge the extent to which it's very isolated cases versus  
10 more common.

11 MR. PYENSON: Thank you.

12 DR. CROSSON: Karen. I didn't see any other  
13 hands. Excuse me one second.

14 MS. BUTO: [Comment off microphone.]

15 DR. CROSSON: I did see your hand, but then you  
16 made a comment. I wasn't clear that you weren't done. So  
17 if you weren't done, go ahead.

18 MS. BUTO: Okay. These are Round 1 comments. I  
19 really had several questions about the reference pricing  
20 part but also one question that applies to both that and  
21 binding arbitration, which is: So would we imagine that  
22 coverage of new drugs would be delayed while either the

1 binding arbitration went through or whatever process there  
2 is under reference pricing for new drugs also played out?  
3 In other words, there would be no interim coverage? Or  
4 didn't you deal with that?

5 MS. RAY: Right. That is a good question. I  
6 think we envisioned both policies to affect a product's  
7 payment. I think there are ways to deal with a delay. For  
8 example, in Germany, the manufacturer sets the price until  
9 the process is played out, and that process can take up  
10 until 12 months.

11 MS. BUTO: Right.

12 MS. RAY: So I think, you know, as we move  
13 forward we can definitely consider that.

14 MS. BUTO: I think it would be a good thing to  
15 touch on because it is a natural question of particularly  
16 reference pricing applies more easily to drugs where there  
17 are multi-source drugs available. So that is one.

18 Secondly, on reference pricing, do you imagine  
19 that reference pricing could apply to Part D as well as B,  
20 because there actually is some overlap. There are drugs  
21 provided under each. Were you thinking like MA plans or  
22 hospitals that reference pricing could be carried over to

1 those? I mean, how were you thinking of that, because  
2 there are so many substitutions between B and D that it's  
3 strange for me to think of just applying a payment change  
4 of that magnitude to one side but not thinking about its  
5 implications for the other side.

6 MS. RAY: Right. So I think the Commission could  
7 consider reference pricing for Part D as well, and I think  
8 there - and I am looking at the Part D people - the  
9 Secretary, I think, has the flexibility to implement a  
10 reference pricing policy under Part D. And so that is  
11 something that, you know, we could consider.

12 MS. BUTO: Okay.

13 MS. RAY: Potentially.

14 DR. CROSSON: I'm sorry. Do you just want to  
15 comment on that, Paul?

16 DR. PAUL GINSBURG: Yeah. I think in Part D the  
17 issue would be the Secretary allowing the plans to  
18 establish reference pricing, because in the sense the plans  
19 already run formularies, that would be part of their job.  
20 So, to me, it's more relevant in Part B because we don't  
21 have a mechanism to actually create incentives to choose a  
22 lower-cost alternative.

1 MS. BUTO: And actually, you bring up - that was  
2 my next question, which is I think they already have the  
3 authority to use reference pricing. And so one of my  
4 questions is why reference - I saw the examples of Arkansas  
5 and the Catholic entities using reference pricing and  
6 achieving savings, but I wondered if, you know, any large  
7 insurers or PBMs are using reference pricing. That would  
8 be helpful information. Because the mechanisms they use,  
9 which is formularies --

10 MS. RAY: Right.

11 MS. BUTO: -- at least from their perspective,  
12 and maybe their business model, seem to work for them.

13 So I'm just - I just lay that question out and  
14 maybe you can address it now or address it in further  
15 discussion.

16 MS. RAY: Okay. We definitely can. Just to  
17 clarify the Part D, it used to be that the plans did have  
18 the flexibility - it used to be that the Secretary  
19 permitted reference pricing under Part D. The Secretary  
20 withdrew that flexibility, I think in part because of the  
21 Plan Finder and how to deal with the prices published,  
22 updated in the Plan Finder.

1 MS. BUTO: Okay. And then my last two questions  
2 are, are you pretty confident that reference pricing could  
3 work for all of the Part B drugs? I mean, I guess I'm  
4 wondering whether that's possible. Are they groupable, if  
5 you will?

6 And then my last question is, would CMS need some  
7 kind of a health technology assessment process like NICE to  
8 actually, you know, find the groupings or assign groupings  
9 for drugs, or would they piggyback on, in the case of  
10 international pricing, reference pricing on the work of  
11 other countries? So I don't know if you've thought about  
12 that.

13 MS. RAY: So both are good questions. I think  
14 some drugs lend themselves to be more groupable than  
15 others, and I think here the Secretary -- there are  
16 academic institutions that the Secretary could seek  
17 assistance from that already do this kind of work. And  
18 that is something that we can flush out a little bit better  
19 the next go-around.

20 DR. CROSSON: Thank you, Kathy. Karen.

21 DR. DeSALVO: Thank you. I want to go to  
22 arbitration but have some questions that relate to what

1 Kathy is, I think, getting to about feasibility and are  
2 there already authorities and/or what would be the burden  
3 of adding a new system.

4 I just wanted some clarification about volume.  
5 I'm thinking about operationalizing a policy like this  
6 inside of HHS and/or outsourcing it, and I'm wondering if  
7 you could just give me some sense, because I didn't see it  
8 in here, of how many drugs we'd be talking about on a  
9 monthly basis or an annual basis, not only in Part B but if  
10 it were to be applied, say, to Part D, would that add  
11 additional burden and complexity to a new process that  
12 would have to be built?

13 MS. NEUMAN: So we haven't quantified the number  
14 of products that might go through this kind of process, but  
15 the way that the criteria would be set for when a product  
16 would be eligible, meaning it would have to have a cost  
17 exceeding some threshold and it would have to have limited  
18 alternatives. Those criteria could be set in a way that  
19 would keep it manageable and focus the policy on the places  
20 where there's the most opportunity for there to be savings.

21 DR. CROSSON: Okay. Jaewon.

22 DR. RYU: Yeah, I had a question on the reference

1 pricing aspect. I just want to make sure I'm understanding  
2 this right. So the reference price would set the price  
3 that Medicare would be willing to pay for the drug. Is  
4 that right?

5 MS. RAY: That's correct, and that would be based  
6 on -- taking the already existing ASP data for each product  
7 and then deciding if the reference price is the minimum,  
8 the average, the median, whatever.

9 DR. RYU: But the manufacturer would still have  
10 the ability to price above that level --

11 MS. RAY: Yes.

12 DR. RYU: -- with the beneficiary then having to  
13 potentially buy up, if you will, if they wanted to go for  
14 that other drug.

15 MS. RAY: That is correct. Now there would be -  
16 the process envisions some sort of medical exception  
17 process.

18 DR. RYU: Okay. So I guess then the question  
19 would be how much transparency around the cost differences  
20 could there be at the point of sale, so to speak, or the  
21 point of prescription, and what's the readiness around  
22 being able to operationalize that? I think we talked about

1 the back end processes a little bit earlier. Is that a  
2 back-end reconciliation? I'm just struggling with the  
3 workflow of how that would happen.

4 MS. RAY: Yeah, that's a good point, and in the  
5 reference pricing example, well, one of them in the paper,  
6 they made a point of educating clinicians and having  
7 clinicians discuss the reference pricing with their  
8 patients. So that is - that would be a component, I think,  
9 more on the front end.

10 DR. CROSSON: Dana and then Jonathan.

11 DR. SAFRAN: Thanks. This is nice work and such  
12 a complicated topic.

13 I have really two questions. The first one is, at the very  
14 beginning of the chapter and of the presentation you talk  
15 about a roughly 10 percent increase in this area of  
16 spending, and roughly half of it being due to price, and  
17 you go on to say that, you know, the price component is  
18 both the shift of medicines being used to more expensive  
19 medicines within a grouping, so kind of the reference-based  
20 pricing issue, and then the introduction of new, expensive  
21 medicines, so kind of the binding arbitration issue.

22

1 I didn't see anything and I wonder if you have  
2 any data on sort of just parsing that, of, you know, how  
3 much of that roughly 5 percent increase in spend is - would  
4 be addressed by the reference pricing solution, meaning,  
5 you know, the shift into more expensive drugs from among  
6 existing drugs, versus the introduction of new expensive  
7 drugs.

8 MS. NEUMAN: I have not tried to break it apart  
9 in that way. We would have more ability to try to break  
10 apart how much is from price increase of existing products  
11 just going up versus to more expensive products, for  
12 whatever reason. So we could go back and think about how  
13 much granularity we could provide there.

14 DR. SAFRAN: Yeah.

15 MS. NEUMAN: But we don't have it for you now.

16 DR. SAFRAN: Okay. I mean, the reason I asked,  
17 it seems like an important thing for us to understand in  
18 order to know the potential impact on mitigating trend  
19 through these two levers that work on different parts of  
20 the spend problem, right? Okay. Great. Thanks.

21 And then my other question relates to binding  
22 arbitration and sort of picks on some of the themes that

1 we've already heard. But I'm trying to get an  
2 understanding of how this has played out in the places  
3 where it's used. So you give a few examples. You give  
4 Germany where this is done with drugs. And I wonder, sort  
5 of along the lines of where Kathy was going, in that case,  
6 I think Germany has a system like the UK with NICE, and so  
7 I'm just curious whether the consideration in the binding  
8 arbitration there is not just the cost but also the cost-  
9 effectiveness of the medication and what we know about  
10 that. But also you mentioned states using this for out-of-  
11 network.

12           And so I just was hoping you could give us just  
13 an understanding of in these models what we know about, you  
14 know, how they find the arbitrators, it is a single or is  
15 it a panel, and how any evidence on the impact on this  
16 approach.

17           MS. RAY: So let me take part of that question.  
18 So in Germany, during the negotiations and in the  
19 arbitration, they consider multiple factors. They consider  
20 the drug's added clinical benefit versus its comparator,  
21 the cost of the comparator, the annual cost of the therapy  
22 of comparable products paid in other countries, those

1 factors.

2 Germany does not, or at least I didn't see any  
3 mention that Germany considers cost-effectiveness, meaning,  
4 you know, qualities or what kind of denominator. It's --  
5 their system is really based on the comparative clinical  
6 effectiveness, added value.

7 DR. CROSSON: Okay. We've got Jonathan and Sue  
8 and then Warner.

9 DR. JAFFERY: Thank you. I just have a quick  
10 question on the binding arbitration but also maybe just a  
11 kind of reaction to Jaewon's question. I guess I'm not  
12 super comfortable, or confident that the workflow of  
13 educating providers to then speak to patients about how the  
14 reference pricing might impact their out-of-pocket costs or  
15 how they would negotiate that, or navigate that. I think  
16 that needs a little bit of fleshing out.

17 The question about binding arbitration, so we  
18 have been talking about drugs and I'm just wondering if  
19 other kinds of emerging therapies, if you envisioned a  
20 similar process for including other kinds of emerging  
21 therapies that are top of mind for people and costs,  
22 particular things like CAR-T, which are technically drugs

1 per se. Would that be included?

2 MS. NEUMAN: So we have not sort of focused on  
3 specific products at this time. CAR-T is a product,  
4 though, that is paid under the outpatient Part B system and  
5 under Part A. So it is something, you know, that we could,  
6 you know, think about what the scope is, but we have not  
7 looked at specific products.

8 DR. JAFFERY: And I guess thinking about through,  
9 as a follow-up to Karen's question about volume that might  
10 be relevant.

11 DR. CROSSON: Okay. I have Sue, Warner, Jon, and  
12 Pat, and then we will move on. Sue.

13 MS. THOMPSON: In terms of what we learned  
14 between 1995 and 2010, prior to the legal challenges, I  
15 mean you outline here what we think we learned about cost  
16 savings, but what did we learn about impact to the  
17 beneficiaries? Do we have any information about  
18 beneficiary perception or experience?

19 MS. RAY: In the evaluations that have been done  
20 on the least costly alternative policies, I do not recall  
21 that that was specifically looked at. What the IG looked  
22 at was the cost savings and if the policy was extended. I

1 don't recall seeing, in any kind of peer review lit search  
2 I've done any kind of adverse effects of the policy.

3 DR. CROSSON: Warner.

4 MR. THOMAS: Have we -- I know on the arbitration  
5 it would probably be virtually impossible to figure this  
6 out, but do we have any idea on the reference pricing what  
7 we think the potential cost savings might be and over what  
8 period of time?

9 MS. RAY: So we haven't done that for the -- in  
10 your paper. What your paper does is it provides a table of  
11 potential groups of drugs, and it has the total dollars  
12 associated with the spending for all the drugs in that  
13 group, but we haven't estimated the reference pricing.

14 Now OIG and CBO looked at reference pricing a  
15 while ago and I could, you know, include those in the  
16 paper.

17 MR. THOMAS: I'm just trying to get a handle on,  
18 you know, what the impact may be, just to determine, you  
19 know, how does that -- what is the cost benefit of the  
20 policy change versus what's the actual savings to the  
21 program. So just trying to get a, you know, at least a  
22 range or a handle on how material that impact could be.

1 DR. CROSSON: Jon.

2 DR. CHRISTIANSON: So I think this is just kind  
3 of a follow-up to Jonathan and Sue. You know, the big  
4 blow-back issue here, of course, is beneficiaries not  
5 understanding those reference pricing and then ending up  
6 paying a lot more than they thought they were going to pay  
7 for a drug.

8 So I was wondering if you had had a chance to  
9 look at some private sector payers, like Calpers and so  
10 forth, and how they handle this whole process of educating  
11 employees, melding in physicians. I am, like Jonathan,  
12 curious about, you know, creating a mandate for physicians  
13 to have to explain reference pricing to every one of their  
14 patients.

15 So it's the complexities of implementation that  
16 you talked about, and this seems like an important one to  
17 try to look at what's happened in the private sector and  
18 see if we can learn anything from that.

19 DR. CROSSON: Pat.

20 MS. WANG: I have two questions. One goes back  
21 to the response that you gave to Jaewon's question. Is it  
22 really the -- I had interpreted reference pricing as being

1 this is the price that will be paid for the drugs, sort of  
2 in exchange for being offered by Medicare, almost like  
3 assignment, that the manufacturer would take that price,  
4 not have the ability to charge up to the beneficiary. Can  
5 you clarify how you think that would work?

6 MS. RAY: So one way reference pricing could be  
7 implemented is, as an example there's three products in the  
8 group and the reference price is \$10. And I want the  
9 product that costs \$15. So that incremental \$5 would be  
10 included in my cost share.

11 MS. WANG: Okay.

12 MS. RAY: That is one way that reference pricing  
13 -- and that typically reference pricing is structured.

14 MS. WANG: Okay. The second question is just a  
15 general question about how rebates would work in either one  
16 of these scenarios. The idea, and I guess the underlying  
17 real question being how do we know that through either of  
18 these we are actually coming up with a lower price, once  
19 you factor in rebates and all the stuff that goes on? In  
20 other words, if a drug is \$10, but after rebate it's \$8,  
21 and a reference pricing or arbitration system results in  
22 the price being \$8.50, then that will not be a victory.

1

2           So it's just a question of how rebates would work  
3 under either of these systems. And also in the comparator  
4 international situations that use references pricing, I am  
5 curious whether they use rebates to the same extent that  
6 they are used here. To me, this is a complicated area, but  
7 it's sort of in there in terms of the total economics, and  
8 I was wondering if you could just tease that out a little  
9 bit.

10           MS. RAY: So under reference pricing the  
11 reference price would be based on, in the group of  
12 products, each product's ASP, and ASP is net of rebates.

13           MS. WANG: Okay.

14           MS. RAY: Okay.

15           MS. WANG: Yep. And for binding arbitration,  
16 would it start also at ASP, or --

17           MS. NEUMAN: So binding arbitration, the two  
18 parties would each make an offer, and we haven't sort of  
19 set -- an illustrative example, haven't set boundaries  
20 around what -- you know, where the Secretary's offer might  
21 be. But that's something that could be thought about, how  
22 it would relate to ASP?

1 DR. MATHEWS: But for a new product in which  
2 binding arbitration might be invoked, there wouldn't be an  
3 ASP to start from. So it would be more like WACC or some  
4 other manufacturer list price.

5 DR. CROSSON: All right. We've got 15 minutes  
6 left for our discussion.

7 MS. BUTO: This is real clear. I just want to  
8 make sure I --

9 MS. THOMPSON: Yeah.

10 MS. BUTO: Back to Jonathan's point, will  
11 providers be paying kind of market prices -- I mean, we're  
12 calling it "reference pricing," but we're really talking  
13 about payment, Medicare payment at a reference price,  
14 right? Will providers still be paying whatever they have  
15 to and maybe potentially absorbing the cost of some of the  
16 savings that Medicare is achieving? Do you know what I'm  
17 saying? In other words, will a provider be buying the drug  
18 at a certain rate, but Medicare's payment is limited to,  
19 say, the least costly alternative level or something like  
20 that? In addition to the beneficiary paying a higher co-  
21 pay if they want the more expensive -- I'm just wondering  
22 if the provider has to absorb additional -- potentially

1 additional costs.

2 DR. MATHEWS: So to ask your question  
3 differently, let's take Nancy's example of three drugs that  
4 are grouped together for purposes of calculating a  
5 reference price, and you've got a \$15 drug and a \$10 drug  
6 and a \$5 drug, and the program says the reference price is  
7 \$10.

8 MS. BUTO: Right.

9 DR. MATHEWS: If the provider still feels that  
10 there is a need to purchase the \$15 drug given the clinical  
11 needs of their patients, that is the price they would face  
12 on the market, although Medicare would only be paying the  
13 \$10 price. Is all of that roughly correct?

14 MS. BUTO: Well, I was actually wondering whether  
15 on the \$10 price the provider might end up paying \$15. In  
16 other words, what's to stop the manufacturer from charging  
17 whatever they think they can get from a provider? That's  
18 what I'm asking. And even though we're paying at a \$10  
19 rate, they're having to pay \$12.50 for the drug, something  
20 more.

21 MS. RAY: But this is -- but, I mean, the market  
22 still operates under the ASP-based system. That part

1 doesn't change under reference pricing. So I guess the  
2 situation of a doctor being able to afford a \$15 drug, I  
3 mean, that potentially happens now perhaps. You know,  
4 whether or not --

5 MS. BUTO: Right.

6 MS. RAY: -- his or her acquisition costs are  
7 less than or greater than the ASP+6 of a \$15 product.

8 MS. BUTO: So you're saying this would continue  
9 to be under an ASP+6 payment system?

10 MS. RAY: Yes.

11 MS. BUTO: So the ASP part, the substitute would  
12 be the reference price rather than the ASP? I'm just  
13 trying to understand how this -- doesn't this substitute  
14 for ASP+6?

15 MS. RAY: The reference price is based on, making  
16 this up, the lowest cost of the ASP of Drug 1, Drug 2, or  
17 Drug 3.

18 MS. BUTO: I got you. I was thinking more of an  
19 international reference pricing.

20 MS. RAY: No.

21 MS. BUTO: But you're saying this is just drugs  
22 within the ASP system.

1 MS. RAY: That's correct.

2 MS. BUTO: Potentially the least costly  
3 alternative.

4 MS. RAY: That's correct.

5 DR. MATHEWS: This is the internal approach that  
6 you discussed, right?

7 MS. RAY: Yes.

8 DR. CROSSON: Okay. Paul, I'm going to call on  
9 you in a second.

10 DR. PAUL GINSBURG: Okay.

11 DR. CROSSON: Okay. Good discussion. I have a  
12 feeling we've done sort of Round 1-1/2 because the point of  
13 this is to try to give input to Kim and Nancy in terms of  
14 what kind of considerations should be brought back to us as  
15 we consider, or not, these ideas. And we've gotten a lot  
16 of them already, so we're going to have a further  
17 discussion, and I would focus on, you know, if we're going  
18 to do these things, what would we need to consider, what  
19 would we need to know, what kind of further information  
20 should we have available to us, et cetera.

21 Paul?

22 DR. PAUL GINSBURG: Thanks. What I was going to

1 say is that I think in a reference pricing situation, it's  
2 the norm that the sales price to the physician -- I mean,  
3 it's usually used in pharmacies, but in a sense, if there's  
4 a reference price, the other drugs usually got their  
5 prices, to down to the reference price so that the issue  
6 doesn't come up.

7           Now here it's more complicated because the  
8 manufacturer is selling to the physician both for Medicare  
9 patients but for other patients as well, so it's not as  
10 clear how that would work.

11           Let me get on to -- you know, in addition to  
12 these materials being excellent, the presentation being  
13 excellent as well, I thought Kim and Nancy did a great job  
14 in answering the voluminous qualifying -- clarifying  
15 questions that we had.

16           [Laughter.]

17           DR. PAUL GINSBURG: They're really to be  
18 commended for that.

19           You know, the context of this is that we're  
20 focusing on situations where there's not much of a demand  
21 constraint for drugs, and, you know, in Medicare, of  
22 course, we have -- in Part B at least we have extensive

1 supplemental coverage. In commercial insurance, of course,  
2 we have out-of-pocket maximums, which we don't have in  
3 Medicare. We have a lot more people with drug coverage  
4 now, and that's one of the reasons that drug prices have  
5 gone up so much, because of less demand constraint. So  
6 when we talk about reference pricing, we're talking about  
7 in a sense energizing the demand restraints. And when  
8 we're talking about single-source drugs without therapeutic  
9 alternatives, we're really talking about creating something  
10 instead of a demand constraint because we can't have a  
11 demand constraint when there's no alternative and when  
12 it'll be paid for by the insurer.

13 I'm very glad that we're not -- that we're taking  
14 this up, these two topics, and not just sitting pat with  
15 what we've done on DVP, because this came up before that  
16 this could enhance DVP. And we don't know if Congress is  
17 going to pursue DVP and, you know, the problems are there,  
18 and if there's a non-DVP approach, it would still be very  
19 welcome.

20 Reference pricing I think is most needed in Part  
21 B. It would be useful to allow plans to do this in Part D.  
22 You know, what it accomplishes as far as getting lower

1 prices may outweigh the challenge as to the plan finder  
2 mechanism, and probably likely not needed in Part A because  
3 the buyers are very sophisticated there, and they do have  
4 strong incentives.

5 I'm really glad you brought up the need to do  
6 something about Medigap for Part B if we're going to do  
7 reference pricing. You know, the Congress realized that  
8 allowing Medigap was a mistake, and they banned it in Part  
9 D. But in a sense, it still, of course, is quite active in  
10 Part B and probably there would have to be a provision  
11 barring Medigap from supplementing a reference pricing  
12 situation, you know, beyond the reference price.

13 I think arbitration is potentially useful in  
14 Parts B, D, and A for the similar reasons kind of across  
15 the board. And I just wanted to make a final comment, that  
16 when you mentioned that we might have neutral government  
17 agencies choosing the arbitrators, it got me to start  
18 thinking about how far policy has shrunken, that when we  
19 deal with surprise billing, some states have gone --  
20 instead of the policymakers making a decision about how  
21 much providers can charge, they go to an arbitrator to make  
22 this decision, kind of something you'd think policymakers

1 should be doing rather than delegating this to an  
2 arbitrator. So the issue comes up as to if there's going  
3 to be a neutral government agency, instead of choosing the  
4 arbitrators, whether they should actually make the  
5 decision. And I realize this is more complicated because  
6 government agencies -- CMS is a very interested party in  
7 the outcome of this, and that may be why we do need to go  
8 to arbitrators or at least get some decisionmakers outside  
9 of CMS to make these decisions so that it doesn't appear to  
10 be one-sided.

11 DR. CROSSON: Thank you, Paul.

12 Okay. So we'll open up now to the broader  
13 discussion, and, again, hopefully we can focus on, you  
14 know, ways to help Kim and Nancy come back to us with more  
15 refined proposals. We'll start with Bruce and then Karen.

16 MR. PYENSON: Well, thank you very much. As you  
17 may have understood from my question, I would like to see  
18 more information about the underpinning of both of these  
19 programs in terms of the relationship of ASP and what  
20 providers are actually paying for drugs. There's a number  
21 of intermediaries in that food chain, and since ASP is  
22 really a very important component of that, I think the

1 terrific work around arbitration or reference pricing needs  
2 the foundation of as much information or insight as we can  
3 get on that food chain. And that I think would include  
4 what our understanding is of bona fide fees and other fees  
5 that are part of the system with the wholesalers and  
6 perhaps the group purchasing organizations. So my fear is  
7 if we don't do that, we might miss out what are the actual  
8 dynamics that determine whether a drug is used or not for  
9 the patient and what are the financial motivations, the  
10 real financial motivations for the providers themselves.

11           So I compliment the work, but at least I'm -- I  
12 feel a personal knowledge gap in that food chain, and I  
13 think it could be very important.

14           DR. CROSSON: Karen.

15           DR. DeSALVO: So thank you, guys, for putting  
16 forward the proposals. I just wanted to ask that perhaps  
17 in the next iteration of this and other policies around  
18 drug pricing, that we think about adding the implications  
19 of the policy, so not only about the burden of execution,  
20 which we heard some about today on the governmental system  
21 or the need to develop a new governmental sense system,  
22 say, for example, in arbitration, but also on the providers

1 and the beneficiaries. And we've talked, I think in  
2 January, about some ways to begin to evaluate  
3 systematically the impact on things like price and spend  
4 and the impact on beneficiaries around access, equity, out-  
5 of-pocket spend, and the quality of care, driving toward  
6 evidence-based medicine. So some of those, at least some  
7 parameters, you know, within the context of the best --  
8 your best-known evidence of what -- how much impact these  
9 policies would have, and not only positive but also the  
10 potential downsides.

11 Thank you.

12 DR. CROSSON: Jaewon.

13 DR. RYU: Thank you, because I think this is a  
14 really complicated area, and I thought the chapter was  
15 really helpful.

16 I guess I just want to touch back on the  
17 operational burden. You know, we spent some time talking  
18 about it earlier. I think this gets to the additional  
19 information that would be helpful in the next round around  
20 -- I guess it was Karen's question. How many of these are  
21 there specifically with reference price scenarios? You  
22 know, what are we looking at? What's the magnitude? And,

1 specifically, where would it fall from a physician or  
2 specialty standpoint? I imagine given it's Part B, it's a  
3 lot of oncology. But, you know, that would be helpful to  
4 know.

5 I think that then helps us inform the operational  
6 burden question around, you know, the buy-up option, so to  
7 speak, and the need for price transparency to counsel  
8 patients and beneficiaries around what their impact would  
9 be financially. If it's entirely oncology and it's  
10 entirely for drugs, you know, just making that up, that  
11 seems doable because they're going to keep coming up  
12 against the same scenarios. And I think that -- I could  
13 picture that being workable, versus if it's a whole host of  
14 drugs, whole host of specialties, I think that becomes  
15 really tough to operationalize.

16 The other is I think it was Pat's question  
17 earlier, I'd be curious where else in the program we have  
18 these buy-up dynamics. I may be remembering this wrong,  
19 but I think with cataract lens implants, we have a current  
20 scenario where ophthalmologists allow patients to buy up  
21 from what is covered under Medicare. It would be neat to  
22 look at those situations and see how those actually play

1 out and how smooth, what's the friction, those kinds of  
2 questions.

3           And then one more thing. Sorry. You mentioned  
4 that one way to operationalize this is to have the  
5 reference price set and then the buy-up option on top of  
6 that. I think this may have been where you were going,  
7 Pat. Is it even possible to have that be considered  
8 payment in full, no buy-up option, and the manufacturer  
9 just has to live with that price? I think that's the other  
10 thing that I might throw into the mix.

11           DR. CROSSON: Dana.

12           DR. SAFRAN: Yeah, I'll be quick because my  
13 points are largely the ones that Karen made, which is I  
14 would love to see in the next iteration something that  
15 helps us get to the next level of understanding of what the  
16 potential impact of implementing these is. And I mean  
17 impact not in the operational sense, though I think those  
18 points are so important and really painting a picture of  
19 who is going to have to do what differently in order for  
20 this to work I think is a very important add. But what I  
21 meant, what I referenced in my question earlier, is of the  
22 roughly 5 percent of the annual trend on this area of

1 spending that is attributable to price, how much potential  
2 impact on mitigating that trend do we feel could be made  
3 through these two mechanisms.

4           The only last thing I'll say is, you know, in the  
5 commercial insurance world, reference pricing is something  
6 that's been out there, and that in general employers have  
7 been very reluctant to adopt, I think largely because of  
8 the fear of the out-of-pocket cost implications. So I  
9 think that's something that we ought to pay a little bit of  
10 attention to here, too. And if I'm understanding how the  
11 dollars flow correctly, we're not expecting this to have  
12 out-of-pocket cost implications for the beneficiary. But  
13 if that's right, we should say it and explain it and so  
14 forth. But I think referencing -- no pun intended -- the  
15 experience in the commercial world with reference pricing  
16 and what the concerns have been and what the successes have  
17 been where there have been some is an important add.

18           DR. CROSSON: Warner.

19           MR. THOMAS: So I think both of these options are  
20 good, and I applaud the work done here. A couple of  
21 comments.

22           I think building on Jaewon's comment of the

1 reference pricing, I think this idea of not having a buy-up  
2 option is something that should be looked at very carefully  
3 and just basically indicating, you know, if there's a  
4 price, that's kind of the price that if someone wants to  
5 sell in that suite or family of options, then they're going  
6 to accept that price.

7 I think the binding arbitration, I think  
8 understanding how often or how many drugs there might be,  
9 you know, going into that process would be helpful to know.  
10 But, once again, I think we have to do something to try to  
11 slow these launch prices. I think the binding arbitration  
12 is a way to get that done, so I'd like to see us push  
13 forward.

14 I would throw one other idea out there that's not  
15 contemplated here, but I would like to see us consider it,  
16 and it's the idea of just a general cap on pricing going  
17 forward. I know that it isn't part of the recommendation,  
18 but I would like to see the team, you know, look at that  
19 option. I just think that we've got to continue to weigh  
20 out options that are going to slow the escalation of drug  
21 costs, and I think a general cap is -- would be one way to  
22 do that and, you know, effectively challenge manufacturers

1 to get much aggressive about how they think about pricing  
2 going forward and living within those certain means, given  
3 that we all live within a capped environment, you know,  
4 with pricing overall as far as, you know, other areas of  
5 the Medicare program. So I'd like to see that considered.

6           The last comment I would make, if it's not a  
7 significant amount of work, it would be nice to try to  
8 understand what we think the economic impact would be on  
9 the program, at least a range, and perhaps even thinking  
10 about a cap option. You know, if we went to a cap of X  
11 percent, I mean, it would seem that looking at history we  
12 could look at how much savings that could generation from  
13 the program, understanding that my guess is we're going to  
14 find that, you know, it's half of the cost increases have  
15 been based on price. And so if we have a cap in there on  
16 what the price increase would be, my guess is we will slow  
17 that trend of spending overall.

18           But I applaud the work, and I think these are two  
19 very good ideas to take us in the right direction.

20           DR. CROSSON: Thank you, Warner.

21           Okay. So we'll start with Jon.

22           DR. CHRISTIANSON: Okay. I'll just sort of pile

1 on what you just said, Warner. I think this is exactly the  
2 kind of activity that MedPAC should be doing. I mean, the  
3 problem, we all recognize, is significant, the rapidly  
4 growing increase in drug spending in the Medicare program.  
5 These are two new ideas. We have the skill to flesh these  
6 out. We may decide not to recommend going on one way or  
7 the other but I think this whole activity that is going on  
8 in this area should be endorsed by the Commission and I  
9 think we should continue to push it ahead.

10 DR. CROSSON: Thank you. Kathy.

11 MS. BUTO: So I want to commend Kim and Nancy for  
12 a good start. I think it's really important for us to be  
13 as thorough as possible in fleshing out these two options,  
14 because they're both under serious consideration. I think  
15 there is some chance that Congress will do something.  
16 Whether or not it will ultimately make it through or not I  
17 don't know, but I think it's important that all the  
18 implications be worked through, and I think MedPAC is the  
19 group to do that.

20 I want to agree with Dana and Warner that it  
21 would be good to know, particularly for each of them, what  
22 we think the impact on overall costs would be, because if

1 it turns out we don't think it's significant there might be  
2 easier ways to slow the growth of spending on drugs, or  
3 more straightforward ways. Both of these involve  
4 infrastructures that don't exist today, and I would just  
5 say let's keep our minds open to that.

6 I will point out that reference pricing in  
7 Europe, that the data suggests that it does reduce spending  
8 but it reduces spending by prices converging to the  
9 reference price, that it's not inherently a competitive  
10 structure except to compete against the reference price and  
11 then once that is achieved you don't get a lot more  
12 movement around competition. So it's kind of different  
13 than the PBM model that we follow today with formularies  
14 and tiering and so on, where there is some dynamic  
15 competition.

16 I do think it's important, on the reference price  
17 option, that we be pretty clear about what process we  
18 envision for creating the groupings, because what we are  
19 talking about, as I now understand it and I think we need  
20 to be clearer here, we're talking about least-costly  
21 alternative for therapeutically similar groups, using  
22 Medicare ASPs. Something along -- maybe it's not least-

1 costly. Maybe it's median-costly or something like that, a  
2 combined payment. But it's not international reference  
3 pricing unless we're also thinking about that, in which  
4 case I think we need to tease those apart.

5 I think there is some real danger in treating  
6 similar drugs for payment purposes as equivalent for  
7 effectiveness and side effects, and so I want to be sure  
8 we're clear that there is an ability to provide appropriate  
9 treatment, even within the construct of this structure that  
10 you've laid out here. There is limited information on  
11 outcomes, as you've pointed out, but at least in some  
12 countries, I think the most extreme is the New Zealand  
13 example, where the country established the lowest statin  
14 rate as the rate it would pay, and cholesterol levels  
15 increased in the population. So there's, you know, some  
16 kind of -- that's probably the most extreme example but I  
17 think the issue of the lack of clinical and outcome  
18 information, it is potentially a problem.

19 Reference pricing is going to reduce R&D on  
20 incremental innovation. Some people think that's a good  
21 thing. I don't think it's a good thing. I think we need  
22 to be aware of that and at least point out that

1 possibility. The examples there are things like childhood  
2 leukemia, cancer treatment, potentially even HIV treatment,  
3 where the changes occurred incrementally over time and if  
4 you structure -- depending on how you structure reference  
5 pricing that kind of investment could be discouraged.

6 I want to actually say that I think there are  
7 areas for further discussion that I hope we'll take up  
8 maybe in the future. Some of them are more easily  
9 reachable, in my mind anyway, things like pass-through  
10 payments for drugs that we could take a look at,  
11 potentially some mechanisms like volume price agreements  
12 between manufacturers and the government.

13 I think as long as we're talking reference  
14 pricing we shouldn't shy away from direct negotiation,  
15 which I know we were trying to do in the binding  
16 arbitration option. But I could actually imagine that  
17 faced with binding arbitration a company might prefer  
18 direct negotiation, because binding arbitration is A or B,  
19 and it's either going to be the government's price or your  
20 price. Why wouldn't you rather go into a negotiation and  
21 see if you can get a better set of criteria and so on? So  
22 it may be that we want to throw that out as an alternative

1 or an option that could be woven into something like a  
2 binding arbitration.

3 I also think that we haven't really discussed  
4 formularies in Part B. It's an effective mechanism. I  
5 don't think we've really explored that as a possibility.  
6 It's a little more hands-on but it seems to me the DVP  
7 proposal gets into that. So I'm hopeful that that  
8 advances.

9 And the last thing I'll mention, which you may --  
10 I think you're probably aware of, is that in Germany a lot  
11 of the savings came from an overall national drug  
12 budgeting, setting -- I think it was like Warner's  
13 proposal, setting an overall -- I hate to use the term SGR  
14 but it was an SGR-like limit on the growth in drug spending  
15 that actually resulted in I think either claw-backs or some  
16 other rebate mechanism to keep drug spending under a  
17 certain limit. Pretty radical proposal, but as long as  
18 we're thinking about these I wouldn't rule out looking at  
19 something like that as well.

20 DR. CROSSON: Thank you. Brian.

21 DR. DeBUSK: First of all, thanks to Kim and  
22 Nancy for an excellent chapter and an excellent

1 presentation.

2           The first time I read through this chapter, you  
3 know, I read it as sort of reference pricing versus  
4 arbitration, sort of policy option A or B, and after a  
5 couple of days to think about it it really seems like a  
6 blended approach. It would be the optimal vehicle. And  
7 this, again, is my opinion.

8           If you go to Chart 14, I think your roadmap is on  
9 Chart 14, and just to build on that model, you know, I  
10 would envision an office within CMS that could do something  
11 -- and I hate to compare, say, the competitive bidding  
12 program, but, I mean, it would be a chassis similar to  
13 that, where if certain triggers are met a drug can be  
14 pulled into this process. I mean, it would be -- you know,  
15 you wouldn't try to do everything at once, but I could see  
16 some pretty obvious triggers like inflation limits, drugs  
17 whose rebates have peaked over 40 or 50 percent. I think  
18 that would be inherently suspect. I think maybe even using  
19 an international reference price, you know, say we're at  
20 125 percent of the G20 maximum, I think there's something  
21 there. And then I also think you could do some type of  
22 internal reference price.

1           But I think it's important, number one, to have  
2 the triggers reasonably well defined, and I also think it's  
3 important to have a mechanism for companies to avoid the  
4 arbitration process if they meet certain -- almost like a  
5 safe harbor. Because what you'd like to be able to do is  
6 say this is what we'd like to see in a good actor. You're  
7 not subject to this process if you can meet certain  
8 criteria.

9           Now if one of these drugs -- and again, ten codes  
10 are 43 percent of our spend here so we're not talking about  
11 doing thousands of drugs -- but if one of these drugs does  
12 trigger this process I would see the baseball-style binding  
13 arbitration. But I think what's important even there is to  
14 set up specific pathways for the Secretary, because I don't  
15 think it's just anything goes arbitration. Number one, I  
16 think it's politically difficult but it's also -- it seems  
17 like a very unguided approach.

18           For example, though, I do think that the  
19 Secretary should be able to make an internal reference  
20 pricing argument, should be able to make an international  
21 reference pricing argument, should also be able to make,  
22 say, a blended codes. I mean, I think there are several

1 proposals, for example, being able -- I don't like LCA but  
2 I do like the idea of using, say, a median price. In LCA  
3 it seems like you make everyone mad except one person,  
4 whereas a median price, you know, half the people get upset  
5 and half the people don't.

6           But I think that there's a -- I do think it's  
7 important to define the triggers and define the tools, and  
8 I think the chapter has a lot of that already. I do think  
9 it's also important, at least for the viability of the  
10 idea, to set aside a few issues, at least, for now. For  
11 example, cost effectiveness. I mean, we could spend  
12 session after session here trying to flesh out what a cost  
13 effectiveness proposal would look like. And I think this  
14 program is too important, in the short term, to necessarily  
15 go down that path in the first iteration.

16           The final thing I wanted to mention, I do want to  
17 agree with Bruce's comment earlier about peeling back some  
18 of these rebates. It's -- ASP, I don't think, is what we  
19 think it is. I think it's significantly higher. Thank  
20 you.

21           DR. CROSSON: David.

22           DR. GRABOWSKI: Thanks for this chapter and

1 presentation. I wanted to just connect a couple of dots  
2 really quickly. Several of the Commissioners raised this  
3 issue around operational burden and I share that concern,  
4 and I wanted to focus on binding arbitration.

5           Karen asked you, in the first round, how many  
6 drugs are we actually talking about here and are we going  
7 to overwhelm our good friends at HHS, which has so many of  
8 these cases. And I come back to, Kathy, the point you made  
9 and I asked about in the first round, around allowing pre-  
10 arbitration negotiation. I think that would be a great way  
11 to actually lower this burden on HHS. If we could --  
12 nobody wants to go to binding arbitration if they could  
13 help it, and so I think that fear would bring a lot of  
14 parties to the table and actually lower the kind of burden  
15 of binding arbitration.

16 So I like both of these ideas as a high level, but we have  
17 lot of work to do to kind of flesh out the details.

18 Thanks.

19           DR. CROSSON: Jon.

20           DR. PERLIN: Let me again, thank you for a  
21 terrific and thoughtful chapter. As I think about the  
22 comments that have been made, and I'm going to back to my

1 earlier clarifying question, you know, it strikes me there  
2 are hydraulics that operate in terms of the different  
3 purchasing of drugs, and I would also put an argument in  
4 for policy coherence. If you do one thing in Part B and  
5 something else in Part A I think it's problematic. I  
6 understand the differentiation Paul offered between drugs  
7 susceptible to binding arbitration versus reference  
8 pricing.

9 But I just note that if you look back at the actual data on  
10 cost increases in hospitals, thinking about Part A, in  
11 2016, 38 percent of the cost increase of hospital care was  
12 attributable to pharmaceutical increases, and those really  
13 related to three buckets -- short-supply generics, branded  
14 drugs, and new entrants. And so it would seem that both  
15 buckets of potential effects on moderating drug price  
16 increase would be important.

17           Parenthetically, I also am strongly in favor of  
18 understanding the implications, both in financial terms as  
19 well as operational terms, and in financial terms it would  
20 be helpful to understand whether we think this would  
21 actually decrease costs or decrease the increase in cost,  
22 which maybe it wouldn't as well.

1           Now I want to make it more complicated. Having  
2 background in molecular neurobiology, it strikes me that it  
3 may seem easy, at one level, to lump and say these things  
4 are similar, but what's similar and what's dissimilar  
5 within a class? What do I mean by that? The straight  
6 example is that when you or I have a headache and we reach  
7 for, you know, over-the-counter thing A versus thing B --  
8 and I'm trying not to use some brand names -- you know, we  
9 do it because one works better. Well, actually, at a  
10 genomic level there's probably a reason that it works  
11 better for an individual.

12           Let me use one that's been very prominent in the  
13 literature, and I will name this drug, clopidogrel. There  
14 is, what, 30 percent of the population who don't metabolize  
15 to the active form, and there are a couple of others. And  
16 so you could say these are anti-platelet or anti-clotting,  
17 you know, drugs that are used in patients who have had  
18 either heart attack or a procedure, stent. And they are  
19 the same but are they really the same when you get to the  
20 sort of genomics of the individual patient.

21           And so, at a minimum, it would seem that as we  
22 contemplate what is in-class versus what is in different

1 classes we need to anticipate that we will have richer  
2 understanding of the differences that, you know, are  
3 expressed at a sort of personal genomic and polyomic level.

4 I realize that complicates it but I think that's  
5 where molecular biology medicine is headed. Thanks.

6 DR. CROSSON: Okay. Warner. Last comment.

7 MR. THOMAS: Just one quick comment, because you  
8 had a couple of options in the presentation. So on the  
9 operationalizing the arbitration price, I think just  
10 adjusting the Part B rate versus going to a rebate, to me  
11 makes a lot more in it. It's easier and we already have  
12 the challenges of, you know, transparency around rebates.  
13 So to me just adjusting the price seems like it would be a  
14 best option.

15 I would come back to, on the reference pricing,  
16 we talk a lot about internal but we really didn't talk a  
17 lot about the international price. And to me, if there's  
18 transparency around what that would look like I think that  
19 would -- and I'm just not sure how easy it is to get that  
20 information. If it is, I think that's something we should  
21 definitely take a hard look at as far as the approach that  
22 we take.

1           And I think Brian's point is a good one of, you  
2 know, looking at the median versus, you know, the LCA, but  
3 I think also understanding what the international  
4 comparator is would be something that would be helpful when  
5 we're thinking about these prices.

6           So I just wanted to refer to a couple of comments  
7 you had in the presentation.

8           DR. CROSSON: Okay. Thanks very much, both Kim  
9 and Nancy, for the quality of the presentation, and it  
10 sparked, I think, an excellent discussion here. We took a  
11 little extra time but I think it's appropriate because this  
12 is an important issue. It's also quite topical at the  
13 moment, given the considerations going on both within the  
14 administration and the Congress. So we look forward to the  
15 next iteration of these policy issues.

16           With that we will move on to the next  
17 presentation.

18           [Pause.]

19           DR. CROSSON: Okay. We'll move on to our second  
20 discussion for the morning session. We are going to come  
21 back to a topic we have talked about before, and that has  
22 to do with Medicare Advantage encounter data and how to

1 make that data accessible and useful for a variety of  
2 purposes. And I think we'll be presenting a recommendation  
3 to that effect.

4           Andy and Jennifer are here, and Jennifer is going  
5 to begin.

6           MS. PODULKA: Absolutely. Thanks so much, Jay.

7           So today Andy and I will present information on  
8 the Medicare Advantage encounter data in follow-up to your  
9 discussions back in April and November.

10           We'll begin with background on how the data came  
11 to be collected and summarize findings from our efforts to  
12 validate the available files.

13           We'll also discuss the expected outlook for  
14 encounter data going forward. And, finally, we'll  
15 introduce the Chairman's draft recommendation for your  
16 discussion.

17           But first a note on terminology. MA  
18 organizations sign contracts with Medicare to deliver the  
19 MA benefits to enrollees. These contracts can include one  
20 or multiple plan benefit packages, and all of our analyses  
21 were conducted at the contract level, but we'll use the  
22 terms "contract" and "plan" interchangeably today.

1 MA encounter data have a long history that began  
2 more than 20 years ago with the Balanced Budget Act of  
3 1997, which required the collection of encounter data for  
4 inpatient hospital services and permitted the Secretary to  
5 collect encounter data for additional services.

6 Initial efforts to collect encounter data  
7 proceeded with some fits and starts. And then, in 2008,  
8 CMS amended the MA rule to resume collection of detailed  
9 encounter data for all Medicare services for risk  
10 adjustment and other purposes. In January 2012, CMS began  
11 collecting such data from plans.

12 I want to pause to highlight the value complete  
13 encounter data could have for the MA program.

14 First, detailed encounter data are the best  
15 vehicle we have right now for learning about how care is  
16 provided to the one-third of Medicare beneficiaries  
17 enrolled in MA, and ensuring that the Medicare benefit is  
18 administered properly to all beneficiaries is an important  
19 function for program oversight.

20 Second, plans have the flexibility to implement  
21 practices that could allow them to provide care more  
22 efficiently than in the traditional fee-for-service

1 program, such as various payment methods, care management  
2 techniques, information systems, and beneficiary  
3 incentives. We would like to evaluate these policies using  
4 encounter data to inform and improve Medicare policies more  
5 broadly.

6           And, finally, administering the MA program  
7 requires the use of fee-for-service claims and many single-  
8 purpose data submissions from plans and providers.  
9 Complete encounter data could replace various data  
10 collection efforts and would ensure that the program relies  
11 on data that are internally consistent and conform to  
12 program rules.

13           We now have access to MA encounter data for 2012,  
14 2013, 2014, and preliminary files for 2015. The  
15 preliminary files for 2015 are the same data that CMS  
16 recently released for public use. Data are collected for  
17 each of the six provider types or settings shown on the  
18 slide, and encounter data are similar to claims data in  
19 that they are expected to include diagnosis and treatment  
20 information for all services and items provided to  
21 enrollees.

22           We've validated the MA encounter data files to

1 determine if they are ready for use in various analyses and  
2 risk adjustment. Our methodology includes two main  
3 categories.

4           First, we checked if each plan successfully  
5 submitted any encounter data for each of the six settings.  
6 We also compared the plans' reported enrollees to CMS'  
7 databases that track MA plan offerings and beneficiaries'  
8 enrollment.

9           It's important to know that when plans submit  
10 encounter data, CMS' system performs automated front-end  
11 checks before accepting each record. Errors or problems  
12 cause the system to reject the submission, which means that  
13 no record will appear in the encounter data files unless  
14 the plan corrects and resubmits. In other words, if  
15 encounters are not present in the data, we can't tell if  
16 that's a result of the plan not submitting or the system  
17 not accepting the record.

18           For the second step of the validation, where  
19 available, we compared MA encounter data to other data  
20 files that include information on MA utilization. For  
21 these comparisons, rather than trying to validate all data  
22 elements, we focused just on first- and second-order

1 questions. So we checked to see that the same enrollees  
2 who received a service that's documented in the encounter  
3 data are also identified in a comparison data set. And  
4 where possible, we checked that dates or service matched or  
5 were at least similar.

6 Our validation found three categories of  
7 encounter data issues.

8 First, plans are not successfully submitting  
9 encounters for all settings. In 2015 only 80 percent of MA  
10 contracts have at least one encounter record for each of  
11 the six settings.

12 Second, the encounter data include a small number  
13 of records that attribute enrollees to the wrong plan. The  
14 paper goes into more detail, but the key takeaway is that  
15 this issue will require a change in data processing to  
16 address it.

17 And, third, encounter data differ substantially  
18 from data sources used for comparison. We'll focus on this  
19 issue on the next slides. But first I want to note that  
20 for today's presentation, we'll be showing results for 2015  
21 for brevity. The 2015 numbers show small gains over 2014  
22 that suggest incremental improvement in completeness. Andy

1 will go into more detail on later slides, but basically  
2 we're concerned about the pace of that improvement and its  
3 ability to yield usable encounter data in the near future.

4           So on the comparison of encounter data to other  
5 data sources that document MA utilization, the four shown  
6 here are independent or external data in that they are  
7 derived from information reported by providers, in this  
8 case including hospitals, dialysis facilities, home health  
9 agencies, and skilled nursing facilities.

10           For 2015, 90 percent of the enrollees who were  
11 included in the independent data reported by hospitals as  
12 having an inpatient stay were also included in the  
13 encounter data. However, of the inpatient stays in  
14 hospital-reported data, only 78 percent had matching dates  
15 of service to the encounter data.

16           Moving to the next line, 89 percent of enrollees  
17 in independent data reported by dialysis facilities as  
18 having dialysis services were also included in the  
19 encounter data. And the enrollee match rates were 47  
20 percent for home health and 49 percent for skilled nursing.

21           We lack good independent data sources for  
22 assessing the completeness of physician visits, outpatient

1 hospital services, and certain other Part B services.  
2 Currently, the best available comparison for some of these  
3 comes from HEDIS, or the Healthcare Effectiveness Data and  
4 Information Set, which is not an external data source, but  
5 is based on plans' summaries of their internal utilization  
6 data that they report to CMS.

7           So we compared the encounter data to these three  
8 plan-generated sources document MA utilization. We found  
9 that 46 percent of MA contracts reported the same total  
10 number of physician office visits, plus or minus a wiggle  
11 factor of 10 percent, in both HEDIS and encounter data.  
12 Match rates for emergency department visits and inpatient  
13 stays were lower at just 10 percent and 27 percent,  
14 respectively.

15           So now I'll turn it over to Andy, who will  
16 discuss the outlook for encounter data.

17           DR. JOHNSON: I'm going to start by giving an  
18 overview of the current feedback and incentives for  
19 encounter data submissions.

20           First, plan report cards show the total number of  
21 submitted, accepted, and rejected records by service  
22 category and report regional and national averages for

1 each. Report cards also compare inpatient encounters to  
2 those reported by hospitals, but the metric is for  
3 informational purposes only.

4           Second, CMS recently implemented a set of  
5 encounter data performance metrics that assess the timing  
6 of submissions and compare each plan's encounter data to  
7 the plan-submitted risk adjustment, or RAPS data.  
8 Thresholds for these metrics are designed to identify plans  
9 that are outliers due to very low encounter data  
10 submission.

11           And, finally, encounter data are used to identify  
12 diagnoses for risk adjustment, which provides an incentive  
13 to submit some inpatient, outpatient, and physician  
14 records, but offers no incentive to submit records for  
15 other types of services or for encounters that do not  
16 reveal additional diagnosis codes.

17           Based on this set of feedback, plans generally  
18 report that their recent years of data are better.  
19 However, we believe CMS and plans should now focus on  
20 increasing encounter data completeness and accuracy.

21           We start by addressing how CMS should assess data  
22 completeness and accuracy. The best strategy is to find

1 evidence of MA service use in independent data sources.  
2 Information-only claims and patient assessments are  
3 submitted by providers for MA enrollees and can be used to  
4 construct metrics of completeness and accuracy that would  
5 help evaluate whether all encounters are being correctly  
6 reported. Available external data sources cover inpatient  
7 and post-acute services, but would not address physician  
8 and outpatient services.

9           Data generated by plans can also be used;  
10 however, comparisons to plan-generated data would test  
11 whether a plan's data processing is internally consistent.  
12 Such comparisons could identify missing encounter records,  
13 but would not evaluate completeness. Available plan-  
14 generated data sources cover a much wider range of  
15 services.

16           These comparisons could tailored to be less  
17 specific, requiring only that beneficiaries are in both  
18 encounter and comparison data sources; or they could be  
19 more specific, requiring matching provider, service date,  
20 procedure, and other information.

21           Finally, providing feedback to plans about their  
22 performance on all metrics and publicly reporting aggregate

1 performance for all plans would help encourage complete and  
2 accurate submissions and would inform policymakers and  
3 researchers about encounter data completeness.

4 Over the next few slides, I will discuss policies  
5 for improving the assessment of completeness and increasing  
6 incentives to submit encounter data. These policies  
7 include expanding the performance metric framework,  
8 applying a payment withhold for encounter data submission,  
9 and using Medicare Administrative Contractors to collect  
10 encounter data directly from providers if encounter data  
11 are not complete within five years.

12 These policies could be developed in the short  
13 term, and the Chairman's draft recommendation, which we  
14 will discuss today, would apply all three policies in  
15 concert.

16 Current performance metrics address the timing of  
17 encounter submissions and comparisons to RAPS data.  
18 Expanding upon this framework would entail incorporating  
19 new metrics that compare encounter data to external and  
20 plan-generated data sources. CMS could publicly report  
21 aggregate performance statistics for the MA program, and  
22 feedback to plans could be more specific, including

1 information about each instance of missing encounter data.

2 Compliance with the current performance framework  
3 addresses only low-performing outliers. However, we find  
4 that using a single threshold to identify outlier plans  
5 does not address the scope of incomplete encounter data.

6 Our analysis found incompleteness to be a broad  
7 issue with nearly all plans needing at least some  
8 improvement. Therefore, applying a payment withhold would  
9 be a more appropriate way to address the incompleteness in  
10 the data.

11 A payment withhold tied to the new performance  
12 metrics just described would offer a financial incentive to  
13 submit complete and accurate encounter data.

14 To implement the policy, a percentage of each  
15 plan's monthly payment would be withheld, making the size  
16 of the withhold correlated with enrollment in the plan and  
17 the number of expected encounter records. The amount to be  
18 returned to the plan would be based each plan's performance  
19 and a range of standards.

20 For example, plans with good performance could  
21 receive their full withhold in return, and plans with near-  
22 good performance could receive most of their withhold, and

1 so on, so that the amount of withhold returned would be  
2 proportional to the performance of each plan.

3 Standards could be set such that the overall  
4 withhold return rates could start at a generous level, with  
5 a high rate of return being easy to attain, and then become  
6 more strict over time. If plans collectively submit  
7 complete and accurate encounter data, the withhold policy  
8 could be phased out.

9 A final approach to improving encounter data is  
10 for providers to submit MA encounter data directly to  
11 Medicare Administrative Contractors, or MACs. Providers  
12 currently submit claims for all fee-for-service services to  
13 MACs and also submit information-only claims for MA  
14 enrollees using inpatient hospital and skilled nursing  
15 services. In addition, MACs currently forward fee-for-  
16 service claims to Medigap plans and Medicaid entities that  
17 have cost-sharing obligations.

18 To use this process in MA, MACs would apply fee-  
19 for-service data edits to Part A and B services to ensure  
20 that submitted records are complete before forwarding them  
21 on to MA plans for payment processing. For supplemental  
22 services, MACs could forward records directly to MA plans

1 without any processing.

2           Last time, some Commissioners expressed concern  
3 about this proposal. Since then, we spoke with a number of  
4 provider organizations that would prefer this policy, due  
5 to the greater standardization in edit processing and more  
6 timely and high-quality feedback. These organizations  
7 found the value to be greater than any concern about adding  
8 additional steps in the claims submission process.

9           To implement this policy, CMS would establish a  
10 timeline of completeness thresholds that each MA  
11 organization must meet. A missed threshold would result in  
12 the use of a MAC for that organization, but other  
13 organizations would continue to submit their own encounter  
14 data. Under this option, MA organizations that prefer to  
15 use a MAC to process and submit encounter data could elect  
16 to do so.

17           That brings us to the Chairman's draft  
18 recommendation that would apply all three policies.

19           The Chairman's draft recommendation reads: The  
20 Congress should direct the Secretary to establish  
21 thresholds for the completeness and accuracy of Medicare  
22 Advantage encounter data and rigorously evaluate MA

1 organizations' submitted data and provide robust feedback.

2 Concurrently apply a payment withhold and provide  
3 refunds to MA organizations that meet thresholds.

4 Starting in 2024, institute a mechanism for  
5 direct submission of provider claims to Medicare  
6 Administrative Contractors for all MA organizations that  
7 fail to meet thresholds, or that prefer this method.

8 Now I'll address the implications of the  
9 recommendation. The recommendation may reduce program  
10 spending relative to current policy. Specifically, if the  
11 performance of some plans results in less than the full  
12 withhold amount being returned to the plan, there would be  
13 a reduction in program spending.

14 The recommendation would not have any direct  
15 effect on beneficiaries.

16 The impact on plans and providers would vary  
17 depending on each entities' current method for processing  
18 claims or submitting encounter data. We note that the use  
19 of MACs in MA may pose implementation problems for a small  
20 set of providers that don't submit traditional claims. We  
21 continue to consider ways to address this situation.

22 Before we wrap up, I want to point out two issues

1 requiring future work that are necessary for ensuring  
2 overall encounter data completeness.

3           The first issue is the lack of available external  
4 data sources for assessing encounter data for physician,  
5 outpatient, and certain other Part B services.

6           To develop external data comparisons, it may be  
7 necessary to patch together comparisons of subsets of these  
8 services. For example, Part D event data and inpatient  
9 data could identify evidence of physician encounters that  
10 we would expect to find in the encounter data.

11           Alternatively, an assessment of these services  
12 could rely on aggregate utilization information from plan  
13 bids. Once developed, these comparisons could be added to  
14 the performance metric framework.

15           The second issue is developing a method to ensure  
16 that the submission incentives and performance metrics are  
17 having their intended effect. One way to do this would be  
18 to link encounter data to plan spending. Fee-for-service  
19 claims data merit a high level of credibility as they have  
20 been fully adjudicated for payment. To achieve a similar  
21 level of credibility for MA encounter data, we would like  
22 to know whether the data are generally consistent with each

1 plan's spending.

2 One approach is to link encounter data to MA plan  
3 bids and check whether utilization for service type is  
4 consistent with encounter data and, therefore, consistent  
5 with the spending amounts on the bid.

6 An alternative approach would be to develop an  
7 additional program audit area to assess consistency between  
8 encounter data and the plan's financial data for payments  
9 to providers.

10 We highlighted these two issues for future work  
11 to differentiate them from the policies included in the  
12 Chairman's draft recommendation.

13 Thank you. I'll turn it back.

14 DR. CHRISTIANSON: All right. Thanks. So this  
15 is obviously complicated work, so there's probably  
16 questions of clarification for Andy and Jennifer. I see  
17 your hand, Brian.

18 DR. DeBUSK: First of all, thank you for a really  
19 well written chapter. My question is on the reading  
20 materials on page 21. You discuss this idea of MA  
21 encounter data being used to calibrate the risk model for  
22 MA payments. And my question -- I've got two questions.

1 My first question is: Let's assume we can get the  
2 encounter data, which we need and deserve. Let's say we  
3 could then accurately assign a cost to each encounter, even  
4 within the context of capitated agreements. But if we're  
5 then using their cost data and their risk score to  
6 calibrate their per member per month payment, wouldn't we  
7 have to build in -- assume a margin or build in a -- I  
8 mean, wouldn't we effectively be setting their operating  
9 margin if we were calibrating to their costs and their risk  
10 score?

11 DR. JOHNSON: I don't think you would have to for  
12 the risk score because the operating margin administrative  
13 expenses I think would be addressed in setting the  
14 benchmarks, which would be a separate process.

15 DR. DeBUSK: But you'd still -- the benchmark is  
16 based on the model. I mean, each year we calibrate now  
17 against RAPS. Basically, it's fee-for-service costs and  
18 scores.

19 DR. JOHNSON: Right.

20 DR. DeBUSK: If we were to calibrate -- and,  
21 again, this seems circulate. If we were calibrating their  
22 payment to their cost and their risk score, and we

1 calibrated it perfectly, it seems like they would make  
2 exactly zero money if we calibrated their payment to their  
3 cost, or we would have to build in a margin of some sort.

4 DR. JOHNSON: I think the margin would still be  
5 built into the benchmark, which is based on an average fee-  
6 for-service spending. So even though the risk adjustment  
7 model would be --

8 DR. DeBUSK: I got you.

9 DR. JOHNSON: -- calibrated to MA population, it  
10 would --

11 DR. DeBUSK: So that what you would do is you'd  
12 develop the benchmark, but then their bid would be above or  
13 below that benchmark.

14 DR. JOHNSON: Correct.

15 DR. DeBUSK: And that's where they would  
16 presumably have profit.

17 DR. JOHNSON: Correct. And calibrating the risk  
18 adjustment model with encounter data would not have any  
19 implications for the benchmark. It would just be a  
20 different way of coming up with the coefficients.

21 DR. DeBUSK: Oh, okay. Then I apologize. I was  
22 thinking you were going to actually use that to calculate -

1 - to determine the benchmark, and that seemed circulate.

2 DR. JOHNSON: Right.

3 DR. DeBUSK: Thank you.

4 DR. CHRISTIANSON: Okay. David and then Pat.

5 DR. GRABOWSKI: I wanted to ask you about Slide  
6 A. I know we've talked about some of these validation  
7 exercise in the past. Inpatient and dialysis, 89, 90  
8 percent enrollees match. Those look relatively strong,  
9 home health and SNFs below 50 percent. Why so low for  
10 those post-acute sectors? That's the first part of the  
11 question. And then is it something about the comparison  
12 here in terms of the denominator, comparing to MEDPAR  
13 information-only claims versus these assessment data that  
14 are done across the board? And I guess this is going to be  
15 my third question loaded on. Aren't there information-only  
16 claims for SNFs too? Is that another comparison there and  
17 did you guys look at that? Thanks.

18 DR. JOHNSON: So in reverse order, there are  
19 information-only claims for SNFs, and we've started to look  
20 at them but haven't built them into the current set of  
21 comparisons we're working with.

22 The -- actually, I forgot your second question.

1 MS. PODULKA: Well, you were asking about why so  
2 long for the last two of the four comparisons here, and  
3 we've talked to providers and plans. Remember we're  
4 looking at 2015 data. That's a few years back. Plans have  
5 expressed that they're having more challenges getting in  
6 certain types of providers, especially the PAC providers,  
7 than they are for inpatient and some others, that might be  
8 going up along with the incremental improvement we've seen.  
9 But we're not sure yet. We will need to evaluate more  
10 recent data.

11 And again, as Andy noted, there are certain  
12 settings and provider types that count for diagnoses. And  
13 so plans have a lot of experience with making sure you get  
14 in that diagnostic information for those providers. That's  
15 not hitting our PAC providers.

16 DR. JOHNSON: And I think the one other point you  
17 alluded to was whether or not there's a difference in the  
18 comparison data sets, which is -- I would agree that the  
19 OASIS and MDS is less -- it's used less for other purposes  
20 and maybe is less complete itself than the MEDPAR  
21 information-only claim data.

22 DR. CHRISTIANSON: Pat.

1 MS. WANG: It's a really important topic and it's  
2 great. It's great work.

3 I think this topic of how do you measure  
4 completeness, it's based on these sorts of what I would  
5 call sources of truth, whether it's MEDPAR or the OASIS.  
6 And so I guess I have some questions around whether you  
7 think that they are really great sources of truth to, you  
8 know, really match. You know, they're directional and  
9 they're important but with some of the recommendations, to  
10 hold them up as the arbiter of whether an encounter data  
11 set is correct or not makes me a little nervous. So that  
12 slides into the next.

13 But on MEDPAR, which is probably the best, is the  
14 most complete sort of source of truth source, is MEDPAR  
15 itself ever audited? And I guess I have -- you know, is  
16 the -- if that's being held as the source of truth that  
17 plans are trying to match their inpatient encounters to, is  
18 MEDPAR itself clean, in a sense? Is it ever audited?  
19 And the related question to that is, how does MEDPAR sort  
20 of possible differences between an MA plan's payment  
21 policies? So, for example, an MA plan may have -- may  
22 apply a 30-day readmission payment policy differently than

1 fee-for-service or what have you. Do you know whether  
2 hospitals -- how does that get reflected in the data that  
3 hospitals submit to MEDPAR, since that is being used as the  
4 source of truth? If there is a denial are they required to  
5 back it out? If there's a medical necessity review that  
6 says this short stay should have been observation, do  
7 hospitals follow strict rules?

8 DR. JOHNSON: I don't know the answer to that  
9 specifically, but I think the general process for  
10 submitting to MEDPAR is that when a hospital submits a  
11 claim to the plan they will submit a copy to the MAC, that  
12 will put that into the MEDPAR file.

13 So it -- I guess working through the sequence, if  
14 there's a denial, I'm not sure if there's a reconciliation  
15 at the MAC for that copied claim, or similarly, how the  
16 readmissions within 30 days would work. That might depend  
17 on the plans' policies for how they require hospitals to  
18 report that data and what claims information they require  
19 them to submit.

20 MS. WANG: Okay. And on HEDIS, which was very interesting  
21 that you used that, are there -- within HEDIS there are  
22 sometimes criteria for which measures. Like, you know, you

1 have to have continuous enrollment. You have to have had a  
2 previous something happen. Were you able to scrub for  
3 that, or did you not intend to? It was just sort of like  
4 let's just see what it looks like. In other words, HEDIS  
5 won't capture the entire universe of what a plan is doing,  
6 no matter what.

7 DR. JOHNSON: Right. We did attempt to apply the  
8 same rules and exclusions that HEDIS says to apply.

9 MS. WANG: Okay. That's cool. Okay. On the  
10 recommendation about sort of using the MAC ultimately, can  
11 you just go a little further into how this could work?  
12 Let's say that there are 10 MA plans in a MAC region. Two  
13 of them are viewed to be outlier poor submitters. So how  
14 do you select -- would all providers then be required to  
15 submit everything to MAC so that those two outliers, you  
16 know, would be needing to submit through -- how does that -  
17 -

18 DR. JOHNSON: So we think that prior to the  
19 policy being implemented the providers would have  
20 instructions to submit the fee-for-service claims to the  
21 MAC and to submit claims to each individual plan, which  
22 might have its own set of rules for submitting claims to

1 the plan. So for those two plans that would have failed to  
2 meet certain thresholds, their instructions to the  
3 providers would be you now submit to the MAC and the MAC  
4 would forward the claims to us.

5 MS. WANG: I see.

6 DR. JOHNSON: And if there's any back-end payment  
7 adjudication that would happen between the plan and  
8 provider afterwards.

9 MS. WANG: Okay, but it would -- I see. So a  
10 provider -- let's say I'm a hospital and I'm submitting to  
11 eight MA plans who have great encounter submissions. For  
12 the two I would now have to come up with a new billing  
13 process to send my claims to the MAC for those MA plans?

14 DR. JOHNSON: It would be different. It would be  
15 the same as the fee-for-service claim process, with the  
16 exception that the plan still might have some edits that  
17 are in addition to the fee-for-service edits.

18 MS. WANG: Okay. Interesting.

19 DR. CROSSON: Dana.

20 DR. SAFRAN: Thanks. Really such important work,  
21 and my question picks up, I think, where Pat was going. I  
22 was really struck by kind of the elegance -- the potential

1 elegance of the MAC as the solution, and wanted to  
2 understand, you know, when you're in the recommendation you  
3 talk about potential varying impacts on different plans and  
4 providers. But when I read the chapter it just seemed  
5 like, you know, like I said, like a pretty elegant solution  
6 since it sounded like every provider, and maybe your  
7 narrative today suggested there might be some rare  
8 exceptions, is using the MAC to submit data for their fee-  
9 for-service business.

10           So I'm trying to understand, are there any  
11 barriers you see at the provider level to just turning that  
12 on for their MA patients?

13           DR. JOHNSON: I don't think it would be worse for  
14 any providers. The providers that preferred the MAC option  
15 felt that they had a lot of instructions across the plans  
16 that were different and sometimes hard to follow, and  
17 sometimes it was about the feedback that they got back from  
18 any errors in their claims submission, where they decided  
19 the MAC is providing very timely feedback that was specific  
20 and that they could follow easily. So it was more of a  
21 standardization of that process that most -- that some  
22 providers thought would be good.

1           With regard to the varying impacts, I think it is  
2 that we heard a number of different pathways that claims  
3 travel, from providers to plans, involving claims  
4 clearinghouses and some other data processing groups. So  
5 it was hard for us to disentangle exactly which pathways  
6 would be better off by using a MAC and which pathways might  
7 actually be worse off, and whether that would make a better  
8 -- a bigger impact for the plan or the provider was also  
9 difficult to say.

10           DR. SAFRAN: So --

11           DR. CROSSON: Okay. Go ahead.

12           DR. SAFRAN: Well, so I guess maybe you're  
13 starting to answer my other question, which was -- I was  
14 trying to understand why, in the recommendation, we're  
15 looking to do this, use the MAC only for providers who are  
16 out of bounds in terms of evidence of the -- you know,  
17 validation of the data they're submitting, and those who  
18 chose it, as opposed to just saying in whatever time frame  
19 it takes to make this operationally work. And it doesn't  
20 seem like it would be long, just given that the fee-for-  
21 service claims are going through that mechanisms. This is  
22 how we're going to do it, because we need the data across

1 these programs to be comparable.

2           So I'm just trying to understand why you went the  
3 route you did.

4           MS. PODULKA: This is one of the elements of  
5 doing our work as a Commission in an open and transparent  
6 manner and trying to take in the interests of all parties.

7           Andy mentioned these various pathways for  
8 processing. That's absolutely true. And we mentioned that  
9 there might be some providers who face obstacles in  
10 submitting their claims to their MAC. We are, in that  
11 instance, referring to what we think is a narrow exception  
12 than the rule. The vast majority of providers in this  
13 country participate in some form of fee-for-service and  
14 some form of managed care. It is a rare provider that is  
15 exclusively managed care or exclusively delegated or  
16 capitation. But we want to make sure that we're not  
17 excluding them from our consideration.

18           Now last time we discussed I think Jon raised the  
19 point that you're raising now. The fee-for-service MAC  
20 option presents what seems like a fairly elegant solution  
21 and it raises the rhetorical question -- why not now or why  
22 not everybody -- and that's for your discussion. We've

1 included it as a fallback that would be triggered  
2 depending, you know, on the performance of these other  
3 metrics and incentives that we envision and giving five  
4 more years, or whatever time period you're interested in,  
5 to see if those work, and if it doesn't, limiting it to  
6 those who have trouble continuing to meet thresholds. But  
7 it's certainly a point of discussion. Do you want it  
8 broader or do you want it sooner?

9 DR. MATHEWS: The other thing, if I could weigh  
10 in here as well, the way we've set it up is trying also to  
11 be sensitive to the considerable investment of time and  
12 resources that CMS and the plans have put into the current  
13 process. It has been a little bit of a rocky process but  
14 when we have talked to plans they do seem to say that a lot  
15 of the, you know, initial rough parts of the process have  
16 been worked out. And it possible that we may see more  
17 rapid improvement in the quality and completeness of the  
18 data that we've seen thus far.

19 And so to the extent those investments have been  
20 made, we could allow that process to continue for some  
21 period of time, before invoking a broader uniform across-  
22 the-board MAC process.

1 DR. CROSSON: Jon, do you want to comment on this  
2 point?

3 DR. PERLIN: I was trying to put it in the form  
4 of a question, for part 1, round 1.

5 DR. CROSSON: Do you want to comment on this  
6 question?

7 DR. PERLIN: If you don't mind. You know, if the  
8 gold standard is the data through the MAC, and providers,  
9 by and large, participate in a fee-for-service program and  
10 have that worked out, and if providers have a diffusion of  
11 effort in terms of multiple approaches and the other is not  
12 working for plans either -- and I really have to listen to  
13 my colleague who comes from that background, Dana -- then  
14 it would seem that there would be a really elegant solution  
15 and it would strike me that the inelegance to both plans  
16 and providers would be a diffusion at this, and most  
17 centrally to the Medicare program itself.

18 So that's an endorsement for keep it simple, use  
19 the processes that are there, and why that seems to get the  
20 gold standard in terms of the data you want.

21 DR. CROSSON: So one point I thought -- sorry --  
22 one point I thought was going to come up that hasn't so

1 far, and I think it needs to be raised, is how does this  
2 work for capitated providers. So do you want to talk about  
3 that, or Jim?

4 DR. SAFRAN: Oh, I'm sorry.

5 MS. PODULKA: I'm sorry.

6 DR. SAFRAN: I was just trying to ask, do you mean  
7 exclusive -- like a provider who is exclusively capitated  
8 and not participating in fee-for-service at all?

9 DR. CROSSON: Yes.

10 MS. PODULKA: Okay.

11 DR. DeSALVO: So like a JenCare kind of a model.

12 DR. CROSSON: Yeah. Right.

13 MS. PODULKA: Okay. So for providers currently  
14 within encounter data that are capitated -- in capitated  
15 arrangements for their plans, those data still come into  
16 the encounter data system. They might look a little  
17 different, for instance. The payment field can be zero  
18 rather than reflecting a payment, because it's hard to  
19 break up a capitated payment. And we've spoken with some  
20 provider groups and plans. Capitation exists in commercial  
21 markets as well. Plans have mechanisms for receiving batch  
22 data from their providers that's still capturing many of

1 the same data elements that are included in claims or the  
2 Medicare encounter data. So this isn't wholly new kinds of  
3 data transfers between providers and plans, even though  
4 they sound different than straightforward fee-for-service.

5 There would need to be some mechanism within a  
6 fee-for-service MAC for, you know, specifications for how  
7 the data would come in, that would probably have to look  
8 somewhat like a claim, but again, could maybe have zero for  
9 the payment field or some other modification.

10 DR. CROSSON: That's the point I wanted to bring  
11 out, is that the majority of the information would be  
12 there. It's just the payment field would be blank.

13 Pat, you wanted to comment on this?

14 MS. WANG: I'll try to phrase this as a question.  
15 I think in the current system of encounter submission it's  
16 likely that the way that people report capitated payments -  
17 - PCP cap is a very obviously, very common example -- it's  
18 probably all over the place. So, you know, you have a  
19 slide in here about things that CMS is recommended to do.  
20 You know, it's a two-way street.

21 I also, on the MAC, I very much respect the  
22 comments of my colleagues here. You know, I'll save this

1 for the comments, but is it not true that if a MAC took  
2 this over you would be expecting the MAC to load contracts,  
3 to conduct -- you know, the specific contracts that each MA  
4 plan has with every single provider type that would be  
5 going -- they'd have to load the payment terms, the payment  
6 policies? What do they do about fraud, waste, and abuse  
7 screening? Would they be expected to sort of stand in the  
8 shoes of an MA plan, or, you know, is this sort of like  
9 blunt instrument, those individual payment arrangements  
10 with some plans, I believe are important for the interest  
11 of their members, would just go away because we're going to  
12 the lowest common denominator?

13 DR. JOHNSON: I think the function of the MAC  
14 would be to ensure that the claims being submitted meet a  
15 basic set of completeness and other edits and checks, but  
16 that the MAC would not be doing payment adjudication, that  
17 they would forward those claims on to the plan to apply  
18 their policies about their benefit package and doing some  
19 of the other functions that you mentioned.

20 MS. PODULKA: And one more thing. You mentioned  
21 would the MAC need to load the entire contract between MA  
22 plans and their providers. No. And, in fact, there

1 exists, in the industry right now, as Andy was mentioning  
2 earlier, a large network of fiscal intermediaries and other  
3 contractors that plans and providers employ for processing  
4 their claims. And the way this works now is that these  
5 companies load specifications each year, for these are the,  
6 you know, requirements for this plan, this plan, this plan.  
7 And they're not just surveying one plan or between one plan  
8 and provider. So they, you know, each year collect a  
9 series of specifications and apply that to the rules.  
10 Those specifications are based on contract terms but it's  
11 certainly not capturing all the proprietary data from the  
12 contract or the full extent of all of that information.

13 MS. WANG: You're referring to the claims  
14 clearinghouses.

15 MS. PODULKA: Yeah.

16 MS. WANG: Did you consider whether the  
17 information -- that is a pathway to get the encounter data?  
18 So in this, with the MAC, would a provider still go through  
19 a claims clearinghouse and the claims clearinghouse would  
20 send it on to MAC?

21 DR. JOHNSON: I think that is the case for some  
22 fee-for-service claims now. So if a provider was

1 submitting to a MAC for an MA enrollee, I think it would be  
2 to their benefit to use the same process, but that the  
3 edits that the MAC applies would provide some  
4 standardization and assessment of completeness of  
5 information, and then it would keep that information for MA  
6 enrollees as part of the encounter records, and then it  
7 could be forwarded on to the plan to do other edits that  
8 are necessary for payment adjudication. But the encounter  
9 record would be collected to CMS prior to that second step.

10 DR. CROSSON: Okay. Let me see. I've got Warner  
11 and Jon, and I think that's it. Right? Okay, Warner.

12 MR. THOMAS: Just a question, just to refresh my  
13 memory. We talked about this before, and, you know, I  
14 always kind of was coming at the conclusion, well, gee, the  
15 plans have to do a better job of this. But then in our  
16 previous conversations it sounded like there were issues on  
17 the receiving as well, that this really was not just a plan  
18 issue. Maybe Pat can comment on this, being in this world.

19 But can you shed some light on that, because it  
20 seems like there's mutual responsibility here, that this  
21 isn't all just on the plan, that it seems like there are  
22 some that are trying to do a better job there that are

1 having challenges on the other side, with the recipient of  
2 the data.

3 DR. JOHNSON: That's definitely true, and some of  
4 the plans we've heard from more recently suggest that the  
5 overall process has undergone a lot of changes and has been  
6 confusing to follow, but has become more easy to work with,  
7 and that the indications we're getting from CMS is that  
8 their process has reached more of a steady state now, that  
9 they've released several iterations of the -- a report that  
10 gives information about diagnoses collected for risk  
11 adjustment, and that they released, successfully,  
12 additional iterations, which was, you know, difficult to  
13 follow. But now it appears that this is more of a steady  
14 state and that the feedback the plans are getting is not  
15 going to change as frequently as it has in the last few  
16 years.

17 MR. THOMAS: So I guess the question I would have  
18 is if we put a policy, or make a recommendation like this,  
19 put it in place, you feel like based on the information you  
20 have that it would be achievable by the plans to be able to  
21 submit this data accurately, hit the benchmarks and the  
22 targets that we're outlining here.

1 DR. JOHNSON: Yes.

2 DR. CROSSON: Okay. Jon? Did I make a mistake?  
3 Did I not have you? Okay. Karen.

4 DR. DeSALVO: Thank you. I had a question  
5 similar to Warren's -- Warner's, sorry, so thank you for  
6 raising that, Warren. I'm teasing.

7 But I also had a question. I just didn't really  
8 -- I wasn't clear on a sort of third bucket of Medicare  
9 beneficiaries. If the goal is -- if the intermediate goal  
10 is to get encounter data to the long-term goal, which is to  
11 make sure there's value add to the beneficiaries and  
12 taxpayers of accountable entities, how do ACOs submit their  
13 data to allow for a comparable to happen to fee-for-service  
14 and MA?

15 DR. JOHNSON: I think all the provider data would  
16 still go through the MACs, the basic fee-for-service  
17 payment mechanisms, and then the ACO infrastructure would  
18 sit on top of that and apply adjustments and their own  
19 payment policies. But the fee-for-service claims process  
20 is still going on underneath that.

21 DR. CROSSON: Okay. So I think we're going to  
22 move on now to a general discussion here. Put up the draft

1 recommendation because the order of business will be the  
2 recommendation. This will be the first time the  
3 recommendation has been presented, so I'd like to have a  
4 discussion from those who wish to about the general support  
5 or not for the recommendation, potential changes, the  
6 implication being that we will bring the recommendation  
7 back for a vote next month. We'll start with Brian.

8 DR. DeBUSK: I would support the recommendation  
9 as written. I think it's good policy. I think it's a  
10 well-thought-out policy.

11 My one comment would be 2024 seems like it's a  
12 little too long. I would be afraid that they might wait  
13 all the way up until 2024. So I would probably bring that  
14 date in some. But other than that, I think this is  
15 excellent policy.

16 DR. CROSSON: David.

17 DR. GRABOWSKI: I completely agree and was going  
18 to say the same thing. 2024 strikes me as a long way out.  
19 I wonder if any of these Commissioners will still be on the  
20 Commission. Not that that's the right sort of finish line,  
21 but that's a long way out.

22 DR. CROSSON: Sometimes that is a consideration.

1 Not in this particular case.

2 [Laughter.]

3 DR. CROSSON: Pat and then Jon and Marge.

4 MS. WANG: It's a really good chapter, and it's a  
5 very important goal. So thank you, guys, for plugging away  
6 at this. It is getting better.

7 The one thing that, Andy, I just want to say is  
8 that even though it's getting better, I do want to note  
9 that even for plans that work on this assiduously, you  
10 know, a gap of like 1 percent or 1.5 percent mismatch is a  
11 lot of dollars for a plan, like potentially ruinous. So  
12 statistically, it may not seem a lot, but it's very, very  
13 meaningful. And so I think that the goal is to improve the  
14 process on both sides.

15 To that end, just in general, I noticed that --  
16 and perhaps you didn't state the encouragement to CMS to  
17 keep increasing the blend of EDS in the calculation of risk  
18 scores. I think that's very motivational to plans, and I  
19 would say that, you know, MedPAC should kind of encourage  
20 them to keep pedal to the metal, because that will really  
21 get the most attention from plans to actually make sure  
22 that their EDS submissions are strong. So I would add that

1 actually to the recommendation or just repeat it.

2           As far as how CMS might be able to improve kind  
3 of the feedback loop to plans, I think that, in addition to  
4 the things that you suggested, it would be very important  
5 for them to add dollars to their reports to the plans, not  
6 just what's the volume of encounters that were submitted  
7 but what is the match of dollars, because if a plan thinks  
8 that they've submitted encounters that are worth \$30  
9 million in cost, for example, and what comes back in terms  
10 of a dollar match is \$20 million, that is like a big deal.  
11 So that would help kind of refine, I think, the work-  
12 around, making sure that things are getting in there  
13 correctly.

14           You know, we sort of talked before about are the  
15 sources of truth that are going to be the arbiter of  
16 whether or not an EDS submission is complete. I'm a little  
17 nervous that they're kind of squishy. The best one is  
18 MEDPAR, and so when it comes to, you know, creating  
19 financial incentives of some kind, it might be a refinement  
20 in a step-wise fashion to encourage development of  
21 financial incentives to submit inpatient encounters that  
22 match MEDPAR, because that is a -- you know, plans get that

1 report today, and maybe more focus on that, because that's  
2 a concrete source. Some of these other matching sources  
3 are really -- I don't think that many of them like the  
4 OASIS and so forth are particularly good to sort of say you  
5 have a good encounter submission rate or not. I think  
6 there's problems on sort of the data source side for CMS.

7           And as far as the MAC is concerned, as you've  
8 described it, you know, it might be an appropriate step for  
9 plans that really are not complying. I would really,  
10 really, really advise against and really think it's a bad  
11 idea to sort of go there tomorrow. It is a very disruptive  
12 system for everybody to sort of flip the way that they're  
13 doing things especially for plans that have invested a lot  
14 to try to get their encounters in correctly.

15           And, finally, on this issue of capitation, I do  
16 think that that needs more attention as the system moves  
17 more towards value-based payments and bundles and things  
18 that are not traditional. I do think -- and I asked my own  
19 staff, like how are we submitting this? And the response  
20 was we're submitting it a certain way, but we think  
21 everybody's probably just submitting it in totally  
22 different ways. So more rules from CMS about specifying

1 that are important.

2           So I think that there's more work to be done on  
3 both sides and that the signals in general, with the  
4 amendments that I've offered that you provided here, are a  
5 good start.

6           DR. MATHEWS: Pat, can I ask a clarifying  
7 question on one of your comments? So with respect to the  
8 completeness and integrity of the comparison data that  
9 we've used to assess the same characteristics of the  
10 encounter data, last year when we made our first attempt at  
11 these kinds of comparisons and then when we did this in the  
12 fall, I think we were pretty explicit that we found some  
13 anomalies on both sides. So we would find records in the  
14 encounter data that were not in MDS, and we would find MDS  
15 records that were not in encounter data, and the same for  
16 OASIS and the other comparison sets.

17           So I think we're acknowledging that there are --  
18 you know, the comparison data sets are not perfect, but if  
19 the goal is indeed to encourage or incentivize MA plans to  
20 submit complete encounter data for all of the purposes that  
21 we've outlined in the materials here and in our prior work,  
22 what other metrics would we use to assess whether or not an

1 MA plan was even close to hitting the mark?

2 MS. WANG: Yeah. I don't know. I don't know. I  
3 think that for -- I think that the reason it's important to  
4 kind of put the pedal to metal on the RAPS-EDS blend is  
5 people will pay a lot of attention to getting that right.  
6 But for the entire data set, you know, I mean, the  
7 comparator source of truth data sources, I don't know  
8 enough about what's available, but I think CMS has to work  
9 on that, too, because right now I think people are  
10 wandering around like -- I mean, plans know what -- and  
11 let's assume it's a plan that has devoted a lot of efforts  
12 and energy to trying to submit correct encounters. There's  
13 no feedback loop that makes any sense. So, you know, I'm  
14 not sure how to solve that problem.

15 DR. JOHNSON: If I could add one point, too, we  
16 didn't prescribe this, but we mentioned that the types of  
17 comparisons that are done could be more specific and  
18 include beneficiary information and dates and other things,  
19 and what we didn't say but we're thinking is that might be  
20 appropriate for a MEDPAR where the comparator data set is  
21 more comprehensive and has a rigorous process that it goes  
22 through on completion. But an MDS or OASIS might have a

1 less specific comparison that is you had a patient that had  
2 an MDS, did that patient have a skilled nursing stay as  
3 well? That might give some acknowledgment of what you're  
4 saying about the comparison data sources.

5 MS. PODULKA: And, Pat, when you mentioned your  
6 comment, I don't know if our last two slides fully conveyed  
7 our sense of willingness to really dig deep into this, but  
8 you mentioned this and we're like, oh, it's almost like you  
9 were in the meeting with us when we were discussing this  
10 internally. We have issues, we're concerned, and so, you  
11 know, if there's opportunity on the schedule, we want to  
12 really dig into what those comparison data sources look  
13 like and how they could be improved; and if you all have  
14 the patience for that, we would be happy to get your input  
15 on it.

16 DR. CROSSON: Bruce, do you have some --

17 MR. PYENSON: Just on this topic, I think a  
18 couple of sources are the audited financial statements of  
19 the MA-PD plans, at least in aggregate, to the extent cost  
20 information is captured. Of course, there's adjustments to  
21 those, but those are audited amounts and often provided in  
22 some detail. Because the MA bids are, in effect,

1 experience rated, there's data in the MA bid information  
2 that would also be relevant. So I think there's things  
3 like that, and that could be helpful. That's more than  
4 encounter. That's dollars and perhaps utilization.

5 DR. CROSSON: Thank you. Okay. Jon.

6 DR. PERLIN: I'm just at the general tenor of  
7 support for this. I think we have agreement that these  
8 data are necessary for all the obvious reasons. I think  
9 also you've indicated that the MAC data are the gold  
10 standard. Pat, I'm sensitive -- and you live in the plan  
11 world. There are lost investments in mechanisms, but  
12 ultimately, you know, I condone the set of parsimony. I  
13 would hope that given an established process, maybe it's by  
14 date certain, that we move to, you know, MAC as the final  
15 common pathway.

16 I think what's difficult is to have, you know,  
17 mechanisms for numerous different simultaneous, and with  
18 numerous different simultaneous, I don't think we'll  
19 resolve the, you know, discrepancies among some of the  
20 data. So, you know, whatever is a reasonable time, but  
21 ultimately moving to a final common pathway in the interest  
22 of parsimony. Thanks.

1 DR. CROSSON: Marge.

2 MS. MARJORIE GINSBURG: Yeah, I just have two  
3 comments. One was whether -- I agree with the earlier  
4 comments that 2024 is too far out. But I also wonder,  
5 maybe that's okay if we have some interim date in between,  
6 something that indicates movement, the appropriate movement  
7 that we're looking for, rather than assuming everything is  
8 going to be done and perfect by 2024.

9 And the other comment was I'm not so enthusiastic  
10 about capturing financial data at the same time we're  
11 trying to capture encounter data. I think right now our  
12 primary interest and primary need is good, clean, thorough  
13 encounter data, and I think that's where we should be  
14 focusing all of our energy. And I worry about making this  
15 too complicated and too much stuff for the plans to engage  
16 in.

17 DR. CROSSON: Okay. Thank you.

18 Other comments? I see Dana and Bruce.

19 DR. SAFRAN: Great, thanks. So I agree with  
20 nearly all of the recommendation, but I do struggle with  
21 the time frame and the scope for the use of MAC. I hear,  
22 you know, what both Pat and Jim have pointed to as

1 investment -- you know, significant investment by plans to  
2 make it better, and I know the data we're looking at are  
3 from 2015, and we don't have much data right now to tell us  
4 how much better has it gotten. That's a problem.

5           But I guess at the end of the day I just -- I  
6 feel that this is so critical to the program's ongoing  
7 success, our ability to compare across these programs and  
8 to compare the ACO program on, you know, common data that  
9 have a common standard behind them. And so I kind of can't  
10 get my mind around a rationale for not moving quickly  
11 toward the elegance of this, with the possible exceptions  
12 of, you know, providers who aren't participating in fee-  
13 for-service at all, and we have to think that through.

14           But I don't know, it sort of strikes me as, you  
15 know, not wanting to move toward electric cars because we  
16 have so much invested in gas stations. You know, I just  
17 think some things are better, and we have to figure it out.

18           DR. CROSSON: Okay. Yes, Bruce.

19           MR. PYENSON: Along the lines of an electric car  
20 versus gas stations, there's another system for obtaining  
21 data from plans that's being applied to the ACA plans with  
22 about 12 million members last year, the individual

1 enrollment, and I think it would be worthwhile looking at  
2 the functionality of that. That includes not just the  
3 information that's used for its concurrent risk adjustment,  
4 but also included the dollar amounts needed for the  
5 transitional reinsurance arrangements that were in place in  
6 the early years. And that's ongoing and functional. It  
7 has puzzled me why a totally different system has been  
8 moving along for CMS -- the Medicare Advantage plans while  
9 the other one seems to be quite functional and useful. So  
10 I think that might be -- if we could add that to the list  
11 of the next two pages up there. But, otherwise, I support  
12 the Commissioner's recommendation.

13 DR. CROSSON: Okay. Thank you, Bruce.

14 Dana, I almost thought you were going to say  
15 something about gas stations and sunk costs, but I --

16 [Laughter.]

17 DR. CROSSON: Okay. So I think we've -- yes,  
18 Pat?

19 MS. WANG: Before abandoning the gas stations,  
20 which some of us would not characterize that that's what we  
21 right now --

22 [Laughter.]

1 MS. WANG: You know, some of the concerns -- and  
2 I would be very interested in learning more. Maybe I don't  
3 understand how great the MACs are. But some of the  
4 concerns that I would have is just delay, an extra step for  
5 a provider who wants to get paid yesterday going through an  
6 extra step, the completeness and reliability of the MAC.  
7 Actually, what makes me nervous is the extra step. It's  
8 always prone to like something disappearing or something  
9 changing and whether it's really as incredibly electric  
10 car-like that that's just going to pass right through to  
11 the plans. So that's part of my concern.

12 DR. DeSALVO: I know you want to end, but I want  
13 to --

14 DR. CROSSON: You've got another runaway  
15 metaphor? Go ahead.

16 DR. DeSALVO: Another runaway -- no, no. Well,  
17 maybe I'll try, just because if there are providers that  
18 are all MA that are not using MACs, it almost adds some  
19 burden to a value-based system which is a direction that we  
20 want to encourage folks to go, capitated models, et cetera.  
21 So I'd just like to give a lot of thought to making sure  
22 we're encouraging movement in a variety of directions which

1 have been mentioned here, but also not adding burden to a  
2 part of the system that's already moving in a direction  
3 that we'd like to encourage movement to value and  
4 responsibility for total cost of care.

5 DR. CROSSON: Okay. Very good discussion. Great  
6 presentation. We look forward to seeing you again next  
7 month.

8 And we've come to the end of our morning session.  
9 If there are any members of the audience, our guests, who  
10 wish to make a comment about the business before us, please  
11 come to the microphone.

12 [No response.]

13 DR. CROSSON: Seeing none, we are adjourned until  
14 1:45 p.m.

15 [Whereupon, at 12:21 p.m., the Commission was  
16 recessed, to reconvene at 1:45 p.m. this same day.]

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1 AFTERNOON SESSION

2 [1:47 p.m.]

3 DR. CROSSON: Okay. Maybe we can get organized.

4 This is the beginning of the afternoon session.

5 We have three items before us for the remainder of the day,

6 and the first one is going to be a discussion of options to

7 try to slow the growth of Medicare expenditures in

8 emergency departments. We have Carolyn, Zach, and Dan.

9 Carolyn, it looks like you are going to begin.

10 MS. SAN SOUCIE: Good afternoon. In this

11 presentation, we will revisit our discussion of options for

12 slowing the growth of Medicare fee-for-service spending for

13 emergency department services. In October, Zach and Dan

14 presented information on the provision of non-urgent care

15 and emergency departments and hospital ED coding practices.

16 Today, we have several updates for you, as well as policy

17 considerations for the two topics.

18 As a bit of context, in the past Commissioners

19 have expressed concern about the rapid growth in Medicare

20 ED spending. To get you started with the discussion, I

21 have updated you requested on urgent care centers as an

22 alternative to EDs. Next, we will address the overall

1 growth in ED spending from two separate policy angles.  
2 Zach will discuss the provision of non-urgent care at  
3 hospital EDs. Then, Dan will discuss the rapid growth in  
4 ED spending relative to coding. The presentation and  
5 discussion from today will culminate in an informational  
6 chapter in our June report to the Congress.

7           As you've heard before, urgent care centers are a  
8 setting of walk-in medical care that offer basic services  
9 and imaging for many common conditions. UCCs are an  
10 increasingly popular setting of care. In 2018, there were  
11 over 8,100 UCCs in operation, which is a 33 percent  
12 increase in the number of facilities from 2013.  
13 Additionally, there was a 73 percent increase in the number  
14 of UCC claims per beneficiary from 2013 to 2017, and in  
15 2017, 7 percent of Part B fee-for-service beneficiaries  
16 were treated in a UCC.

17           Urgent care centers are a lower-cost setting for  
18 the provision of non-urgent care. In part, this is because  
19 UCCs choose to employ nurse practitioners and physician  
20 assistants more frequently than either emergency  
21 departments or physician offices.

22           Additionally, payment to UCCs is much less than

1 to emergency departments for the treatment of similar  
2 patients..

3 The first topic you asked us to look into regarding UCCs  
4 was their quality of care. Similar to clinicians  
5 practicing in physician offices, qualifying physicians  
6 practicing at UCCs participate in the Quality Payment  
7 Program, which includes participation in either the Merit-  
8 Based Incentive Payment System, MIPS, or an advanced  
9 alternative payment model. Little is known about how the  
10 quality of care at UCCs differs from other settings. The  
11 limited existing research on UCC quality is mainly focused  
12 on antibiotic prescribing patterns. It suggests that  
13 providers at UCCs prescribe antibiotics to patients more  
14 frequently than other providers in other settings.

15           The second topic you asked us to look into  
16 regarding urgent care centers was the geographic variation  
17 in the use of both UCCs and EDs for non-urgent care. Given  
18 the overlap of lower-acuity cases that occur in EDs and  
19 UCCs, we created a definition of non-urgent care based off  
20 of seven common conditions. Using this method, we  
21 identified 15 million physician claims involving non-urgent  
22 care across all settings. The majority of these claims

1 occurred at physician offices, but a significant number  
2 occurred at both EDs and UCCs.

3 Our analysis utilized this definition of non-  
4 urgent care to determine geographic variation in the use of  
5 UCCs and EDs. This resulted in three main findings.

6 First, the use of UCCs is generally low across  
7 many markets, but there is some variance. For example,  
8 markets had anywhere from 2 to 25 UCCs claims for non-  
9 urgent care per 100 beneficiaries. Second, markets with a  
10 higher concentration of UCCs have a larger share of claims  
11 for non-urgent care being provided at UCCs and fewer of  
12 these claims being provided at EDs. By contrast, markets  
13 without many UCCs have a larger share of claims for non-  
14 urgent care provided in EDs.

15 Our third finding was there is no definitive  
16 evidence that UCC visits are substituting for ED visits in  
17 individual markets that had a large increase in UCC use  
18 over the last five years. The relationship between UCCs  
19 and EDs appears complicated by induced demand in the  
20 presence of other providers.

21 Now, Zach will present information on the  
22 provision of non-urgent care in hospital emergency

1 departments.

2 MR. GAUMER: Okay. Now we will turn to the topic  
3 of appropriate use of the EDs for non-urgent care, and we  
4 sought to identify the number of ED claims that might be  
5 appropriately treated in UCCs. This was done, in part,  
6 because there is relatively large overlap in the types of  
7 cases treated at EDs and UCCs.

8 Using the definition of non-urgent care Carolyn  
9 described, in 2017 we identified 1.5 million ED claims for  
10 non-urgent care, and this represented 7 percent of all  
11 emergency department claims. However, we do not believe it  
12 is reasonable to assume that all of these claims could be  
13 appropriately treated in the UCC because the beneficiaries  
14 associated with these claims appeared more complex than  
15 beneficiaries receiving non-urgent care at UCCs.  
16 Beneficiaries served at EDs for non-urgent care had higher  
17 average risk scores, a higher average number of chronic  
18 conditions, and were older, on average.

19 Despite the higher average complexity of ED  
20 cases, we also found that a large number of beneficiaries  
21 treated in EDs for non-urgent care had a similar complexity  
22 profile as beneficiaries treated at UCCs for non-urgent

1 care. Specifically, we sought out ED claims associated  
2 with beneficiaries that had a risk score and a number of  
3 chronic conditions at or below levels of beneficiaries  
4 treated at UCCs. Roughly 500,000 ED claims for non-urgent  
5 care fit this profile. This means that as much as 2  
6 percent of all ED claims may be appropriately treated at a  
7 UCC.

8           Using this estimate in conjunction with our own  
9 estimate of the average spending per non-urgent care  
10 encounter, we estimate that in 2017, Medicare paid as much  
11 as \$2 billion more because these beneficiaries were treated  
12 at a hospital ED, rather than an urgent care center.

13           So commercial insurers, state Medicaid programs,  
14 and others in the health policy community have implemented  
15 or proposed a wide variety of policies to address the issue  
16 of non-urgent care in EDs. The most contentious of these  
17 policies is the effort by some insurers to impose  
18 retrospective audits and denials of ED claims. Many  
19 insurers have instead opted to implement education  
20 campaigns to teach patients about how to make decisions of  
21 where they should receive care and also to promote the  
22 value of urgent care centers. Many insurers have also

1 implemented nurse help lines to help patients with their  
2 decision-making. These help lines, also as online  
3 applications, have become widely available to patients in  
4 commercial plans and MA plans, as well as those enrolled in  
5 Medicaid and in the VA.

6           Among other policies, at least 12 state Medicaid  
7 programs are exercising their authority to impose a low  
8 level of cost sharing on beneficiaries who visit the ED for  
9 non-urgent care, specifically.

10           So among the various policies we have observed,  
11 some, such as retrospective claims audits, may  
12 unnecessarily cause financial harm to patients for the  
13 decisions they make about where to seek care. Instead,  
14 policymakers may want to consider a beneficiary education  
15 campaign in which CMS would develop and distribute  
16 educational materials about appropriate ED use. As a part  
17 of this, CMS might consider implementing a nurse help line  
18 to assist with care-setting decision-making. We offer this  
19 policy option because fee-for-service beneficiaries appear  
20 to be among the few groups of patients without access to  
21 this service.

22           Policymakers could also consider expanding

1 quality measurement to include avoidable emergency  
2 department use. Policymakers could consider policies that  
3 improve care coordination between hospital EDs and primary  
4 care physicians, such as IT interoperability and care  
5 management.

6 And now Dan will discuss our second policy topic,  
7 hospital ED coding practices.

8 DR. ZABINSKI: When a Medicare beneficiary  
9 receives care in a hospital emergency department, the  
10 hospital codes the visit into 1 of 5 levels, and each code  
11 reflects a different level of expected resource use to  
12 treat a patient. The payments for ED visits increase with  
13 the level. An odd feature of the codes for ED visits is  
14 that national coding guidelines are not used. Instead, CMS  
15 has directed the hospitals use their own internal  
16 guidelines, which gives the hospitals much discretion in  
17 how they code ED patients.

18 Back in 2005, the coding of ED visits across  
19 these five levels approximated a normal distribution, and  
20 CMS stated that this distribution indicated that hospitals  
21 were billing the full range of visit codes in an  
22 appropriate manner, and they found this a reassuring

1 result.

2           But since 2005, the coding of ED visits has  
3 steadily shifted to higher levels, which has resulted in  
4 the distribution of ED visits being far from a normal  
5 distribution in 2017. For example, the share of ED visits  
6 coded at level 5 increased from 11 percent in 2005 to 30  
7 percent in 2017.

8           We think it is important to understand the  
9 reasons underlying this change in ED coding. On the one  
10 hand, if the change was due to ED patients having medical  
11 conditions that required more intensive treatment or due to  
12 ED patients receiving more resource-intensive care that  
13 produced better outcomes, then the change in coding was  
14 appropriate. But if the change was due to hospitals  
15 providing more resource-intensive care that had little or  
16 no effect on patient outcomes or reflected upcoding, then  
17 the coding changes weren't warranted.

18           In a paper that discussed interviews with  
19 hospital representatives, individuals who code ED visits  
20 for hospitals, and other experts, the hospitals argued that  
21 this change in coding was appropriate because it reflected  
22 older and sicker patients as well as advances in medical

1 care that produced better outcomes. But other experts  
2 disputed the hospitals, saying that the change in coding  
3 was unwarranted because ED patients were unchanged.  
4 Instead, the hospitals were coding to higher levels to take  
5 advantage of the lack of strict rules for coding ED visits.

6 Then an academic paper on ED coding found mixed  
7 results. Specifically, the paper found that hospitals  
8 provided more services and more intensive care to ED  
9 patients, but also the paper found that the change in  
10 services did not explain all of the change in coding,  
11 suggesting that upcoding may have occurred.

12 We also did our own data analysis to investigate  
13 whether ED patients had gotten sicker over time. This  
14 analysis produced three notable results. First, we found  
15 that the conditions treated in EDs was largely unchanged  
16 from 2011 to 2017, and particularly, there was no change in  
17 the principal diagnoses on ED claims, and the reasons that  
18 patients gave for visiting EDs showed very little change  
19 over time.

20 We then evaluated whether the coding of ED visits  
21 varied across geographic areas. Our thinking was that if  
22 ED coding changed because ED patients had gotten sicker,

1 the change in ED coding would have some degree of  
2 similarity across geographic areas. However, we actually  
3 found substantial differences in coding and in how coding  
4 changed across geographic areas.

5           Finally, some argue that the increased use of  
6 urgent care centers has contributed to the change in ED  
7 coding. If this is true, we should see a positive  
8 correlation across geographic areas between beneficiaries'  
9 use of urgent care centers and the rate at which hospitals  
10 code ED visits at the highest level of 5. But we found the  
11 opposite, almost no correlation between the rate at which  
12 beneficiaries use UCCs and the rate at which hospitals code  
13 visits at level 5.

14           We also used data from the National Hospital  
15 Ambulatory Medical Care Survey and found that from 2011 to  
16 2016 hospitals increased the number of services provided  
17 during ED visits, despite no change in the conditions  
18 treated. Most of this increase was for screening services,  
19 especially CT scans and EKGs.

20           We then went a little deeper and used claims data  
21 to analyze the change in services provided during treatment  
22 for 20 common conditions from 2011 to 2017. Much of what

1 we found was not surprising -- hospitals often provided  
2 EKGs for patients who had chest pain and CT scans of the  
3 head for patients with head injuries.

4           But some results were more surprising. For  
5 example, hospitals fairly frequently provided EKGs or CTs  
6 of the head for patients diagnosed with urinary tract  
7 infections. Moreover, we found that from 2011 to 2017, the  
8 rate of use increased by a greater amount for these  
9 surprising uses than for the more expected uses like EKGs  
10 for chest pain.

11           Finally, because the outpatient PPS provides  
12 separate payment for CT scans that are provided during ED  
13 visits, it is important to understand that the provision of  
14 a CT scan during an ED visit should have no influence on  
15 the level at which the hospitals codes the visit.

16           In the early years of the outpatient PPS, CMS  
17 emphasized that it was desirable for the distribution of ED  
18 visits to approximate a normal distribution because that  
19 would indicate hospitals are billing the full range of  
20 visit codes in an appropriate manner. But hospitals'  
21 coding of ED visits has shifted to higher levels from 2005  
22 to 2017, so that we are far from the ideal of a normal

1 distribution. The literature on ED coding and our data  
2 analysis do not provide a clear explanation for this change  
3 in ED coding, but nevertheless, the high concentration of  
4 ED visits at level 5 with no change in patient conditions  
5 likely means that Medicare payments for ED visits are often  
6 too high.

7           Even though hospitals have always used internal  
8 guidelines for coding ED visits, CMS and other entities  
9 made a substantial effort to establish national guidelines  
10 during the early years of the outpatient PPS, but they were  
11 not successful. But to improve the coding of ED visits,  
12 CMS could revisit national coding guidelines. Potential  
13 benefits of national guidelines include that payment would  
14 more accurately reflect hospital resources used to provide  
15 ED care, hospitals would have a clear set of rules for  
16 coding ED visits, and CMS would have a firm foundation for  
17 assessing and auditing hospitals' coding behavior.

18           So to finish, for your discussion today we are  
19 looking for feedback and guidance on the information we  
20 provided on urgent care centers. We also seek guidance on  
21 policy options concerning non-urgent care that is provided  
22 in EDs, and national coding guidelines for ED visits.

1           We will turn it back to Jay.

2           DR. CROSSON: Thank you. Clarifying questions.  
3 Jonathan.

4           DR. JAFFERY: Thanks. It's a great report. Two  
5 questions. One is -- the first one is what do we know  
6 about the effectiveness of some of these hotlines that have  
7 existed for the other populations?

8           MR. GAUMER: We don't know much about, you know,  
9 what their effect has been. I think the only thing we know  
10 at this point is how common they are. And as an example,  
11 in Medicare Advantage, in 2015, 70 percent of plans,  
12 representing 80 percent of patients or members of MA plans,  
13 had access to one of these. I've read, anecdotally, that  
14 they are likely used across all payers, but we don't really  
15 have any research yet that shows us whether or not they are  
16 effective in reducing or increasing the use of anything.

17           DR. JAFFERY: Okay. Great. Thanks.

18           And then the second thing, could you go to Slide  
19 15? Yeah, so this really jumps out in the report and I  
20 think probably a lot of folks were a little bit surprised  
21 by some of these findings. And there may be different  
22 policies or incentives that are at play here. So one of

1 the things I understood, and maybe some other folks in the  
2 room know this better or can confirm or deny this, that  
3 there's some metrics that EDs have about certain things, in  
4 terms of, you know, getting an EKG in a certain amount of  
5 time frame for people over a certain age, if they have  
6 certain diagnoses, which maybe you could see might be  
7 contributing to an overuse of EKGs for conditions where  
8 it's not otherwise indicated. So it would be good to  
9 understand those things, because maybe there's a driver  
10 there, from a policy perspective, that is causing that.

11 And then there are other things like head CT for  
12 UTI, which is really hard to understand. Because it looked  
13 like it was like 14 percent.

14 DR. DeSALVO: Oh, I know the answer too.

15 DR. JAFFERY: Okay.

16 DR. DeSALVO: I'm going to say what I think the  
17 answer is and then we'll let the other gentlemen --

18 DR. JAFFERY: Because I asked a few ED doctors  
19 too --

20 DR. DeSALVO: And then the ED doctor will tell us  
21 exactly what it is. But the -- so there's this nuance here  
22 about what people present with and then what they're

1 actually diagnosed with, and this is kind of classic  
2 scenario where a senior person with a prior history of  
3 multiple strokes comes in and has a new weakness and is  
4 confused.

5           And so you're trying to figure out what's going  
6 on with them, and so you scan their head because you think  
7 they might have had another stroke, as an example, and it  
8 turns out that they just had an infection, which very  
9 commonly gets somebody very dehydrated and causes confusion  
10 and will exacerbate prior neurologic deficits. You fluff  
11 them up with a little water and some antibiotics and they  
12 sort of straighten back up, and then you end up with a  
13 diagnosis of a UTI. But it looked like, when they came in,  
14 it very likely could have been a stroke. It's an extremely  
15 common scenario.

16           DR. JAFFERY: Right. Well, so, I had some  
17 conversations with some folks too and I thought about that,  
18 and I guess that's a clarifying point here. So these are  
19 all people who were not admitted to the hospital then. Is  
20 that correct?

21           DR. ZABINSKI: Correct. Yes.

22           DR. JAFFERY: So I suppose that's a possible and

1 maybe even a likely scenario, just, you know -- and this is  
2 where I was having trouble. So people who present with  
3 that scenario and then, you know, spruce up so quickly that  
4 then they go home, it just still seems like a lot. And it  
5 seems like a lot to be increasing, but perhaps not.

6 DR. CROSSON: Okay. It's a good thing we have  
7 doctors on the Commission.

8 [Laughter.]

9 DR. DeSALVO: "Fluff up" is a technical term.

10 DR. CROSSON: All right. Jon.

11 DR. CHRISTIANSON: So maybe it's a good thing we  
12 have economists on the Commission. I was wondering whether  
13 you broke the data down into whether it's more likely to  
14 see that behavior in for-profit hospitals versus not-for-  
15 profit hospitals.

16 DR. CROSSON: Are you going to answer that?

17 [Laughter.]

18 DR. ZABINSKI: Yeah. Sorry. I like to think a  
19 little before I answer? Let's see, yeah --

20 DR. MATHEWS: But we have not specifically looked  
21 at this. Right, Dan?

22 DR. ZABINSKI: Yeah.

1 DR. MATHEWS: Yeah.

2 DR. CHRISTIANSON: That might get at the issue of  
3 how much that's a clinical phenomenon you're describing or  
4 how much it's driven by financial considerations.

5 DR. ZABINSKI: Jon, that is something I could --  
6 you know, I do have the data to look at that.

7 DR. CROSSON: Okay. Where am I?

8 DR. JAFFERY: [Off microphone].

9 DR. CROSSON: Bruce, we'll go down this way.

10 MR. PYENSON: Thank you. A question on Slide 7.  
11 The second bullet point has an estimate there of 2 percent  
12 of all physician ED claims you thought could be handled I  
13 think at an urgent care center as opposed to emergency  
14 department. And I think you characterized this as based on  
15 a methodology of looking at diagnosis codes and had  
16 mentioned alternate methodology, the NYU criteria, which I  
17 think suggested that it might be a higher number. The 2  
18 percent here I think is comparable to almost the annual  
19 trend in utilization. So I'm curious about the choice of  
20 methodology here because 2 percent is perhaps not an  
21 important number for this. So I wonder if you could  
22 discuss that a little bit.

1           MR. GAUMER: Sure. We tried two different  
2 methodologies. One, the one that we used, we're calling  
3 the "Corwin methodology," a paper published back in 2016  
4 that picked out seven conditions present on claims as the  
5 primary diagnosis, and we identified claims using those,  
6 just as they did. And then the NYU method has a different  
7 set of conditions that they look at. And we ran them both,  
8 and what ends up happening is, you know, using our Corwin  
9 method, we came up with 1.5 million ED claims for what  
10 we're calling "non-urgent care," and my recollection is  
11 that we came up with roughly 3 million claims for non-  
12 urgent care using the NYU method. And it seemed more  
13 prudent to be conservative on this.

14           And also the other factor here was the conditions  
15 that were used for the Corwin method were very common to  
16 what we are seeing in UCCs, in the top 20 list of  
17 conditions at UCCs. And, yeah, that's how we did it.  
18 That's how we made our decision.

19           DR. CROSSON: Karen.

20           DR. DeSALVO: So on Slide 5, where you're looking  
21 at the geographic variation, I had a couple of thoughts  
22 about and wondered if you'd had a chance to look at the

1 penetration of value-based care models by market and if  
2 that was related to use of ED or urgent care services. And  
3 the other variable might be looking at some risk scores  
4 around social determinants of health. There's some data  
5 like Seth Berkowitz's most recent paper in Health Affairs  
6 showing that in the Cambridge Health Alliance, if you  
7 provide either -- if you provide meals, basically, to  
8 individuals who are dually eligible, you can reduce ED  
9 visits and hospitalizations. So that's but one of many  
10 studies that's beginning to show that there are non-medical  
11 reasons that people present, even though on the surface it  
12 might look medical.

13           And getting to the social risk part, I was trying  
14 to figure out where you might be able to pull that easily  
15 in aggregate in Medicare. There's a lot of secondary data  
16 that you probably could pull to get a look at it, but it's  
17 Medicaid, but I'd point you maybe to the Massachusetts  
18 Medicaid program is doing what Arnese Nash has built as a  
19 risk model for a way to start thinking about a total risk  
20 score. But between that and value-based care, you might  
21 find some other causes of either ED use or non-use that  
22 relate to the data.

1           MR. GAUMER: So we did not look at the value-  
2 based incentive models that might be present in these  
3 markets. That's just not a level that we had gotten to.  
4 But just for some background, what we did in picking our  
5 markets was we took the 50 largest metropolitan statistical  
6 areas based on resident population and looked at just what  
7 was going on in those markets, comparing the overall  
8 utilization of EDs for non-urgent care, UCCs, and also  
9 office visits, and you saw it in the paper. But that was  
10 about as deep as we went, but we could go back and look to  
11 see, you know, what else is going on in those markets.

12           DR. CROSSON: Jaewon.

13           DR. RYU: So I have a comment and then a  
14 question. The comment, I was just going to offer up one  
15 other explanation on the EKG, head CT thing. On the head  
16 CT, totally concur with Dr. DeSalvo's diagnostic acumen.

17           [Laughter.]

18           DR. DeSALVO: This is probably the first time an  
19 ER doc and an internist ever agreed.

20           DR. RYU: But on the EKG front, I think the other  
21 thing at the end of this is most EDs now are heavily  
22 reliant on triage protocols in the interest of throughput,

1 and especially with the Medicare beneficiary population,  
2 most of the time you're going to get an EKG before they  
3 even see a physician. And it's something to do with, you  
4 know, something that the patient said upon chief complaint  
5 or, you know, how they presented or even just simple  
6 demographic factors or history of chronic disease buys them  
7 an EKG. So I think that may explain some of it.

8           The question I had, though, was: On page 30 of  
9 the materials, you reference that there's some suggestion,  
10 some articles out there that suggest that the increase in  
11 non-urgent ED use may be due to lack of access in primary  
12 care. I was wondering if you can comment on that a little  
13 more. And specifically the geographic variation that you  
14 see, is any of that tied to -- you know, are there patterns  
15 around availability of primary care?

16           MR. GAUMER: This is certainly one of the  
17 limitations of the work that we've done, and that's why we  
18 put that in there, because we don't have a handle on how  
19 many offices might be available in a market necessary. I  
20 think if you went to the hospital referral region area,  
21 which is slightly smaller, a lot smaller than the MSA that  
22 we used, you might be able to get at that. But there has

1 been research out there that says that part of the reason  
2 could be -- part of the reason we're seeing a spike in ED  
3 use is in some markets you've got a lack of access. But I  
4 think you need to get at the HRR level to really understand  
5 that a little bit better, and there's some research out  
6 there on that.

7 DR. CROSSON: Jon has a question for you, Jaewon.

8 DR. CHRISTIANSON: Yeah, so I was looking for  
9 some explanation, Jaewon, about why there was a change over  
10 time, which I don't think Karen's explanation tells us. So  
11 is that because there's increasing use of these protocols  
12 over time? And is that why we might have seen this big  
13 change from '11 to '17?

14 DR. RYU: I suspect if you did a correlation  
15 analysis around ED volumes during that same time frame,  
16 volumes just spiked, and it put even more pressure on  
17 throughput. Most hospitals today in their EDs, throughput  
18 is the name of the game.

19 The other is I do think EMRs play a role in this  
20 with the decision support, which is for the physician in  
21 their clinical decisionmaking, but it's also for the triage  
22 nurse. So it becomes easier to protocolize certain ways

1 the patients present, and there's, you know, algorithms,  
2 exactly.

3 DR. CROSSON: And I think professional and  
4 institutional liability risk is part of it, too. I just  
5 remember at one point an issue of whether an appropriate  
6 protocol for any patient who had complained of a head  
7 injury was to do a CT scan immediately or later an MRI  
8 before they even saw a physician. So I think there's --  
9 the argument, why the change --

10 DR. CHRISTIANSON: Is that more concern about  
11 malpractice [off microphone]?

12 DR. CROSSON: I think in some venues, yes, some  
13 states. Anyway, sorry. Go ahead. You know, the issue  
14 being, you know, for everybody who bumped their head, you  
15 know, 999 have no intracranial bleeding, but one does and,  
16 you know, can you pick that up clinically, that whole  
17 thing.

18 Where are we? Dana.

19 DR. SAFRAN: So the question I have is whether,  
20 as you researched and wrote this really great chapter, did  
21 you come across any commercial payers who are trying to  
22 address this through payment? So site-neutral payment or,

1 you know, we spent time this morning talking about  
2 reference-based price. I wonder about the use of  
3 reference-based pricing. As I think about those things, I  
4 can foresee, you know, ways of coding that would undercut  
5 the value of policy interventions like that. But I'm just  
6 curious whether there are any as a starting point.

7 MR. GAUMER: So it seemed like when we looked  
8 just at the commercial payers, a small group of large  
9 commercial payers -- Anthem was one of them -- that went  
10 the payment route but went to kind of the payment denial  
11 and audit route, and that's -- those were the only folks  
12 that we saw that did any kind of payment-related thing.

13 A few out there did some cost-sharing  
14 manipulation to expose the patient to a little bit more  
15 burden. And then we saw that in the Medicaid program.  
16 Surprised to see that CMS had a few years back given states  
17 the ability to increase cost sharing for ED non-urgent care  
18 visits. And there are 12 states that are doing that right  
19 now -- or in 2018. But we haven't seen site-neutral-like  
20 policies yet. We haven't come across them. It doesn't  
21 mean they can't be out there, but if you know of any, we'd  
22 love to hear about it.

1 DR. CROSSON: Sue.

2 MS. THOMPSON: A couple of different angles. You  
3 know where I'm going to come from.

4 First of all, as it relates to nurse  
5 practitioners and PAs, whether working in urgent care  
6 clinics or even in emergency rooms, what do we know about  
7 their coding practices in comparison to an MD or DO? I  
8 mean, is there anything going on there as we see more and  
9 more nurse practitioners playing greater roles, especially  
10 in urgent care clinics? I think as we think about the  
11 quality piece, do you have any thoughts about that, Zach?

12 MR. GAUMER: So the only bit that we did to look  
13 at the NPs and the PAs was just to see who was submitting  
14 claims, and we do see a lot more NPs and PAs in urgent care  
15 centers than either the ED or the physician office. But we  
16 didn't really dive into the coding practices of folks and,  
17 you know, whether or not they were picking one of the five  
18 E&M codes or one of the ten E&M codes out there, different  
19 levels of them. And in the ED, I don't know if we know  
20 much about that. Do we, Dan?

21 DR. ZABINSKI: No. I'm trying to think of a way  
22 -- I suppose it's something we could look into. But as far

1 as what we know, not much right now.

2 MS. THOMPSON: Okay. And then the second piece  
3 would be any -- before I go there, take a look at the  
4 footnote on page 35 that speaks to physicians' coding and  
5 the increases we've seen in contrast to Figure 5 on page  
6 36, which is hospital coding for emergency department, and  
7 the comment that hospital coding has gone up at a rate that  
8 exceeds substantially that of physicians' increases. I  
9 thought that was interesting, both going up but one at a  
10 substantially greater pace.

11 Any further analysis we can do to better  
12 understand what's going on there? That just seemed to me  
13 to be interesting.

14 DR. ZABINSKI: Offhand, I can't think of one.  
15 But I'm not really good at thinking offhand.

16 MS. THOMPSON: When you think about -- it's the  
17 same episode of care and the code is looking very --

18 DR. ZABINSKI: Right. I mean, it's true that --  
19 you know, CMS really emphasizes that. What physicians do  
20 and what hospitals do in an ED visit can be -- you know, in  
21 terms of what's required --

22 MS. THOMPSON: Consumed.

1 DR. ZABINSKI: -- the two sides can be really  
2 different. There's some correlation between the level at  
3 what a physician codes and the hospital codes, but it's  
4 not, you know, super tight. And, you know, that's about as  
5 deep as I know on it.

6 DR. MATHEWS: So, Dan, just to ask a follow-on  
7 question to that, is it the case that the CPT codes for  
8 physician emergency services are somewhat more well defined  
9 than they are in the hospital setting where hospitals have  
10 a lot more leeway in terms of how they code a given  
11 patient? And could that be an explanation for the  
12 divergence?

13 DR. ZABINSKI: Yeah, that -- yes.

14 DR. CROSSON: More than somewhat defined. Sorry.

15 DR. ZABINSKI: Yeah, the physician is definitely  
16 more clearly defined, and they have one -- there's a set of  
17 national codes for physicians that they follow, and then as  
18 the hospitals there just directed actually to do -- to  
19 create their own and, you know, so there's a lot of  
20 variation in what an ED visit means from one hospital to  
21 the next. It's pretty much the same, from physician to  
22 physician, they're supposed to all follow the same rules.

1 So as Jim said, I think that's a good point. That could  
2 help explain what's happening.

3 DR. CROSSON: On this point, Brian?

4 DR. DeBUSK: On this point, to ask the question a  
5 slightly different way, if I look at the 1 through 5 levels  
6 of CPT code and the 1 through 5 levels of outpatient, it's  
7 for any given provider, I should be able to calculate the  
8 skew, you know, basically do a correlation, and it is  
9 skewed, you know, basically up or down coded, say one  
10 relative to the other? Let's say the CPT code is the  
11 standard, and then I look for skew either up or down in the  
12 OPC. Couldn't we calculate an index where we could  
13 identify potentially bad actors? I'm not saying there are  
14 bad actors. I think this is where Sue was taking us. You  
15 know, I may look at one hospital that's coded a full 1.5  
16 levels above the CPT level, and then I may see another  
17 hospital that's coded a full level below the physician CPT  
18 codes. And I'm not saying -- to this point, I'm not saying  
19 that the utilization patterns are identical, you know, for  
20 CPT versus an outpatient. But the skew shouldn't really  
21 vary tremendously, I would think, from provider to  
22 provider. Sue, did I -- okay, good.

1 DR. CROSSON: Let me say I agree with should. I  
2 agree with should. But part of the issue here is that each  
3 of the hospitals you described may well be following  
4 exactly their own protocols, which they have developed  
5 independently since there is no national guidelines.

6 DR. DeBUSK: Agreed [off microphone].

7 DR. CROSSON: Okay. Warner?

8 MR. THOMAS: Yeah, and actually it probably  
9 dovetails into this comment, but it's more of a question.  
10 So, obviously, looking at the data, there's a skew over the  
11 past, you know, several years. Did you talk to any  
12 hospitals or review any policy around how they considered  
13 the Level 1 through 5 previously versus how they do it  
14 today? I mean, have they changed their internal policies  
15 or has there been any inquiry about that?

16 DR. ZABINSKI: We had a meeting with the American  
17 College of Emergency Physicians where we talked about it --  
18 ACEP -- and I'm trying to remember. Did they say anything  
19 about a change? I don't recall that. There's, you know,  
20 definitely a sort of -- divide hospitals I guess into three  
21 groups. ACEP and the AHA have both developed coding  
22 guidelines for ED visits. Some hospitals use the ACEP,

1 some use the AHA, and some are, you know, mavericks and on  
2 their own. And CMS tries to encourage hospitals not to  
3 change their coding guidelines frequently. They try to  
4 tell them to keep it maintained and the same over time. I  
5 don't know the extent to which they follow that. I think  
6 that sums up how much we know about it.

7 MR. THOMAS: And I guess in your discussions with  
8 external organizations, what is their -- because, I mean,  
9 it seems like -- and I don't know, we don't really have the  
10 distribution of what the pro fee codes -- because what you  
11 showed here is the tech fee codes, right, for the hospital  
12 code? It's not necessarily the physician code.

13 DR. ZABINSKI: Correct.

14 MR. THOMAS: So has there been a change in the  
15 physician codes as well or just the tech fee codes?

16 DR. ZABINSKI: The physician codes have stayed  
17 pretty much the same over time.

18 MR. THOMAS: Great. Thanks.

19 DR. CROSSON: On this point, Dana?

20 DR. SAFRAN: Yeah. I'm trying to figure out what  
21 this could be. Maybe this is too obvious, but is it  
22 possible that some of what we're seeing in the hospital,

1 increased acuity, is because of the patients who are now  
2 siphoned off going to the UCs who used to come to the  
3 emergency room?

4 DR. ZABINSKI: Our data suggests that's not the  
5 case. In particular, we looked at the rate by geographic  
6 area, we looked at the rate at which beneficiaries go to  
7 UCCs and compared to, you know, line it up with how the  
8 areas are coding ED visits, and if the UCCs are siphoning  
9 off the lower-acuity patients, you should see some  
10 relationship between the extent you have the UCCs and the  
11 extent to which they code Level 5, and there's almost no  
12 relationship between the two.

13 DR. CROSSON: Okay. Marge.

14 MS. MARJORIE GINSBURG: So back to the issue of  
15 what gets patients to the ED instead of the UCC. I think  
16 you referenced early in the report the demographic study  
17 you did showed that it tended to be more lower-income  
18 patients that would use the ED instead of -- is that --  
19 that's right. And then I want to sort of follow up --

20 MR. GAUMER: And that was a finding that other  
21 researchers had come up with. We didn't look at income  
22 ourselves.

1 MS. MARJORIE GINSBURG: So and I also see what  
2 Medicaid programs are doing to try to discourage Medi-Medis  
3 from doing that. So my question was: Did you go into any  
4 depth through focus groups or whatever with folks who, in  
5 fact, would be the kinds of folks that would use this  
6 instead, in other words, in focus groups with lower-income  
7 Medicare beneficiaries, you know, in communities that have  
8 both, to try to find out from their perspective, you know,  
9 is it because they don't know that these other entities  
10 exist? Is it a convenience factor? But what drives that  
11 from their perspective?

12 MR. GAUMER: We haven't done focus groups on this  
13 question, and there is a little bit of literature out there  
14 on this, and a lot of folks point to access and the low  
15 income like you referenced, and difficulty making decisions  
16 not knowing of other access points and just knowing of the  
17 hospital were common things that were in the literature.

18 MS. MARJORIE GINSBURG: That may suggest greater  
19 communications on the part of entities about letting their  
20 members know about UCCs and how to use them.

21 MR. GAUMER: That appears to be the case, and  
22 Carolyn had something else.

1 MS. SAN SOUCIE: Another factor is the location  
2 of urgent care centers. They're mostly in suburban and  
3 wealthier communities, and that might be a big factor.

4 MS. MARJORIE GINSBURG: [off microphone].

5 DR. CROSSON: Pat.

6 MS. WANG: I suspect that from the large data  
7 sets you weren't able to discern this, but I wonder whether  
8 you have any insight into whether the slope, increased  
9 slope in coding to Level 5 correlated with a hospital's use  
10 of national guidelines, whether ACEP or AHA. Do you have a  
11 sense of that?

12 DR. ZABINSKI: We just don't know what specific  
13 hospitals are using to do their coding.

14 MS. WANG: Right, but obviously it's relevant to  
15 the possible policy recommendation that there be a national  
16 set of guidelines. Uniformity is good, you know, but it  
17 might not have any impact on the slope.

18 DR. GRABOWSKI: To follow on --

19 DR. CROSSON: Yeah.

20 DR. GRABOWSKI: I was going to ask a similar  
21 question. National guidelines sound like a great idea, but  
22 are they really going to get at upcoding, or at least in a

1 major way? Could you speak to that, the mechanics of that  
2 relationship?

3 DR. ZABINSKI: Well, let's see. Okay. There's  
4 sort of three -- well, four methods that have been bandied  
5 about as far as the basis for national guidelines. The  
6 biggest ones are using -- you know, the term is  
7 "interventions," you know, basically what sort of things  
8 are the hospital staff doing for the patient, either use  
9 the number or the types of interventions or there's also an  
10 idea of using a scoring system where each intervention gets  
11 some X number of points, and then you add up the points,  
12 and then you apply that to -- you know, however many points  
13 you have, you use that to code the visit. And CMS has  
14 opined on each of the possible methods -- by the way, the  
15 other two methods are like, you know, staff time and then  
16 the fourth one is like patient complexity, like what's  
17 their condition, that sort of thing. And CMS believes that  
18 the -- I think they said that the staff interventions, not  
19 the points-based one but the first one I talked about, is  
20 the least subject to upcoding, and that was -- that was 10,  
21 15 years ago when we were looking into this. They were  
22 sort of pushing in that direction. And that's both the

1 ACEP and the AHA guidelines. They're both based on that  
2 method. And CMS really seemed to be pushing for the AHA at  
3 that time before they just decided to stop trying to  
4 implement the national guidelines. So, you know, upcoding  
5 has been thought about quite a bit on this, and CMS has --  
6 at least used to have ideas on how to prevent it.

7 DR. GRABOWSKI: Just to follow up on that [off  
8 microphone]. So the first method is the least susceptible  
9 to upcoding, but it's still susceptible, right? I mean,  
10 there's still -- or do you not --

11 DR. ZABINSKI: Oh, yeah. Whenever you have  
12 levels, you're going to have upcoding problems. And, you  
13 know, that's the one attraction. In 2014, CMS actually  
14 proposed the idea of one code, and that was -- you know,  
15 they outlined the benefits of it, and one of the top points  
16 they made was that, you know, there's -- it eliminates any  
17 possibility of upcoding, obviously.

18 DR. GRABOWSKI: That would be a nice goal, right?  
19 I think you could almost take Slide 12 and take the title  
20 off of that, and it could be applied to a lot of sectors.  
21 It could be therapy levels in SNFs, for example, and we've  
22 seen the same trend again and again of coding creep. So

1 this is not new to Medicare or to health care more  
2 generally.

3 DR. CROSSON: Brian.

4 DR. DeBUSK: My question really starts with the  
5 last bullet on Chart 5, which talks about the substitution  
6 effect versus the induction effect. But if we could jump  
7 to Chart 12, you know, it's reasonably convincing evidence  
8 the way the histogram shifted. If you were to go back,  
9 though, and assume that in UCCs -- and this is my question  
10 -- in UCCs that a Level 1 through 5 E&M visit roughly  
11 corresponds to a Level 1 through 5 ED visit, if you were to  
12 pile that data back on, would that restore the normal  
13 distribution? Because I know your correlation that you did  
14 was market by market, which I would think would have some  
15 noise in small numbers issues depending on the market that  
16 you were in. But if you just went back and lumped all of  
17 those UCC outpatient visits in, treating them as if they  
18 were ED visits, does that restore the histogram on Chart 12  
19 and bring it back into a normal distribution centered at  
20 Level 3?

21 DR. ZABINSKI: An interesting approach. I'm not  
22 sure.

1 DR. DeBUSK: Okay. I was just curious. The  
2 other things that would be -- again, a follow-up question.  
3 If you were to, instead of percent of ED visits, look at  
4 that as claims per, say, thousand fee-for-service  
5 beneficiaries, in theory you could also measure the  
6 inductive effect, I would think, because if the histogram  
7 retained its shape and just got bigger, then we know  
8 inductions occurred. Whereas, if the shape remained  
9 distorted, I would think it means that upcoding has  
10 occurred.

11 DR. ZABINSKI: Okay. Say that -- sorry.

12 DR. DeBUSK: If you would also normalize the  
13 chart that you did on page 12, if you were normalizing it  
14 based on, say, visits per thousand beneficiaries so that  
15 you weren't looking at it as a percentage of ED visits, you  
16 would then have it in an absolute term. I say absolute,  
17 well, absolute relative to the number of beneficiaries in  
18 the system.

19 DR. ZABINSKI: Okay.

20 DR. DeBUSK: So at that point if you got the same  
21 histogram centered at the Level 3 visit, just a larger  
22 version, then we can assume that induction has occurred.

1 DR. ZABINSKI: Okay.

2 DR. DeBUSK: Whereas if the histogram retained  
3 some of the shape that it has on page 12, you can assume  
4 that upcoding -- I would assume that upcoding has occurred,  
5 because this should capture them both.

6 DR. ZABINSKI: Okay. Got it.

7 DR. SAFRAN: Can I just pile onto that for one  
8 second? Because that was the point that I was trying to  
9 get at before, and I agree that the correlation in the  
10 markets is a little bit -- it's a good idea, but it would  
11 be good to triangulate that finding a little bit.

12 So what if you do this 2006 versus 2017 view for  
13 hospitals that are in markets with UCCs versus hospitals  
14 that are not?

15 DR. PAUL GINSBURG: And I'm not sure that you  
16 have enough volume in UCCs today to have the potential for  
17 it to really be changing the distribution in EDs.

18 MR. GAUMER: And I think that's a really good  
19 point, because when we looked at the different MSAs and we  
20 looked at the share of non-urgent care visits in each of  
21 the markets for each of the different settings, really  
22 small percentages for the UCCs. And it just seemed quite

1 clear that we didn't have quite the volume to move ED  
2 visits in the data quite as much -- not that they aren't  
3 substituting, but -- and in many markets, we saw growth in  
4 all the settings, suggesting there's some induced demand  
5 taking place. And that was the case in a couple of  
6 different studies, including our own. Medicare data shows  
7 that there's been growth overall in non-urgent care, same  
8 in Medicaid, and in some of the commercial-based studies  
9 that we've seen, there's also been growth generally in non-  
10 urgent care cases, suggesting that induced demand and  
11 substitution could be going on at the same time.

12 DR. CROSSON: Kathy.

13 MS. BUTO: I really love the way Brian thinks  
14 about these things. It's fun to turn it on its head like  
15 that.

16 I have a pretty simple question I think I know  
17 the answer to, but I'd be interested in getting your  
18 feedback. Do we know that UCCs really are a substitute for  
19 EDs? Or do they sometimes lead to ED admissions or ED  
20 encounters? Do we have any sense of that progress? I  
21 assume that either EDs or UCCs could lead to physician  
22 encounters, that that would be in many ways logical, if an

1 ongoing condition is detected, neither of those -- so I  
2 would be more interested in seeing whether we know that  
3 UCCs are pretty much stand-alone and they are substitutes  
4 for ED visits where you've got both provider types?

5 MR. GAUMER: The only data that we have that I  
6 can speak to that point using is we looked at the  
7 percentage of cases coming out of the UCC relative to the  
8 percentage of cases coming out of the ED for non-urgent  
9 care in both cases and looked to see within the seven  
10 subsequent days how many of those folks, patients, had an  
11 ED visit. And it was roughly, you know, 4 percent for the  
12 folks coming out of urgent care centers ended up in the ED  
13 within the seven days after; and for similar cases, about  
14 10 percent of folks coming out of the ED had another ED  
15 visit within seven days. However, this is not risk-  
16 adjusted, and those are just straight numbers. And, you  
17 know, I think when we saw that, we interpreted that as,  
18 well, this speaks to the different severity levels that  
19 we've seen, the different HCC scores in the ED than the  
20 UCC. So it also didn't seem like an overwhelming percent  
21 of cases, the 4 percent coming out of the urgent care  
22 center.

1 MS. BUTO: Thank you.

2 DR. CROSSON: Okay. It looks like we're done  
3 with the questions. We're going to move on to the  
4 discussion.

5 I think our intention here is to try to conclude  
6 this issue, so I'm going to invite Jon to begin in a  
7 second, but I'm going to invite discussions about what we  
8 have on the table as policy recommendations. And you can  
9 find those pretty much on Slide 9, policies to encourage  
10 more appropriate use of EDs, the bottom bullets. And then,  
11 in effect, on page 17, the question of whether or not we  
12 would recommend going back, CMS going back and attempting  
13 to establish national guidelines. I think those are the  
14 policy issues on the table. Jon?

15 DR. PERLIN: Well, thanks, Jay, and that's a  
16 really good set-up.

17 Let me first begin by thanking Zach, Carolyn, and  
18 Dan for a terrific report, and it's clear that you  
19 incorporated the feedback from the Commissioners last  
20 discussion on this topic. Much appreciated.

21 In terms of those two general policy frames, Jay,  
22 appropriate use of ED, I think, you know, one of the big

1 signals is exactly how much volume is there to really shift  
2 and what, in fact, are the alternatives. Is the  
3 alternative to ED for low acuity exclusively urgent care or  
4 is it, in fact, appropriately primary care? Hold that  
5 thought, and we'll come back to it in a moment. And the  
6 second is: Would we have a better handle on the policies  
7 through more standardized coding of the emergency  
8 department encounters?

9           So let me divide my comments into the three  
10 chunks: first is some comments on the cost growth that may  
11 help us really contextualize a bit; second, changes in  
12 coding; and, third, some appropriate use care factors,  
13 patient factors, et cetera.

14           I have to say that I, too, was struck that a CT  
15 is neither diagnostic nor therapeutic for a urinary tract  
16 infection, but Karen stole my thunder. I think there  
17 really is a reason that it associates. That's where these  
18 data can be a little bit challenging.

19           So let's get into the data first with, you know,  
20 the cost growth. If you look at Table 1 on page 9, you'll  
21 see that the spend went in a nonlinear fashion. It went  
22 from 2011 to 2012, it was 2.3, 2.4, 2.5, 3.3 in '14, 3.8 in

1 '15, 4.0, 4.1.

2 Framed a slightly different way, the year over  
3 year increase was 1.3 percent '11 to '12, 4.16 percent in  
4 '12 to '13. And then if you go '15 to '16, it was 5.2  
5 percent, and '16 to '17, 2.5 percent. That was not  
6 inconsistent -- in fact, it may have even been lower than  
7 the overall Medicare cost growth.

8 Why do I point that out? If you look at the year  
9 over year cost increase between '14 and '13, it was a  
10 whopping 3.3 over 2.5 billion, or 32 percent, and '15 to  
11 '14, 3.8 over 3.3, or 15 percent. Very different numbers  
12 than the other numbers I mentioned.

13

14 Why is that important? Well, if we travel back  
15 down Memory Lane, that was when the two-midnight rule was  
16 introduced, and you'll recall that that was introduced  
17 10/1/13 and implemented and then delayed, but looked at  
18 that, and so hospitals changed their behaviors. A lot of  
19 patients who might have been admitted instead hung out in  
20 the emergency department and got essentially in-hospital  
21 care or at least observation status in the emergency  
22 department. And so I'm just making the point as we

1 consider policy recommendations that we gear it to what it  
2 is that we think we want to change.

3           What's really interesting, coinciding with that,  
4 if you look at Figure 5 on page 36, which shows increases  
5 in the skew of coding to the right-hand side, or to 5's,  
6 the big jump was in 2010, then it kind of ratcheted down.  
7 And, interestingly, there's absolutely no disproportionate  
8 jump in '13, '14, '15 area. It was just sort of  
9 progression. So it doesn't strike me that the changes in  
10 coding there are correlating with the changes in  
11 expenditures to care for these patients. I just note that  
12 in terms of thinking about what we then do in terms of  
13 contemplating coding and then the patient care factors.

14           So, with that, let me move to the changes in  
15 coding. I know there's no national standard, but during  
16 that period, there was an awful lot of scrutiny, an awful  
17 lot of concern about two-midnight and the like, and there  
18 was a de facto adoption of ACEP and AHA, and I think it  
19 would be interesting to parse those, you know, to gain  
20 better insight. And there may be some regional patterns,  
21 but interestingly, it strikes me -- Jon Christianson  
22 pointed out there may be some differences based on other

1 factors that some of the markets with the lowest coding  
2 were some of the most traditional fee-for-service markets  
3 in the South. I'd just note that in some places where,  
4 frankly, there's higher penetration of investor-owned. So  
5 I don't think that seems to correlate either. So there was  
6 an implementation of a de facto standard, the ACEP.

7           What has changed, and I think this was pointed  
8 out in some of our discussion, is the care of the same  
9 diagnoses changed over time. If I were a patient with a  
10 stroke a decade ago, then I would have come in. Today, you  
11 know, the gold standard is door-to-needle is an hour, and  
12 if don't have thrombolytics, then it's mechanical  
13 thrombectomy. So the intensity of service for the same  
14 nominal diagnosis has changed a great deal.

15           And, oh, by the way, the intensity of data  
16 capture has changed dramatically over that same period.  
17 2009 was the implementation of high-tech and meaningful  
18 use, and since then, I mean, there's just a proliferation  
19 of things that, frankly, would not have been captured in  
20 the fairly telegraphic charting that, you know, I, who  
21 practiced predominantly internal medicine in the ER, would  
22 have done. So you've got EHR with full capture, and that

1 may be driving some of that progressively over the time.

2           Let me come to this concept of the distribution.

3 I don't know that it should look like a normal distribution  
4 unless you, in fact, want to incentivize lower acuity in  
5 the emergency department. Perhaps it should be skewed to  
6 the right because the emergency department is the place for  
7 higher acuity. And so there probably is some distribution,  
8 but we need to align that distribution with what we think  
9 the care should look like.

10           Along those lines then, I would say that a  
11 national guidance or guidelines for acuity would be  
12 rational, but I would think that it should be as, you know,  
13 low burden as possible. It should take advantage of the  
14 electronic health record as de factor mechanism of capture  
15 of data. We take advantage of the standardized outputs,  
16 the continuity of care documents, and other things that are  
17 created.

18           And, by the way, if you are of the belief that,  
19 you know, the implicit incentive of the payment drives  
20 behavior, collapsing into a single code would not drive  
21 preserving the ER for the highest acuity. In fact, you  
22 would have to argue that the incentives would be just the

1 opposite, to discourage. But, in fact, you know, there is  
2 this countervailing force on assuring that all patients are  
3 cared for, and that's called EMTALA. And I want to put  
4 that to the segue to talking about the patient care  
5 factors. Parenthetically, when we're comparing this, you  
6 know, it is important to have good risk-adjusted outcome  
7 measures that allow comparison between environments.

8           So let's go to the third bucket, the patient care  
9 factors themselves. First off, it is ultimately the  
10 patient who chooses where she goes, and, you know, it's not  
11 the hospitals. There is a note that quality metrics should  
12 -- you know, should be applied. But remember, it is the  
13 patient who makes that choice.

14           I think the patient is, by and large, from your  
15 data, which, you know, are terrific, and represented in the  
16 handout as well, shows that the patients are making good  
17 choices. The patients who are coming to the emergency  
18 department, by and large, versus the urgent care centers,  
19 are concentrated in the older old, they've got more  
20 comorbidities, twice the comorbidities, and a higher risk  
21 score. If 1.0 is standard risk then you put it out that  
22 urgent care center patients have a risk of 0.97, slightly

1 below the average risk, while in contrast, those same  
2 patients going to the emergency department have a risk  
3 score of 1.61, significantly higher.

4           And just human terms. If this is two 80-year-  
5 olds, one who is a pretty healthy runner, who's got a new  
6 cough, maybe a little bit of shortness of breath in flu  
7 season, make one choice. You've got another 80-year-old  
8 who has a history of diabetes, heart failure, and  
9 emphysema/COPD, and they've got a little bit of shortness  
10 of breath and a cough, it's very different and quite  
11 rational. And that, to me, is sort of the embodiment of  
12 that difference between 1.61 and 0.97 on the risk factors.

13           You make the point, and I think it's absolutely  
14 right, that education is important. But we've also got to  
15 align that with the realities of incentives. And so the  
16 co-insurance, we need to make sure that it's, you know,  
17 advantageous to go when appropriate to urgent care center  
18 versus emergency department, or, ideally, to primary care.  
19 And I think we have to admit that there is a substitution  
20 effect of emergency department for primary care, and I'm  
21 going to make this point, which I think is that there are a  
22 couple of levels of data.

1           So we know that primary care is nominally  
2 available but is it really available? I did a little bit  
3 of testing in my environment of, you know, practices that  
4 are open to Medicare patients, and discovered that some of  
5 these practices are nominally open but they actually parse  
6 the number of Medicare and Medicaid elderly patients versus  
7 commercial or younger patients just so they can manage  
8 their day.

9           The same rationale why, if you look at any  
10 primary care providers' schedule, they leave more time for  
11 a new patient than an established patient. It simply takes  
12 more time. So they do a little load balancing with that  
13 and the load balancing may not allow for access to that  
14 substitute, and that may be something that we really need  
15 to tie together with work we'll do in terms of  
16 reimbursement for primary care in the sessions that are  
17 coming up during this meeting.

18           Finally, you mentioned the notion of  
19 retrospective denials. Any of us who are clinicians who  
20 have taken care of patients in the emergency departments,  
21 there are many times, in retrospect, where having gotten  
22 the tests back we can say, "Gee, I wish I had just sent

1 this patient home because it's only gastritis." But when  
2 that, you know, individual of a certain age presenting with  
3 certain risk factors complains of chest pain, the only  
4 answer, appropriately, is the full court press.

5           And so that's a little bit of a tough one, and,  
6 of course, when they come with that, even if they are low  
7 acuity, you know, hospitals now, you know, do respond to  
8 the tremendous threat of penalties under EMTALA, in terms  
9 of making sure that any patient who comes for any reason,  
10 be it good or not so good in the technical scheme of  
11 things, is seen and appropriately cared for.

12           Which leads me to the final comment that, you  
13 know, as we put all of this together we shouldn't create a  
14 position where patients feel inhibited from going to the  
15 emergency room for the right reasons. We've not found a  
16 better right reason than the prudent layperson doubts,  
17 which is that, you know, most rational individuals would  
18 find their circumstance as one that is, you know, a threat  
19 to life or at least irreversible harm if not seen timely.

20           So again, let me thank you. I think the work  
21 that you've put together really captures a lot of this.  
22 And then back to Jay's frame, in terms of understanding

1 what's driving cost growth and how do we temper it, I think  
2 the jury may still be out in terms of some of the data and  
3 the suggestion, you know, if it is possible, diving a  
4 little deeper, where there is penetration of urgent care  
5 centers and understanding whether there are any changes  
6 over time, they offer some insights. As to the other, is  
7 there a better rubric for coding, there has got to be a  
8 better rubric for coding. I just offer two suggestions.  
9 One, that it's -- we can't use what worked in 2005, because  
10 that was pre-computer. We need things that are really  
11 calibrated to the present technologies, and two, before  
12 anything is implemented it should be pilot-tested before  
13 being expanded.

14           So again, great job and thanks for capturing all  
15 of the inputs previously. Thank you.

16           DR. CROSSON: Thank you, Jon. So again, I point  
17 your attention to Slide 9, the three sub-bullets. These  
18 are ideas. Yes, like them, don't like them. And then also  
19 to Slide 17, the bottom bullet and sub-bullets, which  
20 essentially say we would ask CMS to revisit the issue of  
21 national guidelines.

22           Support? Lack of support? Marge.

1 MS. MARJORIE GINSBURG: I just want to make one  
2 observation about the 24 nurse hotline, which just occurred  
3 to me. So my suggestion is that, in fact, this should be  
4 integrated into all hospital emergency departments.  
5 They've got nurses there anyway. They have phones there.  
6 They're there 24 hours a day. They practically have the  
7 whole structure set up. It seems to me completely logical  
8 that every hospital ED has a nurse hotline to answer calls  
9 from patients about "should I come in or not?" It just  
10 seems so obvious.

11 So I would bump this up to something more than  
12 initiate, to moving towards a requirement, and what  
13 Medicare can do to make this perhaps financially appealing.  
14 I'm not sure. But it just seems to me this is really a  
15 critical step if we're trying to at least slow down the  
16 traffic going into very expensive EDs.

17 DR. CROSSON: Stronger language in that area.  
18 Yes. Next? Brian.

19 DR. DeBUSK: Specifically to Chart 17, or 16, 17,  
20 yes, I do support the idea of a national guidelines. I  
21 think it's something that's necessary. I would ask that  
22 the guideline at least contemplate, or that when we ask for

1 this, at least contemplate the concept that if a  
2 beneficiary is receiving what amounts to non-emergency care  
3 in an emergency department, that it be coded to an  
4 outpatient clinic visit, not even be coded to an ED visit.  
5 And I realize there are some issues. It sounds sort of  
6 site-neutral payment-ish, and I realize that we've got some  
7 Section 603 issues of the Balance Budget Amendment in 2015.  
8 But I'm not arguing for a site-neutral payment or an  
9 adjustment to the payment, which is, you know, forbidden  
10 statute. What I'm saying is under the coding guidelines  
11 you simply code that non-emergency visit as an outpatient  
12 visit. And again, I'm not an expert in that but I do think  
13 that it actually may be possible.

14           The other thing I was going to mention is I do  
15 wish we'd spend some more time on beneficiary engagement.  
16 I mean, I think altering the cost-sharing structure at  
17 least somewhat -- you know, I love the idea of nurse  
18 hotlines. You know, there were some good ideas in the  
19 reading materials. But I do think we need to be a little  
20 more willing to do some beneficiary engagement in cost-  
21 sharing, particularly for the non-low-income beneficiaries.

22           And I want to leave with a -- you know, we talk

1 about the guidelines, we talk about the beneficiaries -- I  
2 do want to end with a somewhat hyperbolic rhetorical  
3 question. When I drive down the interstate and I see one  
4 hospital system that advertises their ER wait time on a  
5 billboard, I wonder, who are they talking to, because if  
6 someone has an open fracture or a heart attack, I don't see  
7 them looking to the billboard to say, "I think I want to  
8 drive to the hospital that has the 8-minute wait time  
9 versus the 30." But if you are in a situation where  
10 contemplating the wait time of the ED could actually affect  
11 the decision of whether you go to urgent care or to an ED,  
12 you probably answered your own question. You probably need  
13 to go to an urgent care center.

14           And so, again, it's a little fascinating to me to  
15 -- and I realize there's some gray area there, but that  
16 comes back to, I think, the importance of at least  
17 contemplating the idea of turning some of those visits,  
18 even if it's a very small fraction, turning those into  
19 routine outpatient visits.

20           DR. CROSSON: Jon, on Brian's point.

21           DR. PERLIN: Yeah, I agree with the first and  
22 third points but the middle one on coding as an outpatient

1 I think is problematic. It's the hindsight issue.  
2 You know, this reminds me of my favorite philosopher, Yogi  
3 Berra. In theory, theory and practice are the same and in  
4 practice they're not. And the problem here is that, you  
5 know, if that patient with chest pains comes in and gets  
6 out-coded as gastritis, that could have been, you know,  
7 coded under that scheme, coded as an outpatient, the  
8 problems is that you've used the massive resources of an  
9 emergency department, which has to be ready to receive  
10 trauma or stroke or a bona fide heart attack, et cetera.

11 You know, so I think the beneficiary outreach is,  
12 you know, much more effective. But, you know, when you  
13 look at the hospitals with negative 11 percent average  
14 margin on Medicare patients, et cetera, you know, mounting  
15 a structure that responds to trauma, et cetera, if it's  
16 used inappropriately is punitive, you know, and I don't  
17 think serves the need.

18 DR. CROSSON: Okay. Bruce, Karen. I'm sorry.  
19 Did I miss somebody? All right. Let's do Paul first.

20 DR. PAUL GINSBURG: Yeah. On the educational  
21 thing, I do suspect that urgent cares substitute more for  
22 primary care practices than for EDs, for patients that

1 don't want to wait as long. But I think there is potential  
2 for this elderly population. You know, urgent care centers  
3 are relatively new developments. How many elderly people  
4 know where they are near them? Now a younger person can  
5 find that on Google pretty quickly. But it might be useful  
6 for Medicare to send everyone, once a year, a map. Here is  
7 where the urgent care centers are. I think that would  
8 probably be very helpful.

9 DR. CROSSON: So it would be part of the  
10 beneficiary education campaign, specifically.

11 DR. PAUL GINSBURG: Yeah. That's right. I don't  
12 think that emergency departments should go into the  
13 business of nurse hotlines. You know, it works for  
14 insurers because of the incentives. If they can prevent an  
15 emergency it pays for the nurse. But in an emergency room  
16 they're just going to have to divert a nurse to the  
17 hotline, and that's real costs. I'm not sure where to get  
18 a non-MA Medicare beneficiary for that 24-hour advice,  
19 whether Medicare should hire a contractor to do it, which  
20 is perhaps something we should consider, and someone who is  
21 working for Medicare who can save Medicare some money.

22 DR. CROSSON: You're worried about induced

1 demand?

2 DR. PAUL GINSBURG: No. I'm just worried about  
3 burdening the emergency room with having to hire an extra  
4 nurse just to sit at the phone.

5 DR. CROSSON: Got it.

6 DR. PAUL GINSBURG: I think that it seems as  
7 though the absence of national guidelines on ED coding, it  
8 just seems to be -- how can we be responsible and let that  
9 go on? It seems to me that there needs to be some guidance  
10 to hospitals about how to code in these situations. And,  
11 you know, with having the American Hospital Association and  
12 ACEP to work with, you know, I don't know why it wasn't  
13 done before, when they tried, but they ought to at least  
14 try again.

15 DR. CROSSON: I see Kathy nodding, too, as well.  
16 On this point, Pat, or do you just want to get in line?

17 MS. WANG: Yeah, I guess --

18 DR. CROSSON: Well, I had already moved down and  
19 I was moving this way. Do you want to --

20 MS. WANG: I can wait until the end.

21 DR. CROSSON: Go ahead.

22 MS. WANG: Just a quick one on beneficiary

1 education.

2 DR. CROSSON: Yes.

3 MS. WANG: I don't see the issue of UCCs as being  
4 -- I'm not as concerned about the relationship between UCC  
5 visits and the ED as I am with the substitution of UCC  
6 visits for primary care visits. And I think that we should  
7 be very careful. I actually think beneficiary education  
8 should not encourage the use of UCCs for Medicare  
9 beneficiaries. I think beneficiary education should really  
10 focus on appropriate use of the ED and getting your primary  
11 care doctor involved in your care. I don't think it's a  
12 good direction to encourage Medicare beneficiaries to go to  
13 UCCs. I really don't.

14 DR. CROSSON: Bruce.

15 DR. PYENSON: Thank you very much. I have a  
16 couple of comments, but I do support the recommendation for  
17 a national guideline.

18 My first comment is that if we actually thought  
19 that only 2 percent of emergency room visits were avoidable  
20 that would probably count as the most efficient service  
21 covered by Medicare. So I don't think any of us believe  
22 that, that there's lots of potential to make it more

1 efficient. And one of the thoughts on that is whether we  
2 should think about bundling the emergency room facility fee  
3 with the physician fee. And the two are so intimately  
4 related it's hard to -- you can't think of an emergency  
5 room visit without some professional component, and vice  
6 versa. I'm sure they show up in claims occasionally that  
7 way. But that would seem to be a great opportunity to  
8 change some of the fundamentals disincentives that exist in  
9 emergency rooms and some of the challenges that we've seen  
10 with practices that perhaps are not aligned.

11           A couple of comments. I want to report some  
12 observations I have from doing research on the standard  
13 data files 5 percent sample, which might be interesting for  
14 follow-up, which is I found that urgent care centers,  
15 urgent care utilization is actually negatively correlated  
16 with inpatient medical admissions. It is not really  
17 related to emergency room. And emergency room is  
18 negatively correlated with office visits, which makes  
19 sense.

20           The reason for the negative correlation -- this  
21 is on a geographic basis, on the regional basis -- is not  
22 quite clear, but it may have something to do with who is

1 actually -- the sponsorship of the urgent care centers and  
2 things like that. But in areas with high inpatient medical  
3 admissions you tend to see low urgent care centers, and  
4 that might be patterns of demand.

5 So those are my comments.

6 DR. CROSSON: Thank you. Thank you, Bruce.  
7 Karen.

8 DR. DeSALVO: I do think that a national coding  
9 system would be important. Otherwise, at least on the  
10 surface, it looks like a usual and customary, here's what  
11 we think that we spent. So I support that.

12 These other policy options, just a general  
13 comment, which is that in many ways it's exactly what  
14 accountable entities do. So when you're responsible for  
15 the total cost of care and health outcomes of a population  
16 you're going to do a lot to help make sure people are  
17 linked to good primary care that's accessible and only use  
18 the ED when it makes sense and be admitted when it makes  
19 sense and be available 24/7 to help guide and support  
20 people and set quality measures that you can track  
21 progress.

22 So these are generally good tools. I just think

1 independently, I'm not sure what they do in a fee-for-  
2 service system, that if we encourage more broadly the  
3 country to keep moving into models that have downside risk  
4 that are part of a, you know, accountable entity to total  
5 cost of care it would, I suspect, help some of it, which is  
6 why I asked the question about market penetration of value-  
7 based care. So do we have some sense about practice  
8 behaviors related to it?

9           And I want to make a comment about the last  
10 bullet --

11           DR. SAFRAN: [Sneezes.]

12           DR. DeSALVO: -- God bless you -- which is, you  
13 know, to this --

14           DR. SAFRAN: [Sneezes.]

15           DR. DeSALVO: -- this 10 percent -- do you want  
16 to go to the ED?

17           [Laughter.]

18           DR. SAFRAN: No. It would be an inappropriate  
19 visit.

20           [Simultaneous conversation off microphone.]

21           DR. CHRISTIANSON: You can get a CT scan.

22           DR. CROSSON: Listen, you've got three

1 physicians. You ought to be able to pick one of them as  
2 your primary doctor.

3 DR. DeSALVO: Come on to primary care.

4 [Laughter.]

5 DR. DeSALVO: Which is a perfect segue into this 10 percent  
6 number of people who have an ED visit, then another one.  
7 To me that's sort of a really important anchor and speaks  
8 to this need to not just improve coordination but to  
9 incentivize the system to be very available. And one  
10 potential model of that was tried in Massachusetts about a  
11 decade ago with at least federally qualified health centers  
12 who were paid a pretty significant differential to be open  
13 evenings and weekends, especially, for example, on Sundays,  
14 as a mechanism to make them more available, you know,  
15 physically, not just by telephone.

16 So that may be a place -- I should have asked  
17 that, or mentioned that in Round 1 -- but a place to think  
18 about policies that aren't just about coordination but  
19 actually strengthening. And we'll talk about that in the  
20 next two chapters.

21 And I want to flag that from a communications  
22 standpoint the new rules put out by CMS and ONC, a couple

1 of weeks ago, about data sharing and liquidity. There is a  
2 particular component in CMS rule that calls for hospitals  
3 to have to share information about a visit to the ER as a  
4 condition of participation.

5 And so the Medicare program is already stepping  
6 up their game in this expectation of the third bullet,  
7 about we need to communicate and it's not just a nice-to-do  
8 but if you want to be in the Medicare program you're going  
9 to have to have an interoperable system that lets primary  
10 care and others know that this beneficiary was in the  
11 emergency room. So there's some good progress, I think,  
12 that we should encourage that to continue.

13 DR. CROSSON: Thank you Karen. Jonathan.

14 DR. JAFFERY: Yeah, thanks. So in terms of the  
15 national guidelines, I think, like everybody else, I'm  
16 supportive of doing that. It sounds like, at least in the  
17 report, reading the report, that there was maybe some hang-  
18 ups between the fact that ACEP and AHA had different ideas.  
19 And so we could always use binding arbitration if we  
20 continued to have that problem.

21 [Laughter.]

22 DR. JAFFERY: And then in terms of the

1 educational pieces, you know, so one thing is, I think,  
2 given the fact there have been -- there seems to -- that  
3 there's a significant amount of experience with some of  
4 these things, in other environments, I encourage you to  
5 take a look at some of that and see if we could find any  
6 evidence about things that have worked in other places. It  
7 may not be perfectly transferrable to this population, for  
8 various reasons, including some of the things that Paul  
9 brought up, but at least we could learn something.

10 I do think, you know, I like the idea of a  
11 hotline, in general, again, if we have some evidence that  
12 it works. I also would agree with Paul on this point, that  
13 rather than trying to have this dispersed individually,  
14 having something a little more centralized, for a variety  
15 of reasons.

16 And actually kind of building on Karen's comments  
17 about how does this build -- work into value-based  
18 arrangements and thinking about ACOs, who should naturally  
19 have an incentive in the fee-for-service environment, to  
20 want to have these kinds of shifts in care environment, but  
21 also recognizing that there is a bit of a capacity issue  
22 there, and capability issue. So if every ACO is expected

1 to just sort of develop it, this becomes a little bit  
2 difficult, and I wonder if there is an opportunity to allow  
3 some collaboration between CMS here and ACOs in a way that  
4 we haven't seen a ton of, including things like co-  
5 branding. We put out a lot of information to beneficiaries  
6 that comes from the ACO but gets approved by CMS, and maybe  
7 there's a way to have this come from your doctor, through  
8 your primary care doctor or through your ACO, that kind of  
9 builds on a hotline that would be developed more centrally.  
10 So I don't know exactly how that would look yet but there  
11 may be some opportunities there.

12           And then the final thought I had gets back to  
13 Pat's comment about not wanting to necessarily shift people  
14 from -- to use UCCs because of the PCP substitution. And  
15 there is an access issue sometimes, and so I think we have  
16 to think about that, not only what Jon was talking about  
17 before in terms of opening your panel to Medicare patients  
18 but even if you have a doctor who will take you and see  
19 you, if it's after hours or they're too full or it's over  
20 the weekend, that could be an issue.

21           DR. CROSSON: Dana, did you have a comment on  
22 that, or you just want to.

1 DR. SAFRAN: [Off microphone.] Whenever you want  
2 to come around to me I just have one comment.

3 DR. CROSSON: Okay. Go ahead.

4 DR. SAFRAN: So this is something I think I might  
5 have raised the last time we talked about it but it hasn't  
6 come up here. So I just wonder whether we've explored the  
7 feasibility of emergency rooms actually having the  
8 possibility to triage somebody and, once they've done that,  
9 realize that they don't need to be in the emergency room,  
10 have them down the hall in something that gets billed as  
11 urgent care or even -- better yet -- as a physician office  
12 visit.

13 I don't think that runs afoul of EMTALA, though  
14 that's always the question that gets raised, is whether it  
15 does or whether it doesn't. I've heard different legal  
16 counsel in different organizations weigh differently.

17 DR. CROSSON: I'll show you the scars.

18 [Laughter.]

19 DR. SAFRAN: Okay.

20 So that was a question and really just also agree  
21 with Pat's point about encouraging primary care, not UCCs,  
22 over emergency rooms.

1 DR. CROSSON: Thank you. Sue.

2 MS. THOMPSON: And at the risk of stating the  
3 obvious, it's not just the Medicare population that is  
4 overutilizing EDs. I mean, whether we're looking at our  
5 self-insured health plans or commercial ACO, everyone is  
6 looking at ED utilization as an opportunity to reduce  
7 costs.

8 So it just strikes me there's something else  
9 going on with our -- either consumer population or our  
10 health care system or a combination of the two. And it has  
11 to do with wanting more immediate access and caring less  
12 about the primary care relationship that we so very much  
13 desperately want to build on.

14 But there's just something else in the  
15 environment that I just think is worthy of some  
16 acknowledgment as we talk about this.

17 But I wanted to comment on page 9, on this set of  
18 policies to encourage more appropriate use of EDs. And as  
19 I read through those, it just sort of hit me in the face  
20 that every one of these policy options becomes strategies  
21 when you assume accountability for an attributed  
22 population. When you're working at an ACO, you put

1 together some sort of call center. You do beneficiary  
2 education in order to encourage the beneficiary to use the  
3 appropriate setting, to build on the primary care  
4 relationship.

5           And I wonder, as we think more broadly -- I mean,  
6 way out here, 80,000 feet -- in this fee-for-service world,  
7 we continue to have incentives that drive inappropriate  
8 utilization and do not create the best care for the  
9 beneficiaries. If we move to -- and ACOs, I think, are a  
10 stepping stone to something else. But in that environment,  
11 these policies become strategies. And I think that's a  
12 very different way to think about this.

13           DR. CROSSON: Thank you, Sue. Warner.

14           MR. THOMAS: So I guess a couple of comments.

15           One, I agree with Sue. I think that if we can  
16 continue to accelerate the payment methodology, I think the  
17 provider systems will address this in a much more proactive  
18 way and we won't have to kind of set some of these rules in  
19 place.

20           But while we're moving in that direction, I would  
21 say I concur with the recommendation around setting up  
22 guidelines, kind of national guidelines.

1           I would comment that I'm not sure if looking at  
2 urgent care utilization versus ER is maybe the right  
3 comparison versus looking at primary care utilization  
4 versus the ER. You know, what does that relationship look  
5 like? My guess is you'll find that there's an inverse  
6 relationship there. I think people that do have -- getting  
7 back to our discussion this morning -- good primary care  
8 access, great primary care relationships, are not going to  
9 be in the ER and have as much utilization.

10           Now that may not deal with the shift in the  
11 levels, but that would certainly deal with the utilization  
12 of the ER.

13           So I would encourage us to not just look at  
14 urgent care but to look at the primary care or E&M or  
15 primary care utilization of the members and how that  
16 impacts ER utilization, as well.

17           But I would concur with the recommendation.

18           DR. CROSSON: Thank you, Warner.

19           So can somebody please bring me a hat and a  
20 rabbit?

21           [Laughter.]

22           DR. CROSSON: So here's the issue. As I said

1 earlier, I think we would like to kind of get on with this  
2 issue. We're kind of very close. And just based on  
3 scheduling issues, were we to come back in April and go all  
4 through this again, I'm not sure that would be the best use  
5 of time.

6           There are two policy directions on the table.  
7 One has to do with beneficiary engagement and education.  
8 And we've got some good ideas here, but there's some  
9 additional work that needs to be done in this area.

10           I think, for myself, the clarity about the nurse  
11 line would do it and what's the relationship between having  
12 that in a prospectively paid or prepaid environment and  
13 fee-for-service, I think we need more work to be done by  
14 the staff to make that make sense here.

15           And then also the question of are we really  
16 encouraging urgent care use when we ought to be encouraging  
17 primary care physicians. That needs to be put in, as well.

18           Bruce, I don't know that -- I mean, your idea  
19 about bundling is a good one. I'm not sure that we can  
20 deal with that issue in this time frame. But there may be  
21 a time to come back to that again, because that's very  
22 salient.

1           On the other hand, I did hear -- I thought --  
2 almost universal support for the issue of national  
3 guidelines.

4           Can I have the next slide please?

5           [Pause.]

6           DR. CROSSON: I guess we're done.

7           [Laughter.]

8           DR. CROSSON: My sense, based on the discussion,  
9 is that we have pretty close to unanimous support for  
10 national guidelines. We have some questions about why that  
11 wasn't done. I personally agree, it seems to be obvious to  
12 me -- I mean, we talk about policy stuff we discuss here  
13 that's incredibly complicated. This is not easy, but it  
14 seems to be at a lower order of magnitude, in terms of  
15 complexity. Easy for me to say, but that's what I think.

16           So I'm going to look for this, which is a two-  
17 pronged proposal here: that we empower the staff to take  
18 the information that's been discussed here with respect to  
19 the beneficiary engagement and redo that text. Everybody  
20 will get a chance to take a look at that. But that we come  
21 back in an expedited voting process in April, assuming a  
22 bobblehead consensus for this recommendation. And then in

1 the report, which will be in the June report, this appears  
2 as a bold-faced recommendation.

3 So I have a general sense of support for that  
4 direction?

5 Jon, do you want to comment?

6 DR. PERLIN: To state again the recommendation be  
7 accompanied with a recommendation that it be piloted to  
8 test before broad implementation.

9 DR. CROSSON: I think that's fine. We can put  
10 that in the text. Bruce?

11 DR. PYENSON: I'm not sure I agree with that.

12 DR. CROSSON: You don't agree with the pilot?

13 DR. PYENSON: The pilot. I mean, a pilot adds  
14 on, you have to plan for the pilot, you have to do the  
15 pilot, and then you have to evaluate the pilot. I think  
16 this is obvious enough where we just don't have to do that.

17 DR. CROSSON: Jon, could you live with CMS should  
18 consider a pilot, or could consider a pilot?

19 DR. PERLIN: Yes, it's not a question of whether  
20 it's obvious or not. I agree with that. The question is  
21 how would it operate?

22 Let me give you an example. When the quality

1 measures were transferred to electronic, there was one that  
2 sought to discourage long length of stay in the emergency  
3 department. And when the patient went directly through the  
4 emergency department and ended up in trauma surgery before  
5 they were discharged, it actually came out as a negative  
6 wait time and couldn't be scored as positive even though  
7 that's exactly what you want to happen.

8 My point has nothing to do with the support for  
9 it. It has everything to do with practicalities of  
10 implementation of it.

11 DR. PYENSON: And I think that can be easily  
12 handled within an administrative process. The pilot means  
13 you have a demonstration and I think that's an excuse for  
14 delaying it.

15 DR. PERLIN: But how would you know how a  
16 distribution would operate before you actually apply it?

17 DR. PYENSON: We do that all the time in the  
18 Medicare program. Why should emergency room be different  
19 from everybody else in Medicare? It's not like emergency  
20 departments are fragile entities with undercapitalized  
21 organizations with bare management and infrastructure.  
22 This is not a high risk issue for the viability of access

1 to Medicare patients.

2 DR. PERLIN: But you're assuming that you know  
3 how the model would operate from -- let me just throw this  
4 piece out. If the appropriate terminology is not pilot but  
5 actuarially model to make sure that it operates correctly,  
6 then maybe that's the language.

7 DR. PYENSON: Either actuarial or not-actuarial,  
8 I'm sure either way is fine.

9 DR. CROSSON: You said the magic word. Paul.

10 DR. PAUL GINSBURG: On this thing, I don't want  
11 to go too far in micromanaging CMS. If there's an  
12 administrative process, I figure they know how to do it and  
13 we shouldn't be telling them precisely how to do their job.

14 DR. CROSSON: I think, again, this is language  
15 and we'll have some text language to accompany this  
16 recommendation.

17 DR. MATHEWS: Yes, I heard that I was empowered  
18 to do that.

19 DR. CROSSON: To do that, yes. And it will -- I  
20 think we can put in language that CMS should consider what  
21 you said, actuarial analysis, without mandating that they  
22 do that.

1 DR. GRABOWSKI: I sort of raised this in the  
2 first round but I wonder if we want to put some text in to  
3 say national guidelines are necessary but not sufficient  
4 towards addressing -- this is a great step but it's not the  
5 final step. There's auditing and there's all sorts of  
6 other steps we could think about here.

7 DR. CROSSON: No, absolutely.

8 DR. GRABOWSKI: I don't think this is a magic  
9 bullet, so to speak.

10 DR. CROSSON: To me, this is the first step on  
11 the staircase.

12 DR. GRABOWSKI: Got it. Maybe just suggesting  
13 that.

14 DR. CROSSON: For all of the reasons people to  
15 discuss, it doesn't take away upcoding or any of the other  
16 manipulative behavior that can exist.

17 But to me, this is a sine qua non. I mean, how  
18 can you even start unless you have a basis; right? Okay?

19 Done. Okay. Zach, thank you, Dan, Carolyn.  
20 Nice job.

21 [Pause.]

22 DR. CROSSON: Okay. We've fallen a little bit

1 behind, but once again, it was an important discussion.  
2 And now we have another important discussion. Ariel is  
3 going to take us through an additional consideration --  
4 this is years of work that we have been doing -- an  
5 additional consideration about how we may approach the  
6 potential pipeline problem for adult primary care  
7 physicians.

8 MR. WINTER: Okay.

9 DR. CROSSON: And, Ariel, I just want to start  
10 out by thanking you. I thought this chapter was  
11 exquisitely researched and written, and I learned an  
12 enormous amount reading it. So you've got the stage.

13 MR. WINTER: Thank you very much.

14 Good afternoon. As Jay said, I'll be talking  
15 about Medicare's role in the supply of primary care  
16 physicians. I want to first thank Emma Achola and Alison  
17 Binkowski for their help with this work.

18 So this is a follow-up presentation to our  
19 October meeting. I've addressed your comments and  
20 questions from that meeting in the paper. The paper has  
21 been substantially expanded, which is why we're coming back  
22 to you today.

1           So for today's discussion, I'll start with some  
2 background information; describe the future pipeline of  
3 primary care physicians; talk about federal scholarship,  
4 loan repayment, and debt forgiveness programs for  
5 physicians and other clinicians; discuss an idea for a  
6 scholarship and loan repayment program for physicians who  
7 commit to providing primary care to Medicare beneficiaries;  
8 and then talk about next steps.

9           High-quality primary care is essential for  
10 creating a coordinated health care system. The Commission  
11 has made several previous recommendations to increase  
12 Medicare payments for primary care clinicians, such as  
13 establishing a per beneficiary payment.

14           In our June report last year, we described an  
15 approach that would shift fee schedule spending from  
16 procedures, tests, and imaging to the kinds of services  
17 commonly done by primary care physicians -- ambulatory E&M  
18 visits.

19           Commissioners have also expressed interest in  
20 exploring approaches that could have a bigger impact on the  
21 supply of primary care physicians, which is the focus of  
22 today's session.

1           According to a beneficiary survey and beneficiary  
2 focus groups that we conducted last year, most  
3 beneficiaries reported that they are able to obtain  
4 clinician care when needed. Their access to care is  
5 comparable with (or in some cases, better than) access  
6 reported by privately insured individuals ages 50 to 64.

7           However, a small share of beneficiaries who are  
8 looking for a new doctor reported trouble finding one.  
9 They were more likely to report trouble finding a new  
10 primary care doctor than a new specialist.

11           This is a cause for concern because it could  
12 signal a problem with access to primary care for the small  
13 number of beneficiaries who are seeking a new doctor. We  
14 monitor this situation closely every year when we do our  
15 survey.

16           A well-functioning, coordinated delivery system  
17 needs an appropriate balance of primary care physicians and  
18 specialists. But the mix of future physicians is tilting  
19 towards specialists, as we will see on the next slide.

20           In addition, minority, low-income, and rural  
21 students are underrepresented in medical schools. This is  
22 an important issue because many studies show that a diverse

1 health care workforce is associated with better access to  
2 care for underserved populations and higher patient  
3 satisfaction. And students from rural areas and from  
4 ethnic and racial minorities are more likely to choose  
5 primary care careers and to practice in underserved areas.

6           Between the 2013-2014 academic year and the 2017-  
7 2018 academic year, the number of active residents in  
8 family medicine and internal medicine increased faster than  
9 the total number of active residents.

10           In the 2017-2018 academic year, about 20 percent  
11 of all residents were in internal medicine and 9 percent  
12 were in family medicine. Although almost all family  
13 medicine residents end up practicing as generalists, most  
14 internal medicine residents enter subspecialties, such as  
15 cardiology or gastroenterology.

16           According to a survey of third-year internal  
17 medicine residents conducted between 2009 and 2011, only  
18 21.5 percent of them planned careers in general internal  
19 medicine. The remainder planned to enter subspecialties or  
20 hospital medicine or were undecided. And there is evidence  
21 from other studies that the share of internal medicine  
22 residents who become generalists has been declining over

1 time.

2           In the paper, we review the literature on the key  
3 factors that influence physicians' choice of specialty.  
4 The findings vary based on the time period studied, the  
5 group studied, and the analytic methods.

6           Several non-financial issues are important  
7 factors. They are shown here on the slide and are  
8 described in more detail in your paper.

9           In terms of financial factors, there is evidence  
10 that income expectations play an important role, and we  
11 have noted previously that substantial compensation  
12 disparities between primary care physicians and specialists  
13 may discourage medical students from choosing primary care.

14           The evidence that educational debt affects  
15 specialty choice is mixed. Some studies show no  
16 relationship between debt and career choices, but other  
17 studies find that debt is modestly related to career  
18 decisions.

19           Medicare is not in a position to address most of  
20 the non-financial factors that affect specialty choice,  
21 which is why we're focusing on the financial factors.

22           It is important to recognize that medical

1 education debt has grown steeply in recent years, so debt  
2 could be a bigger factor in the future. Median medical  
3 school debt among medical school graduates grew from almost  
4 \$165,000 in 2010 to \$180,000 in 2016, in inflation-adjusted  
5 dollars.

6           Meanwhile, the share of medical school graduates  
7 planning to participate in debt reduction programs  
8 increased from 40 percent in 2014 to 46 percent in 2018,  
9 according to a survey by AAMC.

10           Of those who planned to participate in a program  
11 in 2018, about three-quarters indicated that they were  
12 going to participate in the Public Service Loan Forgiveness  
13 program, which we'll discuss on the next slide. Smaller  
14 shares of students were planning to participate in state  
15 programs, the National Health Service Corps, and military  
16 programs.

17           The Public Service Loan Forgiveness program,  
18 which is run by the Department of Education, provides loan  
19 forgiveness to borrowers who work in a public service  
20 position for 10 years and make at least 10 years of loan  
21 payments while working in a public service job.

22           Public service employers include federal, state,

1 and local governments; the military; and tax-exempt  
2 organizations, such as nonprofit hospitals.

3           This program is not limited to health  
4 professionals. The AAMC estimates that physicians who take  
5 out large loans for medical school can receive a  
6 substantial amount of loan forgiveness through this  
7 program. But in a recent report, GAO found several  
8 problems with the Department of Education's management of  
9 this program.

10           As of April 2018, the department had processed  
11 applications from about 17,000 borrowers for loan  
12 forgiveness but had approved only 55. The high number of  
13 denials suggests that many borrowers are confused about the  
14 program's requirements.

15           In addition, GAO found that the department does  
16 not provide sufficient guidance and instructions to the  
17 contractor that operates the program.

18           HRSA runs two programs that are designed to  
19 increase the supply of primary care clinicians: the  
20 National Health Service Corps and the Primary Care Loan  
21 program.

22           The NHSC provides scholarships and loan repayment

1 for primary care clinicians; it will receive \$300 million  
2 in funding in FY 2019. Recipients must commit to  
3 practicing in a health professional shortage area, in a  
4 site approved by HRSA, for at least two or three 3 years.

5 As of 2018, there were 10,900 NHSC clinicians who  
6 provided care to 11.4 million people. The largest group of  
7 participating clinicians is mental and behavioral health  
8 professionals, followed by nurse practitioners and primary  
9 care physicians.

10 Sixty-three percent of clinicians serve in  
11 federally qualified health centers; other approved sites  
12 include rural health clinics and community mental health  
13 centers.

14 Minorities account for a higher share of NHSC  
15 clinicians than they do of the national health care  
16 workforce. For example, in 2016, African Americans  
17 represented 17 percent of NHSC physicians, compared with 4  
18 percent of the national physician workforce.

19 The Primary Care Loan program provides low-  
20 interest loans to medical students who commit to practicing  
21 primary care. Recipients must practice primary care for  
22 ten years, which includes their residency, or until the

1 loan is paid off, whichever comes first. Unlike the NHSC,  
2 there is no requirement to work in an underserved area. In  
3 FY 2016, there were about 2,600 active borrowers who owed a  
4 total of \$18 million.

5 The program is funded through a revolving fund  
6 that was established with a federal contribution and  
7 matching contributions from medical schools. There is no  
8 annual appropriation.

9 Participating medical schools must contribute  
10 one-ninth of the loan amounts received by their students.  
11 Only 9 percent of the program's borrowers practice in a  
12 medically underserved area, less than 2 percent practice in  
13 a rural area, and less than 3 percent are African American.

14 These HRSA programs might serve as a model for a  
15 Medicare-specific scholarship or loan repayment program.  
16 But the goals of these programs would be quite different.

17 A Medicare program would have a specific  
18 objective: to encourage more physicians to enter primary  
19 care and provide primary care to beneficiaries. By  
20 reducing educational debt, a Medicare-specific program  
21 would provide a financial incentive for physicians to  
22 choose primary care.

1           However, given the mixed evidence from the  
2 literature on whether debt affects specialty choice, it's  
3 difficult to predict how physicians would respond if they  
4 were offered debt reduction in exchange for a commitment to  
5 practice primary care. This incentive may convince some  
6 medical students to choose primary care instead of another  
7 specialty, thus representing a net increase in the number  
8 of primary care physicians.

9           But some number of students who participate in  
10 the program would probably have chosen primary care anyway.  
11 Nevertheless, policymakers could consider such a program as  
12 one option to address concerns about the future pipeline of  
13 primary care physicians.

14           In thinking about a Medicare-specific program,  
15 there are some important design issues to consider. The  
16 first is the size of the program in terms of dollars and  
17 the number of physicians. As one reference point, the NHSC  
18 has received about \$300 million per year in funding since  
19 2011, and it had 10,900 clinicians in 2018.

20           A second issue is how to finance a Medicare-  
21 specific program. One option is to fund it with savings  
22 from the Commission's recommendation to eliminate MIPS, the

1 Merit-based Incentive Payment System. MIPS provides \$500  
2 million per year for exceptional clinician performance from  
3 2019 through 2024, for a total of \$3 billion. When we  
4 recommended eliminating MIPS, our intent was not to produce  
5 budget savings but to consider policies that would reinvest  
6 these funds in clinician payment.

7 Another financing option is to require medical  
8 schools with students who participate in this program to  
9 provide matching funds, as is required under the Primary  
10 Care Loan program.

11 A third issue is whether the program should offer  
12 scholarships, loan repayments, or both. Scholarships could  
13 attract low-income students who might be less likely to  
14 apply to medical school because of its high cost. But loan  
15 repayments are targeted to students who are closer to  
16 graduation and, therefore, have a stronger idea of whether  
17 they're interested in primary care.

18 Fourth, the size and complexity of the program  
19 would have implications for program operations. As the  
20 program gets larger and more complex, it would require more  
21 resources to administer, both in terms of staff and  
22 dollars.

1           The next set of issues relates to eligibility for  
2 the program and the rules for participation. Which  
3 specialties should be eligible? Based on our previous  
4 work, you could think about including the following  
5 specialties as primary care: family medicine, geriatric  
6 medicine, general internal medicine, and pediatrics. The  
7 program could also include behavioral and mental health  
8 clinicians.

9           Another issue is ensuring that clinicians in the  
10 program provide primary care to beneficiaries. The program  
11 could require that clinicians treat a minimum number of  
12 beneficiaries, which is a measure that could be validated  
13 with Medicare claims data.

14           It would also be important to require that  
15 primary care services account for a significant share of a  
16 participant's Medicare fee schedule revenue. For example,  
17 under the Primary Care Incentive Payment program, primary  
18 care visits had to account for at least 60 percent of a  
19 primary care clinician's fee schedule revenue.

20           Another issue is the length of the service  
21 commitment, which could vary based on the amount of the  
22 scholarship or loan repayment received. Because there are

1 multiple design choices for a Medicare-specific program,  
2 and it is difficult to predict the impact of such a program  
3 on physicians' career choices, it might make sense to start  
4 with a small-scale pilot program.

5           A pilot program could test the impact of  
6 different design choices on program operations, physician  
7 participation, and career choices. Policymakers could use  
8 the results to improve the program and decide whether to  
9 expand it.

10           So for next steps, the work I presented today  
11 will be packaged together with our prior work on APRNs and  
12 PAs into a chapter in the upcoming June report. This  
13 summer, we are planning site visits to medical schools that  
14 emphasize primary care and that graduate a high share of  
15 primary care physicians.

16           For today's discussion, we would like your  
17 feedback on whether you're interested in further developing  
18 the idea of a Medicare-specific scholarship and loan  
19 repayment program for primary care physicians. We would  
20 also welcome your comments on the design questions we've  
21 raised.

22           This concludes the presentation. I'd be happy to

1 take any questions.

2 DR. CROSSON: Thank you. Ariel, just to be  
3 clear, when you're talking about the June report, the  
4 assumption here -- correct me if I'm wrong here -- is that  
5 it would contain the analytic information that you've  
6 presented but not necessarily a proposal for this program  
7 because we're going to investigate that into the next term.  
8 Is that correct?

9 MR. WINTER: That's correct, unless you come to  
10 some consensus today around a proposal.

11 DR. CROSSON: Oh. Well.

12 [Laughter.]

13 DR. CROSSON: That should work out okay.

14 MR. WINTER: Absent that, we can lay out the  
15 design choices like we've done in the draft paper.

16 DR. CROSSON: All right. Clarifying questions.  
17 We'll start with Karen.

18 DR. DeSALVO: Fantastic chapter and great  
19 edition. Thank you so much. I wondered about the pipeline  
20 question about the number of graduates in internal medicine  
21 that plan to go into general internal medicine and if  
22 you're able to further break that down into those that are

1 choosing to be a hospitalist compared with the outpatient  
2 physician. As I understand it, that's also a startling  
3 number, that there's a dramatic increase, making the  
4 shortage look even worse potentially than it is. And I can  
5 share some data with you if you haven't had a chance to see  
6 it.

7 MR. WINTER: Right. So the paper I cited by, I  
8 think, West and Dupras did break it down by the choices.  
9 And so 64 percent of them plan to enter subspecialties; 9  
10 percent, hospital medicine; and 4 percent were undecided.  
11 And that relates to the third bullet on this slide, the  
12 21.5 percent who intended to practice general internal  
13 medicine.

14 DR. CROSSON: Jaewon.

15 DR. RYU: Yeah, thanks. I, too, really enjoyed  
16 this chapter. You started the chapter with some discussion  
17 about the fee schedule and the devaluing of primary care  
18 services over time. And then it kind of led into a  
19 discussion about various loan forgiveness programs. I  
20 guess my question was: Which of those two levers would be  
21 more impactful? And do we have any evidence to suggest  
22 that one would be more influential in shaping the

1 decisionmaking of graduating medical students versus the  
2 other? Or is it both?

3 MR. WINTER: So I don't have a direct answer to  
4 that question, but this kind of follows up from the work we  
5 did last cycle that resulted in the June chapter from last  
6 year looking at options for redressing the passive  
7 devaluation of ambulatory E&M services, and the approach  
8 that we discussed and that we modeled in the June report  
9 was to increase payment rates for all ambulatory E&M  
10 service by 10 percent and in a budget-neutral manner, which  
11 would reduce payment rates for all other services by about  
12 3 percent. And that would transfer something over \$2  
13 billion to those types of services.

14 The Commission felt strongly that that increase  
15 should apply to all ambulatory E&M services regardless of  
16 the specialty that provided it. And many of these  
17 services, as you know, are billed by non-primary care  
18 clinicians.

19 And so there was also a lot of discussion at the  
20 time about what are more direct ways, direct approaches,  
21 options that we could pursue that would have an impact,  
22 direct impact on choice of specialty, and several

1 Commissioners suggested that we take a look at loan  
2 forgiveness or debt reduction kind of programs as a  
3 potential option. So that's why we pursued this work. In  
4 terms of which option would have more of an impact? I  
5 don't have the evidence to say.

6 DR. MATHEWS: Right, but just to amplify what  
7 Ariel said, our prior work dealt with things like  
8 identifying overvalued services within the physician fee  
9 schedule and plowing those RVUs back into the fee schedule  
10 more generally. And correct me if I'm wrong, but even when  
11 we talked about modeling a per beneficiary per month  
12 payment, we were talking very small dollar amounts at the  
13 initial stages, \$2.40 a month, something like that. And  
14 the question was: Are these kind of incremental revenue  
15 changes going to be sufficient to influence someone who is  
16 making a decision primary care versus orthopedic surgery,  
17 as much as a more direct approach, here's \$100,000 worth of  
18 loan forgiveness to help start you out on your career.

19 But it was, as Ariel said, in direct response to  
20 Commissioner interest in pursuing something more  
21 immediately impactful.

22 DR. CROSSON: Paul, do you want to comment on

1 that?

2 DR. PAUL GINSBURG: I want to add to that. I  
3 think the Commission believes that fixing the fee schedule  
4 is, you know, the best way to proceed, but that either --  
5 this could either, you know, expedite the change in  
6 response to that, or, you know, we realize we may not get  
7 the fee schedule fixed, and this could be a second-best  
8 alternative to pursue.

9 DR. CROSSON: I agree with that.

10 DR. DeSALVO: Can I add on to that?

11 DR. CROSSON: Yeah, Karen.

12 DR. DeSALVO: Yes, though I -- you see this in  
13 some of the data that you have in this chapter. Financial  
14 drivers aren't the only or even perhaps the most important  
15 decisionmaking, and I keep going back to it's also about  
16 intangibles like the practice environment, the amount of  
17 time you're able to spend with patients, and how you have  
18 continuity and the team that you can assemble based on not  
19 just how much you're paid but how you are paid.

20 So I think that in addition to the rebalancing of  
21 the fee schedule, this gets back again to moving to value-  
22 based care arrangements like, you know, patient-centered

1 medical home and other intangibles, like the retention for  
2 National Service Corps, I think the number is 55 percent of  
3 National Service Corps are retained. Some of those  
4 communities, particularly smaller ones, provide other  
5 benefits to those physicians once they arrive there, like  
6 mortgage or housing or, you know, other supports that help  
7 keep them in those communities that are somewhat financial  
8 but also relate to things outside of the fee schedule.

9 DR. CROSSON: Thank you. Jonathan.

10 DR. JAFFERY: Yes. You said a little bit about  
11 the Public Service Loan Forgiveness program that spoke to  
12 maybe an existing program that's not fully maximized, or  
13 optimized, I should say. Do we have any data? Do you  
14 know, are the other programs that currently exist being  
15 fully utilized?

16 MR. WINTER: That is a very good question. With  
17 regards to the military program, it seems like they are --  
18 I mean, their funding has been pretty stable, as I recall,  
19 and it seems like they're filling their slots. And I'm  
20 referring here to the health professional scholarship  
21 program, which is run by DoD, and has about 3,000  
22 physicians right now who are participating in that.

1           With regards to the NHSC it's hard to say,  
2 because their numbers, as we talk about in the paper, have  
3 gone up from about 3,000 clinicians to almost 11,000  
4 clinicians in the last decade or so, and funding has gone  
5 up as well. But there are also about 4,600 or so, 4,500 or  
6 so unfilled slots at sites that have been approved by HRSA,  
7 for NHSC clinicians, and it is unclear whether there's not  
8 enough money to fund all the people who are applying or  
9 there's not enough people applying to fill those slots.  
10 And we've asked HRSA for that information and have not  
11 heard back yet.

12           With regards to the Primary Care Loan program,  
13 there's been a decline in borrowers, from about 4,500 or  
14 4,600 to -- where is it today? -- 2,600 borrowers. And I  
15 think that's due to -- it seems like that's due to several  
16 factors, the fact that it's a fairly long time frame to  
17 participate in the program. You've got to participate for  
18 10 years, you have to practice a specific specialty, and  
19 also there's been development of more attractive programs,  
20 like the Public Service Loan Forgiveness program or the  
21 NHSC. And if you participate in the PCL you cannot be in  
22 the NHSC. So that's another factor perhaps driving

1 reduction.

2           So that's sort of the best evidence we have right  
3 now.

4           DR. GRABOWSKI: A follow-up to Jonathan's  
5 question?

6           DR. CROSSON: Yeah.

7           DR. GRABOWSKI: Jonathan, I think, was asking  
8 about uptake of these programs, but has anyone actually  
9 evaluated your issue around, are these attracting new  
10 individuals into primary or is this just individuals who  
11 otherwise would have entered primary care? That's kind of  
12 a different issue, but related to whether these programs  
13 are actually effective, not just whether folks are signing  
14 up.

15           MR. WINTER: Yeah, I wish there were evidence  
16 about that. I've not seen any attempt to evaluate that  
17 question in my review of the literature. There have been  
18 some evaluations of the NHSC that have focused, really, on  
19 retention rates within the HPSA or within the HPSA  
20 generally, within 1 year or 10 years after, but have not  
21 attempted to address that question. And that would be  
22 really -- that's obviously a very important question to

1 address.

2 DR. CROSSON: Okay. So let's move this way.  
3 Jon.

4 DR. CHRISTIANSON: So if I understand right we  
5 are concerned about the Medicare beneficiaries will have  
6 access to primary care. We do this annual survey that says  
7 right now, on average, their access is better than people  
8 in private insurance, but we know, around the average,  
9 there's a lot of variation so there may be a lot of areas  
10 in the country where their access is not good at all.

11 So the question I have -- so I would think we  
12 would want to tie a loan program to physicians who  
13 practiced in areas where Medicare beneficiaries don't have  
14 adequate access. But my question is, I don't -- is there a  
15 source of data that would tell us that? I don't think our  
16 survey is scaled to tell us, at any kind of a local level  
17 or a smaller level, whether somebody -- whether Medicare  
18 beneficiaries have adequate access or not.

19 So how do we -- what data are available to help  
20 us link a program to where we really think the benefit  
21 would be?

22 MR. WINTER: Right. So you're correct that our

1 survey is not adequately powered to look at specific  
2 geographic areas where we think there are problems,  
3 although I think generally folks in rural areas report more  
4 trouble accessing -- no? Okay. It's the same. Okay.  
5 Rural and urban are the same.

6 But to address your question, I think one option  
7 could be to look at health professional shortage areas,  
8 which are areas defined by HRSA, where there is a shortage  
9 of primary care clinicians, generally -- not just Medicare  
10 beneficiaries but generally -- and that's, as far as I  
11 know, the best source of data we have for -- if you wanted  
12 to target a loan program or a debt reduction program to  
13 shortage areas. I'm not aware of any off-the-shelf system  
14 that identifies area where there's a problem -- where  
15 there's a shortage of clinicians for Medicare beneficiaries  
16 specifically. I'm not sure how you would do that.

17 DR. CHRISTIANSON: So it's not so much whether  
18 the ratio is lower in one area or another but basically  
19 whether Medicare beneficiaries are having trouble accessing  
20 primary care.

21 MR. WINTER: We don't have a metric for that.

22 DR. CHRISTIANSON: Right. And a lot of your

1 comments here are around clinicians, not physicians per se.  
2 So when you talk about clinicians available that are taking  
3 advantage of these programs that's not the same thing as  
4 physicians, which we seem to talk about. We talk about  
5 physicians, primary care physicians.

6 MR. WINTER: Right. So we were asked to  
7 investigate a program that would be targeted to physicians  
8 specifically. As you correctly point out, the Public  
9 Service Loan Forgiveness program, well, that's for  
10 everybody, you know, not just health professionals. NHSC  
11 is for many types of clinicians and physicians are only 20  
12 percent of the total. The Primary Care Loan program is  
13 targeted to physicians, and that's the one program that we  
14 talk about. And the military program is targeted for  
15 clinicians and other -- sorry, for physicians and other  
16 clinicians as well. So the PCL is really the only one  
17 that's targeted to physicians.

18 DR. CROSSON: You know, I just want to make a  
19 comment on this. As I said earlier, we've been working on  
20 this issue of primary care physician pipeline for a long  
21 time. I'm not sure how long -- 10 years, perhaps, at this  
22 Commission. And I can remember my predecessor Chairman,

1 who came from central Oregon, when we would present the  
2 data about appointment access for primary care, scratching  
3 his head and saying, "Well, that may be the case but that's  
4 not the situation in central Oregon."

5           So, you know, it may be that in the aggregate  
6 rural and nonrural are equal, but I have a strong suspicion  
7 that there are areas of the country where it's very  
8 different than that.

9           Okay. Kathy.

10           MS. BUTO: Sort of a related point. Nurse  
11 practitioners and physician assistants are not included in  
12 the proposal. I understand that we know there's growth in  
13 those areas but I also remember, I think the last go-  
14 around, Ariel, you might have pointed out that increasingly  
15 nurse practitioners are beginning to subspecialize and get  
16 out of primary care.

17           So I wonder whether we ought to think about  
18 including that group. Is that -- did you leave them out  
19 for a reason, just because we were focusing on physicians,  
20 or what exactly were you thinking?

21           MR. WINTER: So the direction that I got, based  
22 on comments from Commissioners last cycle was to focus on

1 physicians, and part of that could be driven by the rapid  
2 increase in the number of NPs and PAs, which has basically  
3 doubled, I think, since 2010 -- yeah, which has doubled  
4 between 2010 and 2017. And so there seemed to be less  
5 concern about people choosing that -- choosing to become  
6 NPs and PAs than about choosing to become primary care  
7 physicians. But it's certainly something you could  
8 discuss, is whether to include NPs and PAs in the kind of  
9 program we're discussing.

10 MS. BUTO: I think, to turn the tide a little bit  
11 back to primary care, we might want to consider if not a  
12 full comparable program to bring them into something that's  
13 maybe a little less than that.

14 The other thing I wondered about is pediatrics is  
15 included in the list of physicians. I mean, with all due  
16 respect to a pediatrician here, I guess I'm wondering why  
17 would we include pediatrics in a program for Medicare?

18 MR. WINTER: Right. So in our prior work, for  
19 example, the recommendation that led to the Primary Care  
20 Incentive Payment program, we included pediatrics in the  
21 list of clinicians that should be eligible for a bonus or a  
22 payment adjustment. And there are some, when we look at

1 the number each year of physicians who treat 15 or more  
2 Medicare beneficiaries, there are about 1,000 or so  
3 physicians who are self-reported to be pediatricians, you  
4 know, in that number. And so you could leave them out if  
5 you wanted to, but including those is not going to make a  
6 huge difference because there are not so many treating  
7 Medicare to begin with.

8 DR. CROSSON: And, Kathy, it was in the context  
9 of a per-beneficiary payment, in which case it was de  
10 minimus.

11 MS. BUTO: But if this program is designed to  
12 actually --

13 DR. CROSSON: Different policy.

14 MS. BUTO: -- get people to sort of gravitate  
15 toward Medicare primary care --

16 DR. CROSSON: So adult primary care.

17 MS. BUTO: -- I don't see that.

18 DR. CROSSON: I would agree that this is  
19 different.

20 MS. BUTO: Yeah.

21 DR. CROSSON: Brian.

22 DR. DeBUSK: First of all, thank you for a really

1 great chapter on a very, very important topic. My  
2 question, in the reading materials I look at page 17 and I  
3 look at page 18, and there's this stark contrast between  
4 these two pages, because you talk about evidence of a  
5 relationship between the characteristics of students and  
6 their specialty decisions, that these things are correlated  
7 with the choice of family medicine, that demographic  
8 characteristics best predict choice of practice, about even  
9 the characteristics of the schools that they use, community  
10 hospitals, you know. I mean, it's just full of evidence in  
11 that this causes that.

12           And then, on page 18, the one sentence that stood  
13 out, "Evidence that educational debt affects specialty  
14 choice is mixed." So, see, a page of this causes that, and  
15 a sea of this is page of mixed. My question is this --  
16 have you contemplated that some programs that are aimed at  
17 the levers that you describe on page 17, or are we jumping  
18 straight to page 18 in our design considerations?

19           MR. WINTER: So that is a very fair question, and  
20 I -- the assumption -- my assumption has been that we were  
21 -- we wanted to focus on things that factors of Medicare  
22 had more control over, and Medicare doesn't have very much

1 control over lifestyle and the design of medical school  
2 curricula, although maybe it should -- that's a separate  
3 question, I think -- and much control over demographics and  
4 control over work hours and things like that. But it has,  
5 perhaps, more control over the income gap, because the fee  
6 schedule comes from Medicare and many private payers use  
7 Medicare as RVU uses as the basis for their payments. And  
8 in terms of debt, the evidence is mixed but, you know, we  
9 were asked to look at whether a debt reduction program  
10 might have some impact on specialty choice.

11           And one other point I'll make is that in terms of  
12 the student characteristics, so there is evidence showing  
13 that students from rural backgrounds, lower SES, from  
14 minority backgrounds are more likely to choose primary  
15 care, and you do see a disproportionately high share of  
16 minorities in the NHSC program, which does provide,  
17 obviously, a financial incentive, but the people who are  
18 choosing that, self-selecting into that, tend to be people  
19 with characteristics that make them more likely to choose  
20 primary care.

21           DR. DeBUSK: Thank you.

22           DR. CROSSON: Pat.

1           MS. WANG: So I also am struck by a couple of  
2 things, and Brian mentioned one of those and you summarized  
3 it at the bottom of Slide 7, that the evidence of the  
4 effect of student debt is mixed, like from zero effect to  
5 modest effect. And so it makes me want to sort of step  
6 back for a second from the idea of creating a new loan  
7 forgiveness program as opposed to maybe fixing the ones  
8 that are out there, making them work better.

9           I guess my question is -- and this is infamous  
10 also by another -- I think I have mentioned this -- I am so  
11 struck by the member of a conversation with a colleague who  
12 is geriatrician, who described how, in the course of his  
13 residency, as it went along, you know, his supervising  
14 physicians would say, "You're so talented. You're so  
15 smart. Specialize." Like he had to resist and buck the  
16 pressure that if you are talented, you specialize.

17           And I just wonder whether there is any literature  
18 or otherwise -- this is payment policy, I understand --  
19 that is along the lines of behavioral economics. Because  
20 we're talking about a -- forget student debt and all of the  
21 rest; that exists -- but that would suggest that there  
22 might be other ways to use the tools at Medicare's

1 disposal, money, to -- you know, there's the fee schedule,  
2 obviously, but whether there are other ways to change the  
3 valuation, I guess, or the status of certain primary care  
4 specialties. And I picked geriatricians, you know, for a  
5 reason, because, to me, they are the ultimate Medicare  
6 physician, you know. A primary care doctor who can only  
7 afford to see you for 15 minutes at a time is fine, that's  
8 one thing, but a geriatrician is going to set his practice  
9 up so that he or she can spend that kind of time with you.  
10 So to me it's a little bit a gold standard, whether it's a  
11 geriatrician or a, you know, internist with whatever.

12           So these are wacky ideas but I just wondered if  
13 there's literature that would suggest that there are other  
14 ways, if there is to be new money, to, short of a fee  
15 schedule, structure a program to incentivize people,  
16 regardless of whether they have debt or not, because loan  
17 forgiveness is sort of a special thing. You need to have  
18 debt. You need to have help paying off your debt. You  
19 know, it doesn't apply equally to everybody, perhaps. That  
20 even if you were going to forgive debt in the amount of  
21 \$100,000, structuring it as a bonus payment instead,  
22 regardless of whether you have debt, whether, you know,

1 Medicare should think about setting up malpractice  
2 insurance subsidization for people who choose primary care  
3 for older people. You know, something that kind of just  
4 elevates the status of people who pick this very important  
5 pathway.

6 DR. CROSSON: So let me just -- I want to comment  
7 on a little bit of Pat, because I think you are hitting on  
8 something here, which is both important and delicate at the  
9 same time. And it has to do with another payment stream  
10 from Medicare and that is for graduate medical education.

11 So we took a run, as a Commission, I think, in  
12 2010, for not exactly this reason, that is primary care,  
13 but more from the perspective of whether or not, in a more  
14 general sense, the residents who were coming out of  
15 training had the mindset, the level of knowledge, expertise  
16 that was needed for modern physicians, and whether or not  
17 some of the Medicare payment for graduate medical education  
18 could be not taken away but redirected to create incentives  
19 for training programs.

20 Now that didn't go over well at the time. But I  
21 do still think that there's something in here, and Jim  
22 reminded me that we're still working on this, in terms of

1 how that money is provided, and specifically, not to be the  
2 reductionist here but just to give an example, you could  
3 imagine creating incentives for programs to distribute the  
4 training of physicians more broadly than is currently done  
5 in, you know, the mother ship, such that, you know,  
6 physicians -- incentives within the GMA payment program to  
7 provide physicians, particularly physicians, you know,  
8 contemplating primary care, or, for example, physicians  
9 contemplating internal medicine, to have a broader  
10 experience in their training so that they see health care  
11 as it is delivered in the community, and get comfortable  
12 with that, as opposed to just simply experiencing, in their  
13 training program, primarily inpatient care services.

14           So again, I don't necessarily want to revisit the  
15 whole issue of GME and its uses, but I do think that there  
16 may be something -- and I'm not sure you were saying that  
17 exactly but you were close to it -- there may be something  
18 in there for us to look at.

19           MS. WANG: Just to be clear, I think that what  
20 you're saying is very relevant and very important, but  
21 short of even touching the GME system, whether there is  
22 something -- again, I use the term behavioral economics --

1 that changes the status of primary care in the eyes of  
2 other physicians, including the attendings who are training  
3 you, that, you know, geriatrics is like, well, it's pretty  
4 cool, you're going to pay your malpractice for the rest of  
5 your life as long as you stay treating, you know, Medicare  
6 beneficiaries. You know, that just kind of would help  
7 people sort of stick to that as a profession.

8 DR. CROSSON: And I heard that, and I can sort of  
9 give you examples from my own training. And, you know, we  
10 had -- when I was a resident training in a large  
11 institution in Boston, as a pediatrician, we had some  
12 rather derogatory names for the physicians practicing in  
13 the community who would refer their patients in, because  
14 all we ever saw were the really sick ones, and occasionally  
15 patients who had not been treated properly, right.

16 Subsequent, you know, during later years of my  
17 residency I actually moved out of Boston myself into a  
18 suburban community, and for reasons I can't remember,  
19 decided to work more at night, actually covering multiple  
20 practices, and got an entirely different viewpoint of what  
21 the community practice of general pediatrics was like.

22 So that's sort of what I'm saying. I think part

1 of that mindset that the physician has, in terms of, in  
2 some instances, not everywhere, but in some instances, part  
3 of that mindset about what is a desirable role for me as a  
4 doctor, what is something which is ego-enhancing, even to  
5 put it that way, can be, in fact, and is, affected by the  
6 environment in which the individual trains and the peers  
7 that the individual experiences. And that was what I was  
8 trying to get at, along the lines I think that you were  
9 thinking.

10 MR. WINTER: And, Pat, I did look for anything in  
11 the literature that tried to evaluate the influence of  
12 status, the kinds of things you're talking about, or  
13 prestige. I couldn't find anything that directly assessed  
14 that, but every year the AAMC does a survey of its medical  
15 school graduates and asks them what factors played the  
16 biggest role in influencing their choice of specialty, and  
17 number three on the list was role model influence, which  
18 was reported by about 50 percent of the graduates. And  
19 that could be kind of a proxy for, you know, if the person  
20 you're training with, learning from influences you or  
21 directs you towards one direction or another, that could be  
22 related to what you're talking about.

1 DR. CROSSON: Where are we? Still on Round 1.  
2 On that point?

3 MS. BUTO: On that point. Yeah, I totally agree  
4 with Pat, and I came at it from the standpoint that -- and  
5 I realize this is a Round 2 comment, but that status would  
6 be related to having more control. So physicians often  
7 feel like they don't have control in Medicare, that they're  
8 required to do a lot of things, and that they are subject  
9 to the fee schedule. If there were some way to grant more  
10 autonomy, control, and convey status that way, whether it  
11 has to do with greater flexibility in whatever, payment  
12 models and so on, but only if you're a primary care  
13 practice, that's where I think you can begin to shift the  
14 status within Medicare of primary care. I don't think it's  
15 about paying each fee more money. I really have never  
16 thought that.

17 Loan forgiveness is one thing, but I really think  
18 it's about being looked to as some sort of an entity to be  
19 reckoned with within the program, and I don't think we have  
20 that now.

21 DR. CROSSON: And, Karen, I think you've made the  
22 same point a couple of times, today even.

1           Okay. So I've lost track. We're still on Round  
2 1, right?

3           [Laughter.]

4           DR. CROSSON: Okay. Any more questions for  
5 Ariel? Dana and Bruce, and then we'll get on.

6           DR. SAFRAN: So in the chapter and in the  
7 presentation, you make a point that a couple time periods  
8 recently, '13 to '14 and '17 to '18, there was a growth in  
9 internal medicine residents, and that's new. We've been  
10 seeing declines, right? Growth relative to other  
11 specialties. And my question is: I know anecdotally in  
12 Massachusetts that with our payment reform work and how  
13 broadly that got adopted, we were hearing that primary care  
14 was now in such demand that, you know, primary care  
15 physicians were coming into Massachusetts from other  
16 states.

17           And so that got me to wondering whether you see  
18 these time periods and this shift as something related to  
19 the payment reform work that CMS is doing, because as it  
20 is, then that's just something important for us to note,  
21 too, that by continuing to pursue that path, CMS is helping  
22 to enhance the primary care workforce and the attraction

1 into that workforce.

2 MR. WINTER: Yeah, that could be on -- as we  
3 noted from earlier-on studies preceding this time period,  
4 you know, about 80 percent or so of internal medicine  
5 residents end up subspecializing. So it's unclear what  
6 percent of the residents, today's internal medicine  
7 residents, also specialize. Maybe it will be less. And  
8 maybe there could be some influence from the greater  
9 attention towards new payment models.

10 The other point I just want to make -- and I will  
11 include this in the chapter -- is at the same time we're  
12 seeing, you know, higher than average growth of internal  
13 medicine and family medicine residents, we're also seeing  
14 very, very slow growth of geriatric medicine residents. It  
15 grew by about -- I think it grew by about 2 percent over  
16 that five-year time frame. So I'll include that to add  
17 some balance to the picture.

18 DR. CROSSON: Bruce.

19 MR. PYENSON: Pass [off microphone].

20 DR. CROSSON: Pass. Okay. So we're going -- I'm  
21 sorry. I didn't see Warner.

22 MR. THOMAS: Just real briefly, and I think, Jay,

1 this goes back to a comment you were making earlier. I do  
2 think the idea of thinking about would it make sense to  
3 have additional funding in GME slots if, in fact, they were  
4 targeted to this area or to community care, you know, kind  
5 of off the campuses, you know, kind of off the tertiary  
6 campuses. I mean, we've done this in our program, it's  
7 been very successful. It's going to grow that pipeline,  
8 and it may just be another tool here, because ultimately it  
9 is about how many people we can train, and this is  
10 attracting people to go into those slots. But we  
11 ultimately need more slots for people that kind of go into  
12 the primary care world. And I just would put that out as  
13 another tool to potentially consider. I know it's more  
14 dollars, but if they were specifically targeted to these  
15 types of careers, I think that would be attractive to  
16 academic medical centers and attractive to people that were  
17 interested in those paths.

18 DR. CROSSON: I think that's fair. I was  
19 actually talking about expanding the number of slots, but I  
20 think that's fair to put on the table, and it would cost  
21 money, but so would a loan forgiveness program, to be  
22 frank.

1           Okay. So we don't have a discussant, so I  
2 thought I'd start a little bit. I think we need to decide,  
3 you know, whether or not this issue of -- and I'll use the  
4 term "loan forgiveness program," but that's kind of  
5 generic. It's essentially a program to provide money to  
6 new physicians to enter and pursue a career in adult  
7 primary care so that they're available to beneficiaries who  
8 want to have a physician perform that function. And I  
9 think Ariel has done a wonderful job giving us sort of the  
10 baseline, the status of where things are, both in terms of  
11 the need and in terms of what's available.

12           The question on the table is: Do we think that  
13 adding a program, however designed -- and there are  
14 multiple design elements -- would substantially improve the  
15 situation we have now? And, you know, I've heard the  
16 comment already: Or would it just be duplicative? Should  
17 we instead invest in improving the existing programs  
18 through HRSA or someplace else?

19           I think it is true that what we're contemplating  
20 here is a little different from the design or the intent  
21 even of any of the existing programs. So there's that  
22 point to be made.

1           So I'm sort of functioning here as the  
2 discussant, so I'll just give a few thoughts of my own,  
3 because I've had some experience kind of tangentially  
4 related to this, and that had to do, you know, with my  
5 prior career in Kaiser Permanente and wrestling with the  
6 problem not about what specialty an individual chose but  
7 the ability to attract physicians in adult primary care  
8 into a system in Northern California which had very diverse  
9 geography, places that were wonderful to live by most  
10 people's standards with nice weather and the bay and  
11 beaches and all that stuff, and then other parts of  
12 California which were on average less desirable, the  
13 Central Valley, for example. And yet we needed physicians  
14 in primary care but also other physicians in those areas as  
15 well.

16           And what we found over a period of time was that,  
17 in fact, providing financial assistance up front did work.  
18 It has to be substantial, and it also in order to work  
19 needed to be associated with a significant time commitment,  
20 the notion being that if you provided to physicians a  
21 substantial amount of money up front but then, you know,  
22 made the forgiveness of that money contingent on -- and it

1 was a ten-year period of time, what you ended up with was  
2 people -- and it was often individuals who came from  
3 backgrounds where they had less money themselves to bring  
4 to bear -- choosing those sites to work in, and then after  
5 a period of time becoming very much a part of those  
6 communities, something that in many cases doesn't occur in  
7 a very short period of time. Two or three years, from my  
8 perspective and my experience, doesn't work very well. But  
9 a significant period of time does, and a significant amount  
10 of money does seem to work.

11           The question -- and I'm not framing the debate in  
12 this way right now as the Chairman. I'm just throwing out  
13 my own ideas. The question is: Do we think it's  
14 worthwhile over the next year or so to have the staff and  
15 then the Commission pursue some idea in this direction? Or  
16 should we be devoting our efforts somewhere else?

17           Jon first, and then we go down here.

18           DR. CHRISTIANSON: Yeah, so we're talking about  
19 spending Medicare money to improve access for Medicare  
20 beneficiaries so that, as I brought up before, for me the  
21 issue of targeting that expenditure is important. And I  
22 think it's really difficult to do geographically because we

1 compute these ratios over fairly broad geographic areas and  
2 populations. But I kind of like the ideas that Pat and  
3 Warner were talking about.

4           Maybe we could distinguish whatever program we  
5 come up with, whether it's loan forgiveness or whether it's  
6 funding of slots, maybe we could distinguish our program  
7 from other options out there by focusing in on  
8 geriatricians and on palliative care specialists who, I  
9 think we would all agree, are specialties that are  
10 underrepresented and serve the Medicare population. And I  
11 would like you to think about and explore options along  
12 those lines, because I just would feel better about the  
13 efficiency of the expenditure of the Medicare funds if we  
14 could think that through a little bit.

15           DR. PAUL GINSBURG: Yeah, actually, before I get  
16 to my other comments, I really like this emphasis that Jon  
17 suggested about geriatrics, because we know the visits are  
18 longer, that, you know, we just wonder why do people go  
19 into this because it's so challenging economically to do  
20 it.

21           What I was going to talk about -- and Jay was  
22 really getting into this -- is we need to talk more about

1 the ratio of the additional primary care or geriatric  
2 physicians we get compared to the ones that were going to  
3 do that anyway and collect the money. And I don't have a  
4 magic answer to that yet, but I think that's what we should  
5 be thinking about coming up with ideas. And that's what  
6 really Kaiser did with the very long commitments, figuring  
7 that that's the way to have people commit to the Central  
8 Valley for ten years, that these really might be people  
9 that you wouldn't have gotten otherwise because of the  
10 money.

11 A couple of other comments. One is that it's --  
12 you know, I can see the type of thinking how the PCL  
13 program requires some contribution from medical schools and  
14 what Ariel wrote was medical school matching funds. But to  
15 me those are perverse incentives for the medical school.  
16 You know, the state medical schools have long been under  
17 pressure to produce a high percentage of graduates headed  
18 for primary care. And here we're saying, oh, if you  
19 succeed, we're going to clobber you because you're going to  
20 have to pay some of the loans, loan forgiveness these  
21 students get. So I think we should really get away from  
22 having the medical schools contribute to the success that

1 they may have achieved by steering the students.

2 I'll stop there.

3 DR. CROSSON: Thank you. Kathy.

4 MS. BUTO: I'll make this very brief. I had  
5 written down "start with geriatrics." I really think if  
6 it's loan forgiveness, then we have people who have already  
7 incurred debt. And if it's targeted at geriatrics, the  
8 only thing I'd add is we ought to consider nurse  
9 practitioners or PAs who are also willing to make a  
10 geriatric specialty commitment.

11 DR. CROSSON: Brian.

12 DR. DeBUSK: First of all, I think the geriatrics  
13 idea is fantastic. I had not considered that, and that's  
14 an easy idea to get behind.

15 I think this is a really important area, and I  
16 think any progress is progress. So if we do wind up with  
17 some type of loan forgiveness program, it's better than  
18 nothing. And I think it is something that the Commission  
19 should definitely take up, and I think this is time well  
20 spent.

21 One of the things that was very encouraging, I  
22 saw in the presentation when you said you were planning to

1 go to some of these medical schools that specialize in  
2 producing primary care physicians, I would encourage you to  
3 do site visits there because those are very, very different  
4 places. They don't feel like ordinary medical schools.  
5 And it's a different culture. You know, no one's going to  
6 tell them they're being foolish choosing primary care  
7 because everyone -- well, I say everyone -- most want  
8 primary care. Again, culturally it's very different.

9           On the site visit I would ask you please ask  
10 them, Where would you spend the money? If you had access  
11 to some type of funding mechanism, would you spend it on  
12 loan forgiveness? Or, for example, would you spend it on  
13 buying more clinical rotation spots in community hospitals?  
14 Which, by the way, I mean, for the primary care schools,  
15 virtually every clinical rotation spot now runs between  
16 \$1,000 and \$2,000 per student per month in years three and  
17 four. They've monetized clinical rotations now.

18           But ask them what they would spend the money on,  
19 because I think you would get some really good ideas, and I  
20 think you would see to these schools -- and I would contend  
21 the majority of the decision to go into primary care has  
22 already been made by the time the school sends the

1 acceptance letter out to the student. I would argue that  
2 the die is cast. And, again, you'll never see me stand  
3 against a loan forgiveness program because any progress is  
4 progress. But I think you're using a very expensive dollar  
5 there, and I think if you go visit these focused factories  
6 and ask them how they would spend that money, I'm not sure  
7 their go-to would be loan forgiveness. It might be on  
8 recruiting. It might be on other forms of -- and then the  
9 final thing, just if you do decide to use some of these  
10 levers on page 17 -- which I do agree when you answered my  
11 question, you know, Medicare doesn't normally engage in  
12 those levers. When you do engage those schools, the one  
13 thing to consider a hope in the design, I'd be interested  
14 in some type of grant program where you hold the school  
15 accountable for producing an increment, don't you dare pay  
16 them for the students they already produce but some  
17 increment in primary care physicians, and then leave it up  
18 to them. Maybe they do it with a class size enrollment.  
19 Maybe they shift their curriculum. But I would leave it up  
20 to them and hold them accountable so that those grants  
21 become repayable loans that they don't deliver on the  
22 primary care students that we, Medicare, feel like we're

1 buying. So good luck this fall.

2 [Laughter.]

3 DR. CROSSON: Jon I think wanted to make a  
4 comment.

5 DR. CHRISTIANSON: Yeah, as an amendment to your  
6 suggestions, would you suggest they have a mix of  
7 osteopathic schools in there as well in terms of starting  
8 out with the notion that you are interested in primary  
9 care?

10 DR. DeBUSK: Well, the osteopathic schools  
11 obviously have led the way in producing primary care  
12 physicians. Since you raised the subject, the one thing I  
13 would caution, I do think osteopathic schools have been a  
14 little bit of a pressure relief valve over the last  
15 probably decade for the primary care shortage. Now that  
16 the residencies have been harmonized with the ACGME so that  
17 the MDs and the DOs are following the same path, what you  
18 will notice is that the osteopaths are starting to  
19 specialize now at allopathic rates. So you are losing that  
20 pressure relief valve, and I think it's going to be  
21 surprising how quickly we lose it.

22 DR. CROSSON: That's a good point. David.

1 DR. GRABOWSKI: Great, thanks. Let me also get  
2 on board on Jon's suggestion about geriatrics. I think  
3 that's a really great idea.

4 I wanted to go also to Paul's point about not  
5 wanting to pay individuals for something they would have  
6 done otherwise. I think that's why we really need a pilot  
7 here. That was the last bullet on the prior slide, on  
8 Slide 14. I think that's really important. And I'd love  
9 for it to be a meaningful pilot where we get to test some  
10 of these design features and actually see what works and  
11 what doesn't work. I think we could learn a lot there.

12 I'm really glad you're going to talk to -- do  
13 these site visits to medical schools that emphasize primary  
14 care. I work at a medical school that doesn't emphasize  
15 primary care, but --

16 [Laughter.]

17 DR. GRABOWSKI: We have made a concerted effort  
18 to take on more students interested in primary care, and  
19 it's actually been a lot more about who we admit than what  
20 we do once they're there, and that really fits, Brian, with  
21 the point you just made. I wonder a lot about whether this  
22 is selection versus steering. And we've certainly had the

1 problem, Pat, you described of losing some students who  
2 said they were interested in primary care and then find  
3 other interests once they arrive. But I do think selection  
4 is really important, and so, Ariel, when you're talking to  
5 these medical schools, I really think it will be important  
6 to learn a little bit more about who they recruit and what  
7 they do once those students are on campus.

8 Thanks.

9 DR. CROSSON: Pat.

10 MS. WANG: So I'm in sync with what folks have  
11 said here. I am a little bit sort of not as enthusiastic  
12 about continuing to explore additional loan forgiveness  
13 programs, at least not before the ones that exist sort of  
14 are working in tip-top shape, because it sounds like  
15 there's more efficiency and more access to be granted with  
16 the programs that exist. And I'm not sure based on, you  
17 know, what you included in your paper, which was  
18 tremendous, that we can actually show the relationship  
19 between loan forgiveness and the goal that we're describing  
20 here, which is to encourage more people.

21 As you sort of pursue these pathways that have  
22 been described, I'd encourage you also to do that kind of

1 qualitative research maybe by talking to individual  
2 practicing geriatricians or palliative care physicians, or  
3 whatever the subset is, to see if they can give you more  
4 insight into what they think might be important, because I  
5 suspect that the more we can understand about sort of the -  
6 - things that have dollar signs attached that create a  
7 different environment for folks who choose this pathway,  
8 both in terms of status but also maybe some perks that go  
9 along with, you know, practicing geriatrics, because that  
10 clearly is for older people. You know, I had mentioned  
11 malpractice before. Maybe there are other parts of some of  
12 the rules that apply to clinician payment that -- you know,  
13 I mean, we just talked about -- we just eliminated kind of  
14 "incident to" billing. Maybe if you're a geriatrician, you  
15 could be allowed to retain "incident to" billing because  
16 you have a workforce of NPs who are kind of supporting your  
17 practice. Those sort of additional perks that would take  
18 some dollars but that would change the status of the  
19 specialty that you've chosen.

20 DR. CROSSON: Thank you, Pat. Jon.

21 DR. PERLIN: Yeah, this really follows from the  
22 sequence of comments, but the question is whether our

1 target is correct. Forgetting incremental benefit from the  
2 investment in the individuals, there's general agreement  
3 and the literature would support that certain institutions  
4 have higher turnout of primary care. Maybe the target  
5 should be the institution. The privilege of being a board  
6 member at Meharry Medical College, one of our historically  
7 black graduate medical institutions, it turns out 80  
8 percent of primary care. The limitation is actually the  
9 resources for additional seats and funding them. You know,  
10 if you just think this through, if you know that's your  
11 pathway and it delivers, maybe in contrast the programs  
12 that already exist -- and I have a good deal of experience  
13 with it from my VA days -- maybe another approach is, in  
14 fact, direct investment in that, and that's our pilot.

15 Thanks.

16 DR. SAFRAN: Can I make a comment on that [off  
17 microphone]?

18 DR. CROSSON: On that point, yeah.

19 DR. SAFRAN: I was just going the same place in  
20 my thinking, and I think prompted a little bit by something  
21 that you said, Brian, but definitely, David, listening to  
22 you and remembering, you know, my own teaching at Harvard

1 Medical School, literally would have the experience of  
2 talking to first-years, asking them, "How many of you think  
3 you're going into primary care?" And almost every hand  
4 would go up -- like three-quarters of the room. And then  
5 teaching third-years and, you know, you'd be lucky if you'd  
6 see a couple of hands in a very big auditorium.

7           And so I just started thinking the same thing,  
8 and the question I have is: Do we go with what Brian was  
9 talking about, which is for the schools that are already  
10 doing a lot of primary care, reward them for an increment  
11 there, versus do we try to reward the schools like you and  
12 I have taught in that aren't really focusing there and try  
13 to reward them?

14           I'm not sure. I could make the case for either  
15 one, but I do think that this idea of focusing on the  
16 institution is one we should play with a little bit.

17           DR. CROSSON: Warner.

18           MR. THOMAS: I would just confirm, you know,  
19 Jonathan's comment about -- I think the loan repayment and  
20 everything I think is interesting. But I think direct  
21 financial support to institutions that can expand this  
22 pipeline is probably a more -- a quicker way that we're

1 going to have the impact, and I think a more direct way.  
2 So I would just encourage us to really look at that as an  
3 option, because I think the impact will be much quicker and  
4 much more direct, frankly.

5 DR. CROSSON: Okay. Sue.

6 MS. THOMPSON: I want to go back to comments that  
7 Kathy made in Round 1 where she was asking about the nurse  
8 practitioners and their role in filling this void of, I  
9 think, the problem we're trying to solve, which is to have  
10 a more adequate supply of primary care. And I am not  
11 absolutely resolved on my thought here, but I do think as a  
12 Commission we need to be careful because I remember last  
13 month, as we were making the recommendation about  
14 eliminating "incident to," we were reminded the Commission  
15 has held Medicare should pay similar rates for similar  
16 care. And I think we left that sort of hanging. And then  
17 I think the question was raised today: What about nurse  
18 practitioners? And yet the statement is, nevertheless,  
19 it's important to maintain an adequate supply of primary  
20 care physicians to ensure beneficiaries have the choice of  
21 receiving primary care services from a physician.

22 So we're not -- we're teetering here on a bit of

1 an issue that we could slide into unknowingly, or not, and  
2 then kind of get caught, you know, but what is our position  
3 on the role of the nurse practitioner or PA in filling this  
4 void and providing primary care? Because there's parts of  
5 the country -- I live in one -- where nurse practitioners  
6 play a key role in the face of primary care.

7 DR. CROSSON: Yeah, go ahead.

8 DR. PERLIN: As someone who came out of VA  
9 experience where it's very much team-based care and  
10 practiced at the highest level of skills, I absolutely  
11 agree in principle. The challenge right now is that, to my  
12 understanding, there's a pretty substantial surplus of  
13 nurse practitioners at the moment, and many are actually  
14 underemployed. My own institution, you know, a substantial  
15 number are working in RN roles because they've not been  
16 able to.

17 So, on contrast, I think both are eminently  
18 capable and patients should have the choice. I think there  
19 is a deficit that's reported and a surplus that's reported,  
20 and that may be the distinction I'd just draw.

21 DR. CROSSON: Let me just add to that. I think  
22 if there's a principle buried in there, it's somewhere in

1 that sentence, and it's kind of like, well, we don't want  
2 the Medicare payment program that applies to physicians to  
3 be a mechanism that so depletes the supply of primary care  
4 physicians in the country that Medicare beneficiaries, no  
5 matter where they live, who want to see a physician for  
6 primary care services cannot because there aren't any. And  
7 that's to say nothing -- I mean, that's completely  
8 consistent with robust support for the role of nurse  
9 practitioners, who are, in fact, probably keeping us going  
10 right now, as you say. Is that helpful? Do you think  
11 we're still teetering on the edge of heresy?

12 MS. THOMPSON: Maybe it's just me, but I feel  
13 like we're teetering a bit on that. But it may just be me.

14 DR. CROSSON: Okay.

15 MS. BUTO: And I thought we made -- somebody made  
16 the point last time that nurse practitioners increasingly  
17 are specializing. They're not going into primary care. So  
18 we obviously have to keep our eye on that. Even if there  
19 is an oversupply, we don't want to disincen nurse  
20 practitioners from pursuing primary --

21 DR. CROSSON: Right, so that's another issue, a  
22 tangential issue, but it's still -- I still think, you

1 know, the Medicare program pays physicians. The Medicare  
2 program has developed over time a way of paying physicians.  
3 We have evidence that, over time, unlike what Bill Hsiao  
4 and the others who developed the RBRVS program initially  
5 intended, it was intended to -- if you read the work at  
6 that time, it was intended as a payment system which would  
7 have the net effect of increasing availability of primary  
8 care physicians for Medicare beneficiaries. And the  
9 evidence is that it did just the -- it and other elements  
10 of -- thank you, Karen -- other elements inherent in the  
11 practice of primary care, which has become much more  
12 arduous and complicated over time, those --

13 MS. THOMPSON: And, again, I'm not completely  
14 resolved on this question.

15 DR. CROSSON: Okay.

16 MS. THOMPSON: I just think we need to spend more  
17 time thinking about it.

18 DR. CROSSON: Okay. All right. Sorry.

19 MS. THOMPSON: That would be my -- and, secondly,  
20 in order to think more about it, I do believe we need to be  
21 watching quality scores as it relates to the work of nurse  
22 practitioners and PAs versus MDs, DOs doing the same work.

1 DR. CROSSON: I agree. Okay. Jonathan? Jon?  
2 Paul?

3 DR. PAUL GINSBURG: [off microphone] something  
4 you said, because there is evidence that the Medicare fee  
5 schedule caused a major shift in money that went to primary  
6 care and away from procedural specialties. It's just that  
7 it didn't law.

8 DR. CROSSON: Oh, okay. All right. So net-net,  
9 over time --

10 DR. PAUL GINSBURG: Over time.

11 DR. CROSSON: But -- okay.

12 [Comment off microphone.]

13 [Laughter.]

14 DR. CROSSON: Sorry. Were you on the work group?  
15 Oh, you both were? Okay.

16 MS. BUTO: PPRC.

17 DR. PAUL GINSBURG: PPRC developed -- made the  
18 recommendations to do that.

19 DR. CROSSON: Okay. I'll extract my feet from  
20 whatever they're currently --

21 [Laughter.]

22 DR. CROSSON: Jonathan.

1 DR. JAFFERY: So I agree with that stream. I  
2 wouldn't want to lose the long-term goal of trying to  
3 decrease the disparities in payments between primary care  
4 and specialists. But I think, you know, Pat, you brought  
5 up this idea of getting at the behavioral economics of  
6 this, and I think there's a real opportunity there or a  
7 need. I'm not sure that status is necessarily the thing,  
8 but, I mean, the preponderance of stuff that we've talked  
9 about today seems to suggest that maybe the financial piece  
10 isn't the most important. And even Jay's example of  
11 success was maybe less about people choosing to do primary  
12 care and geography and convince somebody to live somewhere.  
13 But they were doing what they wanted to do.

14 And so, you know, going back to some things that  
15 Karen said a few times today already, understanding what  
16 makes it appealing to be a primary care physician for  
17 people, and there may be a number of things that are less  
18 tangible than making more money, and being able to get  
19 support for team-based care and relieving the burden of  
20 documentation and being able to associate -- tie in your  
21 work with social determinants of health. You know, I think  
22 getting -- the behavioral economics piece is getting at

1 that and understanding what are those drivers, and then we  
2 can think about how do we invest in them. And then in  
3 terms of these pipelines, understanding where are the most  
4 important pipelines. Is it med school? Is it residency?  
5 Is it both? I actually started residency in a primary care  
6 track, and so, you know, things changed in that place, too.  
7 And that was not between first and third year of medical  
8 school.

9           The GME point is a great one, I think, to think  
10 about how do we direct whether it's primary care overall,  
11 whether it's geriatrics, and I wouldn't want to lose the  
12 palliative care piece that Jon brought up initially either.

13           You know, we give all of the money -- GME money  
14 goes to hospitals, so we shouldn't really be shocked that  
15 people come out wanting to do things that happen in  
16 hospitals. So maybe we can -- maybe that scenario with the  
17 pilot program where we actually start to do more in the  
18 communities, and actually -- I mean, there have been some  
19 small things through HRSA, I think, already that we could  
20 maybe even build on.

21           DR. CROSSON: Okay. I think we've got Karen, and  
22 that's it. Right? Karen.

1 DR. DeSALVO: So to this point about the many  
2 opportunities that CMS might have to improve access to  
3 primary care physicians, just being focused on that, over  
4 time I would like to see us look at all the potential  
5 options -- and some of them have been raised, so I'll  
6 underscore some of it -- is about payment, which not only  
7 influences or affects salary but also a practice's ability  
8 to have a team and infrastructure to be supportive of the  
9 beneficiaries.

10 The second would be around training, so some  
11 significant opportunities, I think, in graduate medical  
12 education funding. And then also an opportunity around the  
13 encouragement component for folks who might engage in a  
14 scholarship or loan repayment program, so encouraging them  
15 to be a part -- requiring them to be a part of an  
16 alternative payment model, whether that's a medical home of  
17 some version or something broader like an ACO, and to, I  
18 think reduce some barriers, I think this is a great idea  
19 Kathy has about lifting some of the regulatory barriers.

20 So specifically on a couple of your points, on  
21 this second one in particular, rather than think about the  
22 primary care visits have to be 60 percent of the revenue

1 from Medicare, that smells to me a little bit like fee-for-  
2 service. And you could generate a lot of revenue without  
3 necessarily a lot of good outcomes. So one other way to  
4 think about it is either a population management, so the  
5 number of beneficiaries and/or, again, to require that  
6 folks are, you know, as a condition involved in alternative  
7 payment models going forward.

8 I do want to swap out pediatrics for palliative  
9 care in the thinking, though I wouldn't only make it  
10 geriatrics and palliative care, though I appreciate the  
11 concept, only just because of the pipeline issue. I think  
12 that if we really wanted to see access to care improve  
13 significantly, we couldn't only do it on the backs of  
14 geriatrics and palliative care. And they probably wouldn't  
15 want to because geriatricians do an extra fellowship to  
16 take care of a certain subset of seniors, and so I think  
17 perhaps thinking more broadly.

18 Just a suggestion and then a final point. The  
19 suggestion is that when you do your visits, in addition  
20 medical school, undergraduate medical education that  
21 focuses on primary care there, I think it's implied, but I  
22 want to be clear for you that the residency programs, the

1 schools that specialize in residency programs, that's a  
2 really important decisionmaking time.

3           And my final point then is about where the money  
4 should flow. Let's see. I'm obviously supportive of the  
5 concept of providing an added support to individuals that  
6 want to do primary care, whether that's scholarship or loan  
7 repayment, and we should explore it, not necessarily create  
8 a program but make sure the ones in existence work and/or  
9 fund them more or encourage people to go work in certain  
10 geographies or certain practices. So there's that  
11 component to it.

12           But I also think it's but one of many  
13 opportunities we have to make improvements using the  
14 Medicare program, but the institutional piece that I would  
15 be concerned about is it doesn't necessarily directly touch  
16 the individual. So they might want to do primary care, but  
17 if they're going to on balance make less money  
18 longitudinally or have a more difficult work environment,  
19 et cetera, why does it -- why would we want to not offer  
20 them a scholarship? I was using Harvard as an example.  
21 People are going to go to Harvard probably if they get a  
22 scholarship or not, but you kind of want to encourage the

1 best of the best, so you give them a scholarship, right?  
2 So I would sort of see this in that same vein. Even if  
3 you're going to do primary care, I'm not sure it really  
4 hurts.

5 But the institution piece is this. There are  
6 probably legislatures around the country that could tell  
7 you that they created medical schools to create primary  
8 care physicians, and it didn't really work out the way they  
9 thought, and they put the money in institutions. So maybe  
10 learn a little more about where that has already been tried  
11 and think about whether that's been successful or not.

12 Thanks.

13 DR. CROSSON: Okay. Jon, on that point. And  
14 then Marge and then we have to stop.

15 DR. CHRISTIANSON: I just wanted to say that it  
16 doesn't have to be either/or. You could have specialized  
17 programs targeted at geriatricians, palliative care. At  
18 the same time you could be pursuing thinking about a  
19 general primary care loan forgiveness program.

20 DR. DeSALVO: Yeah.

21 DR. CROSSON: Marge, close it out.

22 MS. MARJORIE GINSBURG: Yeah, I just wanted to

1 support the comment I think, Pat, that you made earlier,  
2 reluctance to put any additional money in at this time or  
3 urge any additional money for this purpose.

4 I also question whether we should be using our  
5 phenomenal influence with Congress right now to work in  
6 that arena, but instead to do much more about learning from  
7 the medical schools, from the residency programs, how do we  
8 create more primary care docs, what's working to increase  
9 that, and use that as our basic premise for how we move  
10 forward next. It's really a -- it's perhaps even a  
11 doctoral paper from somebody in your shop, Ariel. But I  
12 think that's the missing piece right now. We really don't  
13 know all the pieces of what encourages doctors to go into  
14 primary care and stay in primary care.

15 DR. CROSSON: Okay. This has really been a good  
16 session. As I said earlier, Ariel did a very good job  
17 building us a base that we could work off of. We've got a  
18 lot of ideas. They're not all the same ideas. But each  
19 one of them I think has merit, and so, Ariel, your job,  
20 should you choose to accept it --

21 MR. WINTER: Do I have a choice?

22 PARTICIPANT: No.

1 [Laughter.]

2 DR. CROSSON: -- will be to take this and begin  
3 to build on it, and I think you are already intending to go  
4 out into the field and try to, you know, actually get some  
5 information from people who would execute on whatever ideas  
6 we come up with. And I think that's going to be very  
7 valuable to us the next time we take this up. So thanks  
8 very much.

9 Kathy?

10 MS. BUTO: Just a very quick point. This may not  
11 lend itself to a June chapter. Maybe we could tee it up?  
12 I guess what I'm hearing, I've heard so much today that I'm  
13 thinking there's no reason why we couldn't take more time,  
14 right?

15 DR. CROSSON: Oh, no. Let me go back to what I  
16 said in the beginning of the session, the question, anyway,  
17 I put to Ariel, because I think we are going to have a June  
18 chapter. But I think, you know, based on this discussion,  
19 it will not include the solution. It will include the  
20 analysis, the excellent work that has been done to analyze  
21 the problem and perhaps describe the current state of  
22 affairs. You could also potentially, you know -- I'm not

1 telling you how to write it, but potentially set up in the  
2 chapter the fact that this additional work is going to go  
3 and maybe a little bit about some areas that we're going to  
4 explore. Does that make sense, people?

5 Okay. Thanks very much, Ariel.

6 [Pause.]

7 DR. CROSSON: Okay. Let's move forward here. I  
8 think we are at the end of the day, and Kate's going to  
9 take us through our final look at the mandated report on  
10 clinician payment. This is, as you may remember, a request  
11 that we look at least some provisions of MACRA as it might  
12 affect physician income to date or physician income going  
13 forward. And I think we're about ready to complete this  
14 work, so, Kate, take us galloping through your  
15 presentation.

16 MS. BLONJARZ: The last session today, as Jay  
17 mentioned, returns to a mandated report on Medicare  
18 clinician payment that I last talked about in September.

19 So today I'll cover the mandate, give an overview  
20 on Medicare payment for clinician services, consider some  
21 longer-term trends in payment adequacy indicators, and give  
22 an early look at a new analysis showing how shifts in the

1 site of service affect fee schedule volume and spending.  
2 And I want to thank Kevin Hayes and Brian O'Donnell and  
3 Emma Achola for their help with the work.

4 I'm looking for your feedback on the draft  
5 chapter as we finalize it in our June report to the  
6 Congress.

7 So as part of the Medicare Access and CHIP  
8 Reauthorization Act of 2015, the Congress asked MedPAC to  
9 consider the effect of the statutory updates between 2015  
10 and 2019 in four areas -- efficiency and economy of care,  
11 supply, access, and quality -- and asks us to consider any  
12 future updates necessary to ensure beneficiary access.

13 Because I don't have data for the entire time  
14 frame, I also report some of the measures over the past  
15 decade when the statutory updates were generally consistent  
16 to those between 2015 and 2019.

17 This slide has background on Medicare's payment  
18 system. The program pays for clinician services in all  
19 settings using a fee schedule of more than 7,000 codes.  
20 CMS updates the payment amounts each year and applies any  
21 yearly update to the fee schedule conversion factor.

22 The fee schedule updates over the past decade

1 have generally been in the range of no update to 1 percent  
2 per year. Under current law, there is no statutory update  
3 between 2020 and 2025, but there is an incentive payment.

4 Payment rates for each service can also vary by a  
5 number of other factors -- geography, clinician type, and  
6 setting.

7 When I covered the mandate in the fall, I  
8 reviewed our payment adequacy framework and what our  
9 measures looked like over a longer time frame than I  
10 usually do in our yearly update. All that detail is  
11 covered in this mailing materials and summarized here.

12 In general, we find that access to clinician  
13 services for Medicare beneficiaries has been stable and as  
14 good as or slightly better than access for individuals with  
15 private insurance.

16 The number of clinicians billing fee-for-service  
17 Medicare grew, led by significant growth in NP and PA  
18 billing. Volume growth varied over time and by type of  
19 service. And quality is indeterminate.

20 Medicare's payments for clinician services were  
21 about 75 percent of private PPO rates, and that's a slight  
22 decline over the past five years.

1 Overall, our payment adequacy indicators have  
2 been notably stable in the context of updates of between 0  
3 and 1 percent each year. and we'll continue to monitor the  
4 indicators in the future.

5 When we see concerning trends in these payment  
6 adequacy indicators, we consider whether Medicare payment  
7 is implicated, if a change to the overall payment rate is  
8 necessary, or if other Medicare policy changes are called  
9 for.

10 There are three examples on the slide of the last  
11 one. As Ariel just covered, income differences by  
12 specialty has motivated some of our work on ensuring an  
13 adequate supply of primary care services. Due to growth in  
14 advanced imaging, MedPAC made recommendations for changing  
15 the payment rates for some of those services. And due to  
16 shifts that we perceived in the site of service from low-  
17 cost to high-cost settings, MedPAC made recommendations in  
18 2012 and 2014 to set site-neutral payment rates for certain  
19 services.

20 One thing I wanted to do as part of the mandate  
21 is to give a little color to some of the indicators, and so  
22 we did a deeper dive on volume trends in the context of

1 site-of-service shifts.

2 Services may shift across settings due to changes  
3 in safety profiles, clinical practice, or payment  
4 differences.

5 Our measure of volume captures both units of  
6 service and intensity, as measured as RVUs. And when  
7 services shift settings, these RVUs can change. So fee  
8 schedule spending and volume growth is sensitive to site-  
9 of-service shifts.

10 In our March reports, we have generally given a  
11 few selected examples of services we see shifting. This is  
12 the next step, a more comprehensive analysis of how site-  
13 of-service shifts affect volume and spending.

14 This slide shows the illustration of an  
15 evaluation and management visit provided in the office or  
16 outpatient, shifting from the physician office to an on-  
17 campus hospital outpatient department.

18 When the service is provided in the physician  
19 office, on the left, the total RVUs for the service are  
20 just over 2. When the service is provided in the hospital  
21 outpatient department, the total RVUs drop to 1.45. That's  
22 because the fee schedule practice expense declines and

1 there's an additional payment through the OPSS.

2 But just from the fee schedule perspective, it  
3 looks like the RVUs decline by about 0.5 when the service  
4 shifts from the physician office to the outpatient  
5 department. It looks like these RVUs disappear.

6 So if there is a trend in services shifting from  
7 the physician office to the OPD, this dynamic will  
8 artificially dampen volume growth, because recall that our  
9 measure of volume incorporates RVUs to capture intensity.

10 This table has our preliminary findings of fee  
11 schedule volume growth if we held the share of services  
12 provided in each setting constant over time. The first  
13 column is our traditional measure of volume growth, and the  
14 second column holds site of service constant over the  
15 entire time period. Another way to say it is that this is  
16 what volume growth would have been if the services had not  
17 shifted across settings.

18 Overall, volume growth would have been almost 40  
19 percent higher -- 1.5 percent per year instead of 1.1 per  
20 year.

21 Imaging and tests would have grown at rates of  
22 1.2 and 1.0 percent per year, respectively, instead of

1 generally flat growth for the unadjusted numbers.

2           You might note here that it appears that major  
3 procedures are shifting from the OPD back to the physician  
4 office because volume growth is higher for the unadjusted  
5 numbers. But what's actually happening is that there's a  
6 sharp decline in hospital-based cardiovascular procedures  
7 and a concurrent increase in physician office vascular  
8 procedures.

9           The last two slides covered RVUs and volume, but  
10 there's an associated effect on spending. So the services  
11 shifting from the physician offices to the OPD results in a  
12 decline in RVUs, and this causes fee schedule spending to  
13 decline. But total Medicare spending is significantly  
14 higher. That's because there's an additional payment  
15 through the outpatient prospective payment system, and  
16 that's the bar on the top right. For this E&M service,  
17 when it is provided in the physician office, Medicare pays  
18 \$74.24. When it's provided in the OPD, Medicare's pays  
19 \$168.11. So two things are happening. Fee schedule  
20 spending declines, and total Medicare spending goes up.

21           What this means for the volume analysis is that  
22 as services shift from one setting to another, it will

1 affect fee schedule volume, fee schedule spending, and  
2 total Medicare spending. And it can happen via changes to  
3 the number of RVUs for the service and also the units of  
4 services, which I didn't cover today but is in your mailing  
5 materials.

6           These changes have downstream effects on our  
7 measures of fee schedule volume and spending, and we plan  
8 to continue this work over the coming year and may  
9 incorporate some of it into the yearly payment adequacy  
10 assessment.

11           To go back to the mandate, over the time period  
12 that we reviewed, Medicare's yearly payment rates have been  
13 in the range of 0 to 1 percent. During this time frame,  
14 the payment adequacy indicators were mostly stable. Access  
15 to care was steady. Volume growth varied and can be  
16 sensitive to the site of service; quality is indeterminate;  
17 and Medicare's payment rates relative to private payment  
18 rates fell slightly because private payer growth outpaced  
19 Medicare's payment rates.

20           But despite this divergence in Medicare and  
21 private prices, it has not led to a divergence in reported  
22 access. In fact, Medicare still continues to be slightly

1 better on some measures.

2 I should note here that in the fall, Paul, you  
3 raised the idea that Medicare's low payment updates for  
4 clinician services might be a factor in the migration of  
5 services to the generally higher-paid hospital outpatient  
6 department. But there are other reasons those services may  
7 shift as well.

8 The mandate asks us to weigh in on any necessary  
9 future updates for clinician services needed to ensure  
10 access, and we believe we can best do so by considering the  
11 most up-to-date information each year through the payment  
12 adequacy assessment. And we just completed our 2019  
13 payment adequacy assessment, finding generally consistent  
14 trends with what I just presented and making a  
15 recommendation for current law -- which is no update -- for  
16 2020.

17 So this material will be finalized in a chapter  
18 in the June report to the Congress to meet our mandate  
19 deadline, and I welcome any suggested edits to the mailing  
20 materials.

21 I am happy to take comments and questions, and I  
22 look forward to your discussion.

1 DR. CROSSON: Thank you, Kate. Very clear.

2 Questions for Kate? Pat.

3 MS. WANG: Kate, can you just help me understand  
4 something? I just want to make sure I understand Slides 9  
5 and 10. Is this saying that if services had not shifted  
6 from the physician office to the hospital setting, they  
7 would still have increased in volume? I mean, holding the  
8 site of service constant, because there was some masking  
9 with RVUs, I mean, what is this Table 9 telling us?

10 MS. BLONJARZ: So what this is trying to convey  
11 is we have always reported kind of physician volume,  
12 clinician volume as kind of one measure of access and, you  
13 know, a potential indicator of mispricing. But there's a  
14 problem where when services are provided in the hospital  
15 outpatient department, from the physician side part of the  
16 action is missing, and we just can't see it. So when  
17 services shift from one setting to another, it looks like  
18 it goes from, you know, a high RVU service to a low RVU  
19 service. But that's because there's all this other action  
20 over there that, because Medicare pays in silos, you know,  
21 I can't see it very well.

22 So what we were trying to do is say let's say

1 that shift didn't happen and everything was kind of static  
2 over time, what would volume growth actually look like?

3 MS. WANG: Right, okay.

4 MS. BLONJARZ: And it would have been higher than  
5 what we have been able to calculate and report.

6 MS. WANG: So then on Slide 10, which talks about  
7 the effect on spending, this is a combination of the higher  
8 sort of per service payment in a hospital OPD and the  
9 growth in volume. Is that correct?

10 MS. BLONJARZ: This is just for one service.  
11 This is only one service.

12 MS. WANG: Oh, okay. I'm sorry

13 MS. BLONJARZ: Yeah, and so the takeaway here is  
14 kind of that it appears the physician spending declined,  
15 and then total spending went up, and it's because, you  
16 know, part of the physician payment is kind of going away,  
17 and then there's this additional OPD payment.

18 MS. WANG: Okay. But there is sort of a net of  
19 the cost of the shift which takes out of the equation that  
20 volume has also increased. I see this price differential  
21 is -- it's a lot, but in total spending for these services,  
22 it's a combination of increases in volume as well as

1 increasing in price?

2 MS. BLONJARZ: Yes, and so one thing we did, when  
3 we did the work to put this table together, is we kind of  
4 accounted for the trend in volume for all of the services,  
5 you know, because we wanted to say, okay, if a service was  
6 being provided a great deal more over this time frame, we  
7 wanted to account for that. The only thing we were holding  
8 constant was where the service was provided.

9 MS. WANG: Thank you.

10 DR. CROSSON: Questions? Jaewon.

11 DR. RYU: I just want to make sure I'm  
12 understanding the shift dynamic correctly. If you go to  
13 Slide 8 and I think it shows up again on Slide 10, the  
14 practice expense component of the RVU calculation is what  
15 goes away when you go from an office visit to a hospital  
16 outpatient setting.

17 MS. BLONJARZ: It's part of the practice expense  
18 component. The idea is --

19 DR. RYU: I got it. But can you give some  
20 examples of what that would be? Because the expense  
21 clearly doesn't go away. It's just now bucketed under  
22 hospital outpatient. Is that right?

1 MS. BLONIARZ: Right [off microphone].

2 DR. RYU: So what would some of those things be?

3 MS. BLONIARZ: I believe that indirect practice  
4 expense -- Kevin?

5 MR. HAYES: Stays [off microphone].

6 MS. BLONIARZ: Stays -- indirect practice expense  
7 is paid through the physician fee schedule no matter where  
8 it occurs. But like OPD, the OPD payment could be rent and  
9 overhead -- is that right?

10 MR. HAYES: Supplies [off microphone].

11 MS. BLONIARZ: Supplies.

12 DR. CROSSON: Okay. Bruce.

13 MR. PYENSON: Thank you very much, Kate. Just a  
14 question in the calculation. Would you get the same  
15 results if you just looked at the work component over time?

16 MS. BLONIARZ: Sure. But let me make another  
17 distinction. One reason that -- when Kevin put kind of the  
18 work together to do the volume analysis about a decade to  
19 15 years ago, you know, he wanted to account for intensity  
20 as well, right? And so what you might lose if you only did  
21 the work piece is if someone is -- if a higher PE service  
22 is substituting for a lower PE service, so like a service

1 is going from an X-ray to a CT scan, you might not pick  
2 that -- you might kind of be netting that out of the story  
3 if you only did the work thing. But I think it's a similar  
4 idea. It's kind of trying to get at the same answer.

5 MR. PYENSON: So thinking about how we use these  
6 numbers, you know, we say something like here's how much  
7 spending is going up in effect, and we perhaps think about  
8 that compared to inflation or other metrics. So I'm  
9 struggling to think of what's the right way -- I mean, the  
10 work component is kind of the -- think of that as what the  
11 physician keeps, kind of, you know, benefits and things of  
12 that sort. So help me think that through.

13 MS. BLONIARZ: Let me try, and you can tell me  
14 whether this is what you're thinking. You know, one story  
15 that we hear is, you know, volume growth really slowed  
16 down, right, in the physician fee schedule services. I  
17 think here it slowed down some, but not as much as it might  
18 appear, right? So that's kind of one takeaway.

19 I think there's a similar story with spending,  
20 which is, you know, physician spending has been relatively  
21 flat, but, you know, what's actually been happening is  
22 those services are just kind of being paid through another

1 payment system, and because of how packaging occurs in the  
2 OPD, I can't always pull it out and kind of give you, you  
3 know, a real number.

4 I do think it implicates how you might want to  
5 think about pricing, updating, and setting rates for  
6 services that are, you know, primarily work or, you know,  
7 mostly work versus services like some advanced imaging  
8 which are almost entirely practice expense. You know,  
9 those might be a little more like a commodity than a  
10 physician service.

11 MR. PYENSON: That's very helpful. Thank you.

12 Another approach might be to pull in the, you  
13 know, OPPS into that. That's different streams. But I'm  
14 wondering what that would be useful for.

15 MS. BLONIARZ: And that's definitely something we  
16 want to do. We've had to kind of just be a little smart  
17 about how we identify the site-of-service shifts that shows  
18 up at least three and we think probably four or five  
19 different ways in the fee schedule. And so once we have  
20 done that for RVUs, then we'd love to do it for spending  
21 and say, well, what is the net effect of all of this, you  
22 know, services shifting across settings?

1 DR. CROSSON: Okay. Let's proceed with the  
2 discussion. Kate has asked for input into the report as it  
3 exists in its semifinal version. Input for Kate in terms  
4 of the report before it's finalized? Bruce and then  
5 Jonathan.

6 MR. PYENSON: This is a really great report.  
7 Thank you very much. The only recommendation I would have  
8 is I would welcome at least a little more detail on the  
9 other two examples, maybe not the full-blown analysis that  
10 you did for E&M, but chemotherapy administration, you know,  
11 sort of -- I think that would show the whole physician  
12 piece going away for the administration and the CT. So I'd  
13 welcome those examples, at least at a high level.

14 DR. CROSSON: Jonathan.

15 DR. JAFFERY: Thanks, Kate. This is a great  
16 report. I think I've got much more clarity around sort of  
17 the mechanics of how payments are different in the two  
18 sites and actually how the whole volume issue gets  
19 perturbed in a different way. It's actually a little more  
20 complicated than I realized, which I think I could say  
21 about pretty much everything we talk about.

22 And I would echo, I think that would be helpful,

1 Bruce's suggestion would be helpful. I think, you know,  
2 not for this mandate or this report, but, you know, as we  
3 talk about these things on an ongoing basis, I think sort  
4 of to echo some of the things we talked about earlier  
5 today, you know, if we look at the updates, currently, the  
6 current state is that there are updates for multiple years  
7 in this sector, which is different than the other ones.  
8 And so, you know, I think that we should think about taking  
9 an opportunity to maybe suggest things that could move the  
10 program in a way that aligns with some of our other goals  
11 around maybe adjusting payments in a different way than  
12 they currently are for the differentials between advanced  
13 alternative payment models and not, for example -- which  
14 wouldn't sort of relieve us of our obligation on an annual  
15 basis to make sure that they're still adequate, just like  
16 we have now even another set for the foreseeable future.

17 DR. CROSSON: Sue.

18 MS. THOMPSON: A quick comment, Kate. As I read  
19 the chapter, you spent some time talking about the survey  
20 and about the fact that response rates are going down, and  
21 overall in general across the country, response rates are  
22 going down. And I was left wondering, do you still have

1 confidence? And while you resolve it by saying going  
2 forward we will continue to monitor, make sure it  
3 reconciles with other surveys, but I'm assuming other  
4 surveys are seeing corresponding reduction. So there's  
5 just a piece there that I was left feeling less than  
6 convinced you were convinced. So that would just be a  
7 comment I would make as you reread, to maybe strengthen  
8 your confidence in what we're looking at, if that makes  
9 sense.

10 DR. CROSSON: Brian and then Paul.

11 DR. DeBUSK: First of all, I really enjoyed  
12 reading the report. I think it clearly fulfilled the  
13 mandate that MACRA set forth, so congratulations. It looks  
14 great.

15 The one thing, to build on Bruce's point, it  
16 does, though, really underscore a vulnerability that we  
17 have in our analytics. I mean, I know I'm showing a firm  
18 grasp of the obvious, but here's my one part that I'd like  
19 to contribute. If I remember correctly, when we were doing  
20 the -- when we did the site-neutral adjustment, instead of  
21 just forcing the rate, didn't we do something like we took  
22 40 percent off of the OPPS rate and added -- in the

1 balanced budget amendment, the way we first did that, there  
2 was a treatment there where we basically brought the fee  
3 schedules -- we implemented site-neutral payment, but we  
4 did it by taking a percentage of the OPPS and adding the  
5 PFS back in, something like that.

6 MS. BLONJARZ: I think that's right. So there's  
7 kind of three actions that have happened on site-neutral:  
8 what MedPAC recommended, what the Congress enacted, and  
9 then CMS has taken additional administrative action. One  
10 of them involves 40 percent.

11 DR. DeBUSK: Well, the reason -- I wasn't asking  
12 it to put you on the spot. I was just thinking, for  
13 initial direction -- because I was going to feel really  
14 badly if I said, "Hey, great report, and oh, by the way,  
15 figure this analytics thing out so our numbers are  
16 consistent."

17 I was just thinking about something along those  
18 lines. You guys may be able to come up with an adjustment  
19 on the OPPS side in aggregate that would allow us to  
20 normalize and see through the difference in site-of-service  
21 shifts, so that when we do look at trends over, say, the  
22 last decade, we can see through them because we've got a

1 normalization factor that's being applied to the OPPS  
2 component.

3 I know I botched that, but I think you understand  
4 what I'm saying.

5 MS. BLONIARZ: I totally understand the point,  
6 yeah.

7 DR. DeBUSK: Okay. Thank you.

8 DR. CROSSON: Paul?

9 DR. PAUL GINSBURG: My thing is editorial, and I  
10 can give it straight to Kate.

11 DR. CROSSON: Okay. Then Kathy and David.

12 MS. BUTO: My point is just that in listening to  
13 Kate, you know, the relationship between the site-of-  
14 service issue and the adequacy of clinician payment became  
15 a lot clearer to me. I was trying to understand that  
16 issue. And I would encourage you -- I went back and looked  
17 at the conclusion again -- to really highlight the fact  
18 that although the mandated report is supposed to address  
19 adequacy of clinician payment, it really -- in order to  
20 fully understand the adequacy, you've got to look at in  
21 this case the site-of-service shift to understand the full  
22 payment for sort of the underlying practice expenses. I'd

1 just be really explicit about that because I'm not sure  
2 that it comes through all that crisply the way you just  
3 described it. And I think that would help them understand  
4 why we think, you know, in a sense there's more than enough  
5 payment here.

6 DR. CROSSON: David and then Jon.

7 DR. GRABOWSKI: Great. I wanted to pick up on  
8 Sue's comment about the response rates. I also found that  
9 concerning, and this isn't headed in the right direction.  
10 I think that's pretty obvious. This is more of a big-  
11 picture comment or maybe sort of an idea for down the road.  
12 One approach that we've taken, obviously, is to survey  
13 beneficiaries about their access. There's a different  
14 style of study which is called an "audit study," where you  
15 actually call up physicians and ask about, you know, how  
16 long would it take me to get an American people, obviously  
17 with the vignette that I'm a Medicare patient or I'm a  
18 commercial patient. And that's a different strategy. It  
19 doesn't get at all the kind of questions that you have  
20 here, but that could be an alternate strategy down the  
21 road, and we can't get beneficiaries to pick up the phone.  
22 So an idea.

1 DR. CROSSON: Jon.

2 DR. PERLIN: Yeah, just to follow up on two  
3 things. One, the comment on the survey, you may recall  
4 earlier I made the recommendation that we should also  
5 survey on the physician side on how they divide their time.  
6 So if their practice is open, you know, are they blocking  
7 time for patients that are other than Medicare?

8 The larger issue is that I want to tie this  
9 together with our last discussion. In the last discussion,  
10 we were talking about the incentives or disincentives to go  
11 into primary care, and I couldn't agree more that the two-  
12 factor theory of motivation that there are things that are  
13 gratifying and there are social cues. There's another  
14 piece that is financial. And in that latter part, in terms  
15 of this, how are we thinking about the differences in terms  
16 of how the reimbursement actually gets to the providers?

17 So in the practice, at least traditionally, the  
18 physicians have either been self-employed or part of a  
19 practice; whereas, as the shift goes to hospital-based  
20 outpatient units, they may actually work for the hospital,  
21 and there may be less direct relationship between what  
22 Medicare is paying and how the physician is compensated,

1 which is more likely to be either through a hospital or  
2 perhaps a very large physician staffing group.

3 I'm just wondering how we deal with that in terms  
4 of thinking about how the incentives ultimately affect the  
5 physician choices in primary care and the ultimate ability  
6 to obtain access.

7 MS. BLONIARZ: So I would say, you know, about  
8 ten years ago we did look at physician compensation, and  
9 even at that point, I think we were a little surprised by  
10 how RVU-dependent it still was, despite, you know, interest  
11 in that time in salaries and other forms of compensation.

12 I think that as the physician sector has -- you  
13 know, now it's a greater share of physicians are owned or  
14 have some financial arrangement with the hospital or health  
15 system. I think that that might be a little less true, but  
16 I think we also, you know, in some of our focus groups and  
17 site visits, are still surprised at how much is RVU-based  
18 versus -- or it's a salary plus productivity, which is  
19 RVUs, even though the structure may be, you know,  
20 employment or a joint venture or something like that.

21 DR. PERLIN: I hear you and agree with what you  
22 say. The mandate here is examining the relationship of

1 Medicare's payments to clinicians and the supply and  
2 quality of care. I think not in this report but further  
3 down the road, somewhere we're going to have to figure out  
4 how to contemplate this relationship given that the  
5 reimbursement has changed from being more direct to the  
6 physician or per practice versus the current, which is  
7 through some probably very large intermediary with  
8 probably, to be sure, productivity expectations. But, you  
9 know, I think this issue of primary care adequacy is going  
10 to be one that will challenge us.

11 Thanks.

12 DR. CROSSON: Okay. Thank you, Kate. You got  
13 some good input here. Thank you so much for doing this  
14 work.

15 We are finished with the work of the day. We now  
16 have an opportunity for public comment. If there's any one  
17 of our guests -- and thank you, the ones who stuck it out  
18 this long. If any of you would like to come up to the  
19 microphone and make a comment, now is the time to do that.

20 [Pause.]

21 DR. CROSSON: Okay. So we have one individual  
22 coming to the microphone. I'd ask you in a minute to

1 identify yourself and any organization or institution you  
2 are affiliated with. Please make your comments and limit  
3 them to two minutes. And when this light comes back on,  
4 the two minutes will have expired.

5 MS. EMMER: Very good. I'm Sue Emmer, and I'm  
6 representing the Council of Academic Family Medicine.

7 First of all, I want to thank you for your report  
8 on primary care and issues raised beyond loan repayment are  
9 very important to us. We're really interested in how best  
10 to use GME to promote primary care access and training.  
11 And in this regard, we really want to raise two issues.

12 The first is the issue of THCs, teaching health  
13 centers. That's not something that came up today, but it's  
14 a model that we think you should look at. It's not  
15 something that's paid for right now under Medicare, but it  
16 does allow for payment to institutions, which is something  
17 you talked about. So we think if you look at that and  
18 maybe -- the real problem in that right now is lack of  
19 funding. So if you could look at that as a model under  
20 Medicare, we think that would be a great solution.

21 And there's also the need to remove the  
22 disincentives within GME for training in rural areas. So

1 we think if we could look further into that, it would  
2 promote greater access in that area.

3 Thank you.

4 DR. CROSSON: Thank you for your comments.

5 Seeing no one else at the microphone, we are  
6 adjourned until 9 o'clock tomorrow morning.

7 [Whereupon, at 5:20 p.m., the meeting was  
8 recessed, to reconvene at 9:00 a.m. on Friday, March 8,  
9 2019.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 8, 2019  
9:00 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
KATHY BUTO, MPA  
BRIAN DeBUSK, PhD  
KAREN DeSALVO, MD, MPH, Msc  
MARJORIE GINSBURG, BSN, MPH  
PAUL GINSBURG, PhD  
DAVID GRABOWSKI, PhD  
JONATHAN JAFFERY, MD, MS, MMM  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
PAT WANG, JD

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P R O C E E D I N G S

[9:00 a.m.]

1  
2  
3 DR. CROSSON: Okay. Let's see if we can begin  
4 the morning session. Welcome, everybody. I'd like to  
5 welcome our guests. This is the Friday morning session.  
6 Today we're going to be focusing on post-acute care topics.

7 The first one will be a discussion about the  
8 potential to use episode-based payments in post-acute care,  
9 and Carol is here to do the presentation.

10 DR. CARTER: Good morning, everyone. Today we'll  
11 continue our discussion of a unified payment system for  
12 post-acute care, and our began on this in 2015 and resulted  
13 in a mandated report in the June report of 2016. Since  
14 then, we've taken up variety of issues that I'll review in  
15 a minute.

16 I'll present information today that you requested  
17 on a design for a prospective payment system that would  
18 establish payments for an episode of post-acute care, and I  
19 want to thank Brian O'Donnell for his help with these  
20 materials.

21 Just a reminder of the post-acute care landscape.  
22 Spending across the four settings -- that is, home health

1 care, skilled nursing facilities, inpatient rehab  
2 facilities, and long-term-care hospitals -- totaled almost  
3 \$60 billion in 2017. We and others have documented that  
4 similar patients are treated in the four settings, yet  
5 payments can differ substantially, in part because each  
6 setting uses its own payment system. And there is limited  
7 evidence to guide placement decisions, so it is not that  
8 surprising that Medicare spending per capita varies more  
9 for post-acute care than for any other Medicare service.

10 Further complicating the picture is that there  
11 are setting-specific assessments and outcome measures, so  
12 the patients treated and the outcomes of the care cannot be  
13 easily compared.

14 Finally, each year the Commission reports that  
15 fee-for-service payments for PAC are high relative to the  
16 cost of care, which distorts the benchmarks for MA and  
17 ACOs.

18 For those of you who were not here in 2016, we  
19 completed a mandated report on the recommended design  
20 features of a unified payment system for post-acute care.  
21 The unit of service was a stay, and we'll talk about that  
22 in a minute.

1           Payments would be based on the average cost of  
2 stays and would be adjusted using patient and stay  
3 characteristics such as a patient's age and their  
4 comorbidities. There would need to be a large adjustment  
5 for home health stays to reflect the setting's much lower  
6 costs. The design should include short-stay and high-cost  
7 outlier policies.

8           Based on our analysis of 8.9 million PAC stays in  
9 2013, the Commission concluded that a unified payment  
10 system design using administrative data was feasible and  
11 could accurately predict the cost of stays for most of the  
12 40 or so patient groups that we evaluated.

13           In terms of impacts, compared to current policy,  
14 payments under a stay-based PAC PPS would be redistributed  
15 considerably across patient conditions and decrease for  
16 patients who receive rehabilitation care that appears to be  
17 unrelated to their clinical characteristics. Payments  
18 would become more equitable across different patient  
19 conditions compared with current policy because the  
20 differences in profitability would be more uniform.

21           As a result, providers would have less financial  
22 incentive to prefer to treat certain types of patients and

1 avoid others. Payments would be redistributed across  
2 providers based on the mix of patients they treat. Because  
3 payments would decrease for high-cost providers that treat  
4 patients who are similar to those treated in lower-cost  
5 settings, the payments for them would decrease.

6           Since 2016, the Commission has discussed several  
7 other issues. To begin to pave the way for a unified  
8 payment system, the Secretary could begin to redistribute  
9 payments within each setting before a PAC PPS is  
10 implemented by blending PAC PPS payments with setting-  
11 specific payments. This would increase the equity of  
12 payments across different conditions by directing payments  
13 towards medically complex care.

14           This past fall, you discussed the need to align  
15 regulatory requirements across the different settings, and  
16 that information will be included in this year's June  
17 report.

18           To keep payments aligned with the cost of care,  
19 the Commission recommended that the aggregate level of  
20 payments be lowered by 5 percent when the PPS is  
21 implemented, and that revisions and rebasing would become  
22 part of the regular maintenance of the PPS. Last year, we

1 looked at payments for back-to-back, or sequential, PAC  
2 stays, and that discussion led to a request to examine  
3 episode-based design.

4           In our discussion of sequential PAC stays, we  
5 noted that a stay-based payment system does little to  
6 dampen fee-for-service incentives for volume or encourage  
7 providers to offer a continuum of care that would cut down  
8 on the transitions that some beneficiaries experience in  
9 the course of their treatment.

10           In contrast, an episode-based payment system  
11 would encourage providers to deliver an efficient mix of  
12 PAC and would also encourage institutional providers to  
13 offer a continuum of care. This would benefit  
14 beneficiaries by reducing the number of transitions that a  
15 patient may experience over their course of care. Such  
16 transitions are often disruptive for beneficiaries and put  
17 them at risk for poor handoffs.

18           Let's look at how a stay-based and an episode-  
19 based design differ.

20           All of our work to date on a unified PPS  
21 considered each PAC stay as an independent event, shown in  
22 the first row. If there are two back-to-back stays, such

1 as when an IRF patient is seen in an IRF and then  
2 transitions to a home health agency, there are two separate  
3 payments that are made.

4           Yet about a third of PAC stays are part of a  
5 sequence of care, where patients transition from one  
6 setting to another or extend their care, such as in back-  
7 to-back home health stays. In an episode-based design, a  
8 single payment would be made for the combination of stays  
9 that make up the episode of post-acute care. Note that the  
10 episodes that we'll be exploring include only post-acute  
11 care, and other services, such hospital or physician  
12 services, would not be included in the bundle.

13           To conduct this work, we used the same approach  
14 that we've used before, designing a payment system that  
15 would establish payments based on patient and stay  
16 characteristics. We started by updating the stay-based  
17 model using 2017 data to reflect more current costs and  
18 utilization.

19           Like the stay-based design, the episode design  
20 would include a home health adjuster given this setting's  
21 much lower costs, and, again, we used separate models to  
22 establish payments for routine and therapy care and non-

1 therapy ancillary services, such as drugs, because the  
2 benefits differ slightly across the settings. We kept  
3 payments budget-neutral to the current level of aggregate  
4 spending in 2017.

5 This time around, we changed the way we estimated  
6 routine costs to use readily available cost report and  
7 claims information. Thus, the design no longer relies on  
8 any data from CMS' post-acute-care demonstration. The  
9 stay-based designs are very consistent with what we've  
10 previously reported and are included in the paper.

11 Then we constructed episodes from individual PAC  
12 stays that are within seven days of each other. To  
13 evaluate the feasibility of an episode-based design, we  
14 focused on solo and pairs of stays that made up a little  
15 over two-thirds of PAC stays. The idea was if the results  
16 looked promising, we could expand our analysis to include  
17 episodes that span over a longer period of time, such as  
18 four or five sequential PAC stays.

19 We want the PPS to reflect differences in the  
20 cost to treat beneficiaries. I've listed on the slide the  
21 various factors we used to risk-adjust payments. It  
22 includes a patient's age and disability status, the primary

1 reason to treat, their comorbidities and risk score,  
2 medical complexity, cognitive status, and other  
3 disabilities such as difficulty swallowing. Note there are  
4 multiple factors aimed at capturing patient complexity  
5 without relying on functional assessment data. All of  
6 these factors use readily available information from claims  
7 and other administrative data.

8           An episode-based PAC PPS would establish accurate  
9 payments for most of the almost 40 patient groups we  
10 examined and would also increase the equity of payments  
11 across conditions. And you can see this on this slide by  
12 comparing the numbers in the columns.

13           Under current policy, seen on the left, payments  
14 are 12 percent higher than costs, and that's the payment-  
15 to-cost ratio up at the top. The ratios centered on 1.12,  
16 and you can see that the current ratios range from 1.01 to  
17 1.2, indicating why providers prefer to treat some patients  
18 over others.

19           In contrast, look to the right-hand column, you  
20 can see the overall average is the same, but the range in  
21 payment-to-cost ratios is much narrower. The episode-based  
22 approach would redistribute payments, again, from the types

1 of care that include rehabilitation therapy that's not  
2 predicted by patients' clinical characteristics and moves  
3 Medicare payments to episodes for medical complex care  
4 needs. With a much narrower range in profitability,  
5 providers would have less incentive to selectively admit  
6 certain types of patients and avoid others.

7           But the picture is a little more complicated.  
8 When we look at payments and costs for episodes of  
9 different lengths, even for just these episodes that  
10 included solos and pairs of stays, we see that there would  
11 be considerable over- and underpayment.

12           We grouped episodes into those that only include  
13 home health care, those that only include institutional  
14 care, and a mix into three lengths -- relatively short,  
15 medium, and long -- based on the distributions of lengths  
16 of stay or, in the case of home health care, the number of  
17 visits. Here I've shown the results for the episodes that  
18 include only home health care and only institutional PAC.  
19 But the mixed stays, episodes, are in the paper. On the  
20 left are ratio of payments to costs under current policy,  
21 and on the right are what payments would be under an  
22 episode-based PAC PPS.

1           Compared with current policy, the range in  
2 payment-to-cost ratios under an episode design would be  
3 much wider. This is because episode-based payments are  
4 based on the average costs across all episodes -- short,  
5 medium, and long -- whereas the current policy, multiple  
6 stays trigger separate payments for each stay.

7           In an episode-based design, payments for short  
8 episodes, those circled in green, would be more than double  
9 their cost. And, conversely, episodes that are long, those  
10 circled in yellow, payments would be about three-quarters  
11 of their cost, with payment-to-cost ratios of 0.72 and  
12 0.76.

13           One way to dampen the effects of an episode  
14 design would be to create a single outlier pool instead of  
15 separate pools for institutional and home health episodes.  
16 With a single pool, home health episodes would be much less  
17 likely to qualify for an outlier payment because of their  
18 lower costs, and costly long institutional PAC episodes  
19 would be more likely to qualify for an episode payment.

20           We compared outlier policies that include  
21 separate pools for home health and institutional PAC with a  
22 single, combined pool. With separate pools, fewer home

1 health episodes, even long ones, would qualify for outlier  
2 payments.

3           Conversely, the share of institutional PAC  
4 episodes qualifying for outlier payments, especially long  
5 ones, increases. Yet payments would remain out of  
6 alignment with the costs of the care. Short episodes would  
7 remain highly profitable, and long episodes would be  
8 unprofitable. So the takeaway here is that a single  
9 outlier pool helps but doesn't correct the problems that  
10 we're seeing with over- and underpayment associated with  
11 short and long stays.

12           So far our analysis has indicated that an  
13 episode-based payment design would create incentives for  
14 providers to furnish shorter episodes over longer ones.  
15 But the differences in the payment-to-cost ratios for long  
16 and short episodes reflect, to some extent, the differences  
17 in the patient characteristics. That is, the patients  
18 included in the "short" group are likely to be different  
19 from the patients included in the "long" group. And so  
20 this next analysis estimates the profitability of episodes  
21 of different lengths holding patient risk constant.

22           This table shows the average profit or loss for

1 the patient of average risk for episodes that include only  
2 home health or only institutional PAC.

3 In the first column, we see that the home health  
4 agency furnishing a short episode for the average risk  
5 patient would make about \$2,300, while furnishing a long  
6 episode would incur losses of about \$2,000.

7 In the second column, you see an institutional  
8 PAC provider furnishing a short episode would make about  
9 \$11,600, but long episodes would incur a loss of about the  
10 same magnitude.

11 If past industry behavior is any guide, the large  
12 differences in profitability could influence provider  
13 behavior. Providers would have strong financial incentives  
14 to keep episodes short. If current practices include  
15 unnecessarily long PAC stays, shorter PAC episodes may  
16 simply be more efficient PAC. But an episode-based design  
17 could result in premature discharges. Providers would also  
18 have a strong financial incentive to avoid patients who are  
19 likely to need extended care and to withhold costly care  
20 within the episode. The decision to transfer the patient  
21 or to extend care would be more complicated -- and we  
22 walked through an example in the paper -- but could be

1 driven by financial considerations rather than what's best  
2 for the beneficiary.

3           So let's review where we've been. The Commission  
4 explored a stay-based design and, given the incentives for  
5 unnecessary post-acute care, we examined an episode-based  
6 design. Both models could establish accurate payments for  
7 patients with different clinical conditions. However, an  
8 episode-based design would result in substantial  
9 overpayment for short stays and underpayments for long  
10 ones. This could increase PAC efficiency, but it also  
11 might lead to patient selection and stinting on care for  
12 beneficiaries who require post-acute care for longer  
13 periods of time.

14           While fee-for-service in general encourages  
15 volume, we think that the risk of unnecessary episodes may  
16 be lower than the risk of unnecessary stays. Under either  
17 design, the decision to initiate PAC is not controlled by  
18 the PAC provider, but the decision to extend care is more  
19 under a provider's control. In a stay-based design, this  
20 could generate additional volume; whereas, in an episode-  
21 based design, this would be less true.

22           Compared with an episode-based design, a stay-

1 based one may result in more handoffs mostly between  
2 institutional providers, and this may expose beneficiaries  
3 to the risk of poorly coordinated care.

4 Both designs would streamline the current four  
5 separate payment systems into one and could lower CMS'  
6 administrative costs, but a stay-based design would be  
7 easier for CMS to implement and to administer.

8 Over the past four years, the Commission has  
9 evaluated stay-based and now episode-based designs, and  
10 both designs would establish more accurate and equitable  
11 payments compared with current policy, but each has its  
12 strengths and weaknesses. A stay-based design would  
13 continue to encourage unnecessary PAC services and may  
14 result in more handoffs between providers, but it would be  
15 less likely to result in patient selection and stinting on  
16 services.

17 Conversely, an episode-based approach has  
18 features that are, in theory, attractive -- like increasing  
19 PAC efficiency and lowering the number of transitions  
20 between PAC providers. But we're concerned that an  
21 episode-based design could result in unintended adverse  
22 consequences such as patient selection, withholding of

1 care, or decisions about whether to transfer the patient or  
2 to extend care being based on financial considerations  
3 rather than what's best for the beneficiary.

4           So we plan to include this information in the  
5 June chapter, and we look forward to your comments and  
6 suggestions. And we're particularly interested in gauging  
7 your preference for a stay-based versus an episode-based  
8 design.

9           DR. CROSSON: Thank you, Carol. Very excellent  
10 analysis and clear presentation. So we're open for  
11 clarifying questions. Brian.

12           DR. DeBUSK: First of all, great chapter and  
13 great work. I really like the analytic rigor. But I had a  
14 quick question, and this is really for my own  
15 clarification.

16           In the stay-based design, we have the dichotomous  
17 variable that made the adjustment for the fact that really  
18 home health isn't an institutional-based -- I mean, to me  
19 it's no different than the physician fee schedule, how you  
20 adjust for facility-based versus non-facility-based care.

21           When you went to the episode model, if I  
22 understand it correctly, instead of using the dichotomous

1 variable, what you really did was two adjusters -- one that  
2 would adjust to your taking it down if it's home health  
3 only, and then you were trying to do a blended -- like a  
4 dichotomous adjuster in case it was home health and an  
5 institutional blend. So it's sort of a -- it went from  
6 dichotomous to sort of a three-state variable. So that  
7 part I've got.

8           Was the issue -- and this is the clarifying  
9 question -- the fact that the transition -- you know, we  
10 were really trying to model something that was continuous  
11 as three steps? Because in theory, you know, the home  
12 health length could be relatively short, and then I could  
13 go to institution or I could be in home health for some  
14 time. Was that some of the analytic problems that we were  
15 trying to stretch something that is, at least in theory,  
16 continuous, you know, the handoff point, into three -- into  
17 basically three somewhat dichotomous variables?

18           DR. CARTER: We were really just trying to  
19 reflect the different levels of cost that would be  
20 included. If you have a mixed stay, you're going to have  
21 one -- one of those stays is going to be substantially  
22 lower cost than an institutional stay. And so if you don't

1 have an adjuster in there, those payments -- the predicted  
2 costs for those episodes is just going to be wildly off,  
3 and it's because part of that episode is home health care.

4 DR. DeBUSK: I think your approach was clever,  
5 insightful, and well executed. I was just curious if the  
6 challenge was the bucketing and the fact that -- I mean,  
7 there is no way to do a continuous variable there. I get  
8 it. You have to -- I think you did what had to be done. I  
9 was just curious if that's where the fit issues came up in  
10 the episode-based model.

11 DR. CARTER: I'd have to get back to you on that  
12 because I'm not sure I'm really following your question.

13 DR. DeBUSK: Okay.

14 DR. CARTER: I'm sorry.

15 DR. CROSSON: Okay. I have Paul and David and  
16 Kathy. Paul.

17 DR. PAUL GINSBURG: Yeah, you've done a really  
18 great job, Carol, in really dissecting what this is all  
19 about. And I think the big question that hangs over this  
20 is, you know, there's a fairly substantial degree of  
21 patient-to-patient variation here. And the question is  
22 always: Does that reflect different variation in patients'

1 needs? Or how much of it reflects the variation in  
2 efficiency of the providers of post-acute care? And I know  
3 there's not a simple answer, but your judgment on that  
4 would be very informative to me.

5 DR. CARTER: So our designs are relying on  
6 current practice, and so whatever effects you see are  
7 comparing to the incentives that are already built into the  
8 payment system.

9 There are a lot of back-to-back home health  
10 stays, and that's partly a reflection of the benefit. And  
11 so I don't know if that's unnecessary care. I wouldn't go  
12 that far. But it is what you see in the current practice.

13 If you move to an episode-based design, that  
14 might change. I think in skilled nursing, I mean, there's  
15 lots of evidence that those stays receive care that is not  
16 commensurate with patient need. And what we're seeing from  
17 the BPCI and CJR evaluations are the savings are because  
18 there's less PAC use, shorter SNF stays, and more patients  
19 shifting from SNF to home health. So I think there's some  
20 efficiencies there.

21 Did I say "efficiencies"? I mean  
22 "inefficiencies." Sorry.

1 DR. CROSSON: On this point, Jon? Oh, you just  
2 wanted -- okay. David.

3 DR. GRABOWSKI: Great. Thanks, Carol. This is  
4 great work, as always. I have two questions. The first  
5 one really builds off of Paul's question. Anytime you do  
6 an exercise like this, you just acknowledge it's really  
7 based on current practices, and so everything you're  
8 observing, the distributions of spending across the  
9 different sectors and utilization, it all goes back to the  
10 underlying incentives within these different systems.

11 And so I'm curious. SNFs are about to undergo  
12 this huge shift to the patient-driven payment model. How  
13 does that affect this kind of exercise where we're going  
14 from a very therapy-driven payment system with the RUGs  
15 right now to a much more condition-specific payment model,  
16 which is, by the way, very consistent with a lot of what  
17 you've advocated here. But I'm just curious. Would that  
18 change any of this, or how would this potentially change  
19 this kind of exercise?

20 DR. CARTER: So the home health is also staged to  
21 undergo a similar kind of transformation. I think some of  
22 the redirection of funds within each of those settings

1 towards medically complex care is going to be occurring  
2 with the changes in those payment systems. So when we see  
3 some -- some of the redistribution effects that we're  
4 seeing here with this kind of design will occur already  
5 with those designs, and so we're going to see smaller  
6 impacts.

7           And so you might say, well, so why bother? And I  
8 think the reason we would say you should still bother is we  
9 see similar patients treated in the different settings, and  
10 so we do want to align the payments across the settings  
11 when patients are the same treated in different settings.  
12 But some of the redistribution will occur because of the  
13 redesign -- and, you know, the LTCHs are undergoing  
14 transformation as well with their dual payment structure.

15           So all of that, when this goes to be implemented,  
16 some of the impacts I suspect are going to differ from what  
17 we show, and it's because whatever the current year that's  
18 used is sort of the baseline, we'll have incorporated some  
19 of those changes.

20           DR. GRABOWSKI: Great. My second question is  
21 around -- I really appreciated both the text that's  
22 summarized in Slide 14, just illustrating the tradeoffs

1 across the two approaches. And I think the big concern  
2 with the stay-based design is if you pay based on stays,  
3 you're going to get more stays, and the unnecessary volume.  
4 So I'm curious if you have thoughts about if you go to that  
5 model, how do we prevent those kind of continuous handoffs?  
6 And I don't think to date we've done a very good job with  
7 home health. You just suggested that. We've had a lot of  
8 these multiple home health episodes. How can we build in  
9 some checks? It seems like it's got to go beyond just  
10 certifying these additional stays. I don't know if you  
11 have thoughts there.

12 DR. CARTER: Yeah, I do. We've thought about  
13 this. And so one thing I think you could do is include a  
14 measure of spending in a value-based purchasing program so  
15 that when you are -- part of your performance is measured  
16 on your downstream spending that you've referred patients  
17 to next setting, for example, so that would be one thing,  
18 looking at Medicare spending as a performance measure.

19 I do wondering whether 2 percent is a big enough  
20 number given the margins in these sectors. I think you  
21 might want to take a larger value-based purchasing withhold  
22 and then reward performance based on that given the

1 financial performance.

2           We've had conversations here on how to improve  
3 the ACO program, so sort of a broader umbrella. How do you  
4 get entities to take responsibility and risk from broader  
5 definitions of care? This is just trying to improve  
6 efficiency of PAC, but we've got, you know, a bigger  
7 problem out there. And so kind of beefing up the ACO  
8 program would be another -- those are two ideas, anyway.

9           DR. CROSSON: Kathy.

10           MS. BUTO: So I was wondering, Carol -- and it  
11 may be in the paper but I didn't pick it up -- if you could  
12 say something about for the episodes with only home health  
13 care under your episode-based design and the episodes with  
14 only institutional -- the short, medium, and long stays,  
15 what's the distribution there? Did you in home health see  
16 much more short stay, medium? And institutional, were  
17 there more medium and long? I'm just curious about the  
18 distribution.

19           DR. CARTER: So we based those definitions on the  
20 distribution. We didn't say, oh, we think short means this  
21 and long means that, and so whatever it doesn't meet those  
22 criteria, the middle. We based short, medium, long on the

1 distributions. But the distributions were broad. I'm  
2 trying to remember, which is never a great idea, but I  
3 think the average number of visits in a home health short  
4 stay were like eight visits and then long were 45. So  
5 there's a big difference in the number of visits that are  
6 captured in a single episode. And that's just for these  
7 solos and pairs.

8 MS. BUTO: Right. And so you found that of the  
9 solos and pairs you looked at, there was a pretty even  
10 distribution of stays along that -- in those three  
11 categories? That's what I'm trying to get at there.

12 DR. CARTER: So we forced those definitions into  
13 those buckets.

14 MS. BUTO: Oh, okay.

15 DR. CARTER: If you're asking a different  
16 question of like, well, if you hadn't done that, what does  
17 the distribution look like --

18 MS. BUTO: What does it look like, right.

19 DR. CARTER: I'd have to get back to you on that.

20 MS. BUTO: And then the second question I had was  
21 -- because I like the idea of an episode-based payment for  
22 some of the reasons David mentioned. I'm wondering if

1 you've thought at all about are there some sort of acute-  
2 care discharges for, say, joint procedures or something  
3 like that where episode-based might make more sense. In  
4 other words, we might generally prefer stay-based, but that  
5 there are some conditions for which there are efficiencies  
6 and episode-based might make more sense. I don't know if  
7 you've gone that distance in thinking about it.

8 DR. CARTER: We haven't thought about that. I  
9 think mixing and matching would be pretty complicated to  
10 administer and maybe for a provider to know, oh, okay, this  
11 patient, I'm thinking about a stay, and then the next one  
12 an episode. But we haven't actually -- we haven't thought  
13 about that.

14 MS. BUTO: Yeah. I was thinking more about, you  
15 know, a provider for hip surgery or bypass surgery knowing  
16 that there's a bundle that includes post-acute versus their  
17 not knowing one way or the other. In other words, there  
18 would just be some surgeries, for example, that naturally  
19 included post-acute care in them rather than having a stay-  
20 based payment. But there may be so much variation in  
21 patients based on other factors that that's not really  
22 practical or fair.

1 DR. CARTER: Mm-hmm.

2 DR. CROSSON: Jon.

3 DR. PERLIN: Let me add to the kudos for a  
4 terrific chapter and really an exquisite presentation of  
5 it.

6 This is incredibly complex from a provider  
7 perspective. You know, this question is really about why  
8 certain inefficiencies occur. So there are multiple  
9 mechanisms of inefficiency you've identified that range  
10 from patient selection to more handoffs, more sites of  
11 care, to a higher level of care than is necessary.

12 What I'm really wondering is your perspective on  
13 how this will affect getting to the right level of care  
14 initially. And, you know, I say that from a very practical  
15 framework in the sense that sometimes the satisfying answer  
16 is what's available, not what's optimal.

17 Is there any way as you contemplate this that  
18 there would be design features that would help to  
19 accelerate really the optimal placement at the first of  
20 potentially multiple stays? Thanks.

21 DR. CARTER: I think that when we've talked about  
22 implementing this, we have talked about regulatory

1 alignment and moving towards patient-based regulations as  
2 opposed to what's the shingle on the door. So if you did  
3 that and let's say you were treating somebody who was on a  
4 vent or with high, really high therapy needs, not run-of-  
5 the-mill therapy needs, you would have to meet a different  
6 level of criteria in order to almost be licensed to provide  
7 that service. And if that were true, then if you were a  
8 patient in the hospital getting ready for discharge, you  
9 would have a list of providers that actually meet the  
10 conditions required to have almost the license to treat  
11 that type of patient. So I think actually think it could  
12 get better.

13 I also know that we've talked here about how to  
14 improve the discharge planning process and allowing  
15 discharge planners to not just provide a list but maybe  
16 make recommendations, but there's been disagreement about  
17 whether that's a good idea.

18 But I do think having sort of licensing by  
19 service -- and that sounds worse than what I mean, but just  
20 -- I mean, I see that as a way to make sure that the  
21 providers actually have the capability and skill mix to  
22 treat the patients that they're treating. So you all have

1 to meet some basic competence and equipment and staffing  
2 and training and all that stuff, but then if you go after  
3 patients with special care needs, you have to meet  
4 requirements that are specific to the capabilities needed  
5 to treat that patient.

6 DR. PERLIN: I think it's fundamentally a  
7 question of load balancing in some way. You know, what is  
8 the availability of a particular level of care on a  
9 particular day of discharge? It varies. So I think  
10 there's more work in just the vein you've identified of how  
11 you do the load balance to make sure that whatever  
12 capacities are available can actually be ratcheted up or  
13 ratcheted down to match appropriately with the clinical  
14 needs as opposed to sort of being forced into the peg of  
15 what happens to be available at the sort of window of  
16 discharge from acute settings.

17 DR. CARTER: Yeah, I do -- I mean, one of the  
18 advantages of a PAC, at least as we see it, is there is  
19 more flexibility across providers to be a broader range of  
20 what you want. So if you're an IRF but you actually want  
21 to treat more SNF-level patients, you would have that  
22 flexibility. And the converse would be true. High-end

1 SNFs could look and feel a lot like IRFs, but they're not  
2 licensed as IRFs right now, and they get different  
3 payments. If they wanted to go after a higher intensity  
4 patient mix, they could, as long as they met those  
5 criteria.

6 So it might be that the availability would  
7 actually get easier because there would be more  
8 flexibility. I don't know.

9 DR. CROSSON: Marge, are you on his point or  
10 separate?

11 MS. MARJORIE GINSBURG: I think I'm on his points  
12 [off microphone].

13 DR. CROSSON: Okay.

14 MS. MARJORIE GINSBURG: I want to back it up a  
15 little bit because I was very confused by the episode-based  
16 model. We've got four different vendors, and we assume  
17 they're not all being run by the same company. How do you  
18 divide the money? I can't figure out how, if we start off,  
19 it gets referred to a higher level of care to an IRF and  
20 then they need to go to home care after that. That's my  
21 first question, just what's the mechanism for sharing the  
22 pot?

1           And the second question is: Home health care,  
2 even though it's part of the continuum, is so much less  
3 expensive, the model is so different than institution-  
4 based. I had a hard time reconciling -- except for the  
5 stay-based, you know -- how that fits in with the others  
6 that are institution-based.

7           DR. CARTER: Well, your first questions, we've  
8 thought about that because it is complicated. You have a  
9 single episode. Now how are you going to divide up the  
10 payment? You could either -- CMS could apportion the  
11 payment based, let's say, on costs. So let's say there's a  
12 \$10,000 episode, but the first provider really provided  
13 two-thirds of the cost of the care, and so they would get  
14 two-thirds of the payment, and CMS would do that in making  
15 payments, you know, in real time to the different  
16 providers, knowing that there's a max and it's the episode  
17 amount, so you could do that. You know, that's  
18 complicated. It's a back-office function CMS doesn't now  
19 have to do.

20           The other would be to pay the first provider and  
21 make that entity responsible. That one makes me nervous  
22 because we have a lot of small providers in this space, and

1 they don't have the ability to bear risk and really the  
2 administrative function to pull that off. So I'm not crazy  
3 about that idea.

4 MS. MARJORIE GINSBURG: Who's got control then  
5 [off microphone]?

6 DR. CROSSON: Marge?

7 MS. MARJORIE GINSBURG: Who's got control then of  
8 deciding that the patient needs to go from one PAC to  
9 another?

10 DR. CARTER: Well, I mean, that's true now,  
11 right? If you're a patient that's in a SNF or an IRF, and  
12 the patient no longer needs that level of care, then you  
13 refer a patient to home health care. And this wouldn't be  
14 different than what currently goes on when you no longer  
15 need -- I mean, most beneficiaries want to go home, and so  
16 it's trying to get patients strong enough to be able to  
17 maneuver at home. So I don't see that as really different  
18 than what's going on now.

19 DR. CROSSON: Dana, Jonathan, and Warner.

20 DR. SAFRAN: Beautiful piece of work, Carol. I  
21 have two questions.

22 One, it might be helpful to put back up Slide 14.

1 One of the things that you emphasize as a potential  
2 advantage is that this model would be less volume inducing  
3 than a stay-based model, and I just want to push on a  
4 couple of assumptions there.

5 One is with the information you've shared with us  
6 about how advantageous financially a shorter stay is. I  
7 just wonder whether you did any modeling or sensitivity  
8 analyses that would look at how -- whether if you're  
9 inducing short stay and then people are bouncing back, you  
10 know, I just wonder how you considered that.

11 And also with respect to the assumption about  
12 potentially less volume, I wonder about -- I'm not very  
13 knowledgeable about how much the PAC providers are  
14 affiliated with hospital providers, but since that's  
15 oftentimes going to be the source, I wondered whether, you  
16 know, having this model could, in fact, be volume producing  
17 because it's a separate stay from the hospital but the  
18 hospital has an interest and the PAC provider has an  
19 interest in the volume there.

20 So those two questions about the volume  
21 assumption, and then I have a question about the assumption  
22 on handoffs, care coordination.

1 DR. CARTER: Okay. So right now there's just as  
2 much incentive for volume as under any of these designs,  
3 right? So whatever financial arrangements are encouraging  
4 or discouraging or neutral about referring patients to PAC,  
5 that's the landscape we're in.

6 If one of the things you need to think about is  
7 with larger dollars at stake with an episode, does that  
8 induce volume, right? And right now we're just -- with a  
9 stay, it could be it's a smaller bundle and there are fewer  
10 dollars. Do you think that there would be more incentive  
11 with a larger pot of money, if you will? I don't know. I  
12 guess the only thing that I am thinking is right now there  
13 is no disincentive for encouraging patients to PAC.

14 We haven't done any sensitivity analysis, but I  
15 understand what you're asking about, but we didn't do that,  
16 just to see what might happen.

17 DR. SAFRAN: And then this is sort of related to  
18 that question, but I thought in the reading materials, on  
19 Table 2, the data were really interesting, the distribution  
20 of the solo and pairs, and I was surprised how much is  
21 solo, how much is just home health --

22 DR. CARTER: Oh, yeah.

1 DR. SAFRAN: And so getting close to two-thirds  
2 that are just solo, and so -- and if you add into that the  
3 one pair of home health/home health, you're up to 83  
4 percent. So that made me wonder, too, about a point of  
5 sensitivity around the seven days, right? So the question  
6 was, again, because of this financial incentive for short  
7 stays, could we either end up with folks who say, well, you  
8 know, let me move this patient on to some other provider so  
9 that, you know, I have a shorter stay that's -- you know,  
10 that portion of the payment is more advantageous to me.  
11 And that might tape a little bit into Marge's question of  
12 how would CMS apportion the money across.

13 But it also made me think about how often a  
14 provider would say, well, seven days is not very long, and  
15 so if this patient is discharged soon and comes back in  
16 eight or more days, you know, I'm up for another episode.

17 DR. CARTER: Right.

18 DR. SAFRAN: So I just was curious about your  
19 thinking on those possibilities that could undercut the  
20 value that you rightly point to related to better  
21 coordination and better handoff.

22 DR. CARTER: Well, we picked seven days really

1 because of home health. If we were just looking at  
2 institutional, we would have made that a much narrower  
3 window, because most of those transfers happen the same  
4 day. But home health, you know, I was thinking, we were  
5 thinking somebody could be ready for discharge, but then it  
6 takes a while for a home health person to actually come to  
7 the patient's home. And so you might shorten the window,  
8 but you need to have, I think, some gap because those  
9 transfers don't have -- the patient goes home, but home  
10 health doesn't necessarily happen that same day. So you  
11 need some kind of gap in there. And it is true, if you had  
12 a smaller window, you'd see more stays, and you'd probably  
13 see more needing to glue together more things, more  
14 individual stays.

15 We didn't do any sensitivity analysis about what  
16 would this whole thing look like if we used three days or  
17 something like that, if that was part of your question.

18 DR. SAFRAN: [off microphone].

19 DR. CROSSON: Jonathan.

20 DR. JAFFERY: So thanks, Carol. This is great  
21 and I really appreciate the summaries, in particular, about  
22 the different maybe strengths and weaknesses or concerns.

1           So I think, you know, one of the things that you  
2 called out is in the episode-based design there may be some  
3 incentives or pushes for organizations to create more of a  
4 comprehensive approach to delivering PAC services across  
5 the spectrum and sort of developing, I guess, even new  
6 entities that would do all that. There's something about  
7 that that feels appealing to me, like it could create some  
8 benefits for beneficiaries and for the program.

9           I guess what I'm really struggling with is that  
10 we're not -- I'm trying to decide whether state-based or  
11 episode-based is better. We're not just dealing with  
12 trying to compare the pros and cons of each one but also so  
13 many unknowns about unintended consequences in each of  
14 them. And so it creates this matrix for me that's just  
15 hard to - not only can I not have to weigh what's going to  
16 be better if this happens but I don't even know if it's  
17 going to happen.

18           So my question is, have you thought about or  
19 conceived of, would it be feasible to think about testing a  
20 couple of different versions of payment systems in  
21 different parts of the country. I mean, I know you're  
22 probably, you know, groaning about the administrative

1 complexity that you talked about a minute ago. But, you  
2 know, there are so unknowns here.

3 DR. CARTER: Well, we sort of have that with BPCI  
4 and CJR, right. We have time-limited bundles. It's true  
5 that they're different than these. They're broader  
6 bundles. They include hospital care and physician care.  
7 And so we are testing that in different parts of the  
8 country.

9 You could go with a pilot. I mean, my worry  
10 about pilots is they sort of take a long time and you don't  
11 -- I guess I just worry about their value.

12 DR. JAFFERY: Yeah, I mean, there's no question  
13 that there's plenty of downsides to that. There are just  
14 so many unknowns that I'm --

15 DR. CARTER: Yeah, well, and that --

16 DR. JAFFERY: -- and then you add to that the --

17 DR. CARTER: -- in the end, leads me towards  
18 going with -- personally, if you woke me up in the middle  
19 of the night. You know, a stay-based design is more like  
20 what we have, and so there are fewer unknowns than going to  
21 an episode where you're asking for a whole different level  
22 of risk to be assumed.

1 DR. JAFFERY: So I guess that's sort of an add-on  
2 question, is if you went to a stay-based design and did  
3 that for a period of time would that preclude you from them  
4 having it be a transition towards an episode-based design  
5 later on, once we saw some of the impacts, and would that  
6 be an easier transition than going the other way around?

7 DR. CARTER: You know, it's funny. We talked  
8 about that last week, and yes, I mean, it would be a good  
9 transition. Providers would learn how to deal with a  
10 single payment, right, across the settings. I think a lot  
11 of what they would need to learn they would be encouraged  
12 to learn under a stay-based design. So you could move  
13 towards that. Then you do have the administrative  
14 complexities of who gets the money and how do you divide  
15 it. But, you know, those are things that we could figure  
16 out. But, yeah, you could start with one and move to the  
17 other.

18 DR. CROSSON: I've got Warner and then Jon and  
19 then Jaewon and Karen.

20 MR. THOMAS: Carol, thanks for the great work on  
21 the chapter. A couple of questions, I guess one going to  
22 an earlier comment where you're talking about, you know,

1 providers being able to recommend or direct patients. I  
2 mean, where does that fit into this model? I mean -- and  
3 would that be part of the recommendation of this model to  
4 be able to loosen some of those restrictions so that there  
5 would be more ability to direct to organizations that, you  
6 know, have known quality metrics, known utilization? Any  
7 thoughts on that?

8 DR. CARTER: So we did have a conversation about  
9 this, was it last year?

10 DR. MATHEWS: Yeah. Do you want to take this or  
11 do you want me to?

12 DR. CARTER: So, well, I'll start and then I'll  
13 probably not quite get it right.

14 So we had a conversation about whether discharge  
15 planners could recommend, and what would that mean, and  
16 what information would a hospital need to use in basing  
17 that decision. But there wasn't agreement around the table  
18 about whether that was good and what it would look like.  
19 And so we did have a chapter that sort of talked through  
20 how important this was but didn't land with a conclusion  
21 about, yep, we should do this.

22 I do think that licensing by -- I mean, keep

1 using that word and it isn't quite the right word, but if  
2 providers had to have licensure for different levels of  
3 service that would help, because if you were a hospital  
4 trying to place somebody you couldn't place them in a  
5 facility that wasn't licensed to treat that type of  
6 patient. So that might help.

7 And I guess that's all I -- do you want to --

8 DR. MATHEWS: Let me try and jump in here.

9 DR. CARTER: Yeah.

10 DR. MATHEWS: Everything Carol said is correct  
11 about our conversations about giving acute care hospitals  
12 the ability to direct patients to post-acute care settings  
13 that have a certain track record with respect to quality  
14 outcomes, that kind of thing. But all of the work that we  
15 have been doing over the last several years, with respect  
16 to the unified PAC PPS, is independent from and separable  
17 from that particular decision. So as we've been developing  
18 the most recent iteration of this work we have not  
19 contemplated the referral idea as an integral part of what  
20 we're talking about now.

21 MR. THOMAS: Okay. Thank you. We'll come back  
22 to that, I guess, in Round 2.

1           My second question is just around looking at ACO  
2 or certainly successful ACO entities and their data in  
3 post-acute versus the general. Are you seeing, you know,  
4 kind of any differential there that would lead you to  
5 different conclusions or a different approach of how you  
6 think about the unified PAC in this proposal, in general?  
7 I mean, it seems as though -- and I guess is there any  
8 difference in post-acute utilization in ACOs versus kind of  
9 the general Medicare population?

10           DR. CARTER: My understanding from the ACO  
11 results is that a lot of their savings are coming from  
12 post-acute care, either by shortening the SNF stays or by  
13 shifting patients from SNF to home health. And so if you  
14 were to move to this, some of those savings would be  
15 scooped up in the payment system. And so those two things  
16 can coexist but it is true that the savings would accrue  
17 differently.

18           MR. THOMAS: Okay. So I guess, do we have data  
19 kind of that's available that would help us consider this  
20 proposal as far as what the changes -- what the potential  
21 changes could be in post-acute care, especially in a more  
22 managed environment?

1 DR. CARTER: We can think about that. I mean, I  
2 think the ACO folks are actually looking at that as one of  
3 their projects, is specifically how do they use PAC  
4 differently. And I think that's something on, you know, a  
5 longer time frame. There's, you know, grinding through  
6 data issues at this point. But that is exactly one of the  
7 things we're asking ourselves.

8 MR. THOMAS: Okay. Thanks.

9 DR. CROSSON: Jon.

10 DR. CHRISTIANSON: So most of the time when we  
11 are talking about payment we talk about it in the value-  
12 based framework connected to quality indicators. This  
13 discussion is kind of divorced from that. If we introduced  
14 some sort of portion of the payment connected to quality-  
15 based indicators for post-acute care would that change the  
16 way that we would think about the plusses and minuses of  
17 these two approaches?

18 DR. CARTER: I don't think it would make me think  
19 about these differently. I think it's a way to incent  
20 thing and that would be irrespective of the design. We've  
21 talked, in the past, about a PAC value-based purchasing and  
22 needing to have the same one across the four settings, and

1 it should be not just one measure but multiple measures and  
2 a measure of resource use and quality measures like  
3 readmissions or admission, readmission measure and  
4 discharge to community, things like that.

5 I do think a VBP, as I said before, can dampen a  
6 volume incentive and that would apply to either design. If  
7 you wanted a measure of care coordination you could do  
8 things like how long did it take once you discharged the  
9 patient to actually see a physician. I mean, I think there  
10 are indicators of each of these where we could try to  
11 encourage providers to do -- have different behavior and  
12 create what we think of as the right incentives for  
13 providers, but they would affect either design.

14 DR. CHRISTIANSON: What about the concern about  
15 withholding of care under the episode-based model? Would  
16 that be less of a concern if we had a good value-based  
17 payment model?

18 DR. CARTER: Yes. And so do things like measures  
19 of readmission or potentially avoidable admissions or ED  
20 visits would tell me that providers -- those would be  
21 decent, I think, indicators. They're gross but they would  
22 be a good start towards looking at that.

1 DR. CHRISTIANSON: So that is one area where if  
2 we thought about this expanded the way we think about this,  
3 to think about it in a value-based design, we might weigh  
4 things a little differently between the two?

5 DR. CARTER: Oh, I see what you're saying. Yeah,  
6 they would affect both of the things, but it might incent -  
7 - more likely it might be qualified because you have a  
8 value-based purchasing policy on top of that. So even  
9 though one design might encourage or discourage something  
10 you at least are trying to tap that down or amp it up with  
11 a value-based purchasing policy.

12 DR. CHRISTIANSON: And would -- just the way you  
13 think about it, would you even think about either one of  
14 these two designs without some sort of a value-based  
15 component to it?

16 DR. CARTER: I think you need to do both at the  
17 same time.

18 DR. CROSSON: Jaewon.

19 DR. RYU: Yeah, I had a similar question, just on  
20 the volume incentive and how to dampen it, and I think Dave  
21 touched on it, as did Dana. But you had mentioned under  
22 the stay-based, you know, you could introduce something

1 like a measure of spending element to try to dampen that  
2 volume.

3 Any thought on almost like a readmission to any  
4 PAC setting, and maybe seven days isn't out far enough.  
5 Maybe it's within 30 days or something like that. I guess  
6 my question would be how feasible, and would that truly  
7 dampen, you know, either the handoffs or the volume aspect  
8 under the stay-based. And I think if it does, and I'd kind  
9 of go where Jon's going, where I think the plusses and  
10 minuses might weigh out differently.

11 DR. CARTER: I'm not quite sure -- I didn't catch  
12 your example of the seven day. That's a seven day for  
13 what?

14 DR. RYU: Yeah, I was just saying, you know,  
15 seven days may be too short of a window, but if you, yeah,  
16 like a --

17 DR. CARTER: Yeah.

18 DR. RYU: -- like a readmission into any PAC  
19 setting, 30 days out, let's say, if that was your quality  
20 measure it seems like that could help address the volume  
21 incentive.

22 DR. CARTER: Right, as long as there was enough

1 risk and reward for having a high performance, that's  
2 right. Yeah.

3 DR. RYU: But is that feasible to collect and  
4 would that be administratively pretty --

5 DR. CARTER: No, I think that's --

6 DR. RYU: -- is it heavy lifting? Is it --

7 DR. CARTER: -- straightforward.

8 DR. RYU: Okay.

9 DR. CARTER: Yeah.

10 DR. CROSSON: Karen.

11 DR. DeSALVO: Carol, can you share with me how  
12 the risk model accounts for some of the social drivers and  
13 social determinants? It may be embedded in some of the  
14 scores. But this seems like an area that's particularly  
15 sensitive to people's housing situation and social support,  
16 and so I would love to hear more about how you've already  
17 been able to incorporate that.

18 DR. CARTER: Right now our model doesn't look at  
19 those things. So if they're not picked up in comorbidities  
20 or impairments or disabilities we haven't captured that.

21 One thing we did look at, not this time around  
22 but back in '16, the IRF payment system has a kind of -- I

1 think of it as a DSH payment. It's called something  
2 different. And when we looked at whether you would  
3 continue to need that, you know, it wasn't a slam dunk but  
4 it looked like maybe. But we do think that you would want  
5 to have that policy for all the settings. It doesn't make  
6 sense to have it for one. You would want to do it for  
7 everything. And we didn't model that but that would be the  
8 one thing that we have looked at.

9 DR. CROSSON: Paul.

10 DR. PAUL GINSBURG: Carol, the analysis you've  
11 presented was at the beneficiary level, so you showed with  
12 the two, three systems the impact for a beneficiary as to  
13 how much the provider would be paid compared to in  
14 different situations. Have you done this analysis at the  
15 facility level? So that, in a sense, where the patients  
16 were kind of randomly distributed and it would probably  
17 look, particularly for larger facilities, much more benign.  
18 But probably that's not random.

19 DR. CARTER: Oh, we have done the impacts by  
20 provider type and ownership and at least one of the tables  
21 -- I'm looking at Table 4 -- shows the provider type. And  
22 I can include in the -- in Table 3 -- it just was getting

1 really long. But we have its brother for the provider  
2 characteristics, and it moves money in the way that we've  
3 found before. It moves money from for-profits to  
4 nonprofits and from freestanding to hospital-based.

5 DR. PAUL GINSBURG: One other aspect. Just as  
6 the individual provider level, what kind of distribution  
7 you find as far as, you know, are these going to be  
8 gigantic gains and losses at the individual provider level  
9 or much less so?

10 DR. CARTER: So we didn't look at that this time  
11 but we did back in '16. We did a lot of -- or maybe it was  
12 '17. We looked at the distributional analysis because of  
13 providers and their provider, and some provider -- there  
14 was a wide distribution of impacts, which led the  
15 Commission to a recommended three-year transition as one  
16 way to soften that.

17 DR. MATHEWS: But we've also made a deliberate  
18 effort to focus more on the impacts by patient condition.  
19 We're trying to bring more rationality to the way Medicare  
20 pays for post-acute care and mitigate the incentives to  
21 select some patients and avoid others that are embedded in  
22 the current for-payment system. So we fully expect that

1 there will be some potentially significant impacts for any  
2 given individual provider, but the goal here is to make the  
3 system much more rational from the patient's perspective  
4 and from the program's perspective.

5 DR. CROSSON: Marge.

6 MS. MARJORIE GINSBURG: Is the problem -- or  
7 maybe I should ask which is the larger of the issues --  
8 that patients are being referred to PACs that are  
9 inappropriate for their needs or is the problem that where  
10 they end up is simply providing more care than is needed,  
11 and that's what's driving their profits?

12 DR. CARTER: We saw redistributions of both  
13 types. So when we look at, say, the impacts on IRFs, one  
14 of the reasons why their payments go down is a lot of their  
15 patients are similarly treated in SNFs, which add a much  
16 lower cost. So we did see that kind of distribution  
17 between setting, because lower-cost settings treat many of  
18 the -- not always, but many of the same types of patients.  
19 So you do see that.

20 We also saw redistributions more along the lines  
21 of what you were suggesting, which is, you know, for  
22 example, a lot of SNFs provide what look like unnecessary

1 therapy care. And so if you're a provider that's tended to  
2 have that kind of therapy practice you're going to see a  
3 reduction in your payments because we don't predict those  
4 costs -- the characteristics of those patients don't  
5 predict those kinds of payments. And so if you're a  
6 provider that's had that kind of therapy practice you're  
7 going to see larger impacts. So it's both.

8 MS. MARJORIE GINSBURG: So right now does CMS do  
9 retrospective chart reviews, if you will, to verify that  
10 the patient was appropriate for this level of care, that  
11 the care they got was absolutely necessary? Or how do you  
12 reconcile inappropriate care in a financially meaningful  
13 way that hopefully will dampen overuse in the future, or do  
14 you?

15 DR. CARTER: CMS does very little auditing. Some  
16 of the information that we've had actually comes from the  
17 Justice Department and OIG that have done extensive studies  
18 of -- I'm more familiar with the SNF space. There have  
19 been multiple cases settled because of inappropriate,  
20 unnecessary care that's been provided to beneficiaries. So  
21 it's more those arms as opposed to CMS. But you're right,  
22 it would take medical record review and that's expensive

1 and it doesn't happen very often.

2 DR. CROSSON: Jon.

3 DR. PERLIN: On this point, just a practical  
4 reality that really gets back to my earlier question of how  
5 these systems will help in terms of load balancing. If you  
6 have a patient who is in acute care and needs to go to a  
7 SNF, and really is not stable for home health, needs that  
8 sort of support, you can make the choice, if you can't find  
9 a SNF bed, to go to an IRF, because the patient would be  
10 safe there, but you can't say "I'm just going to send the  
11 patient to home health." And so there's just an inherent  
12 challenge there where the patients end up, frequently, at a  
13 level of care higher than is necessary because of the  
14 resources available.

15 And, you know, I would look -- and this is why,  
16 back to Jon and others' thread of questions on sort of  
17 quality metrics and this issue of load, what other  
18 mechanisms would help in either of the systems in terms of  
19 either doing the load balancing or amongst similar entrants  
20 in the same level of care, identifying those that had, you  
21 know, higher performance. You know, parenthetically. I  
22 mean, you could have a four-star in a lower-performing

1 market that actually is better than a two-star -- I'm  
2 sorry. Yeah, a four-star in a lower-performing market that  
3 is worse than a two-star in a higher-performing market.  
4 And, you know, just not an adequate sort of way to triage  
5 the patient. So got to figure that piece out on both load  
6 and performance.

7 DR. CROSSON: Okay. Carol, could you put up the  
8 last slide?

9 So we're going to have a discussion now, and I  
10 think it would be helpful to Carol and the rest of the  
11 staff to give us a direction here, which direction we want  
12 to go in. So I'm going to ask David to start, and then,  
13 you know, weigh in. It's complicated, but which direction  
14 do you think we should go?

15 DR. GRABOWSKI: Great. Thanks, Jay.

16 Once again, Carol, great work. I really  
17 appreciate this, although I don't know if I should be  
18 saying "thank you" or "I'm sorry." I was one of the  
19 Commissioners that really pushed you down this road toward  
20 modeling this.

21 [Laughter.]

22 DR. GRABOWSKI: I think I helped make a

1 complicated issue even more complicated. But I do think we  
2 learned a lot here, and in particular, I was very  
3 concerned, as I suggested earlier, about the volume  
4 effects, and that if we pay by stay, we're going to get  
5 lots more stays. And so that's what really led me to think  
6 about an episode-based payment.

7           You did a really nice job in the chapter and in  
8 the presentation illustrating why in theory the episode-  
9 based payment system makes a lot of sense in practice.  
10 It's a little bit more complicated than that. Jon, I don't  
11 think I can repeat the Yogi Berra quote from yesterday, so  
12 I won't try. But, you know, theory and practice don't  
13 always link up.

14           And so, Jay, to answer the question, I think I'm  
15 favoring the stay-based design largely because I think it  
16 guards against some of the unintended adverse consequences  
17 like patient selection, withholding of care, basing  
18 decisions to transfer extend care on financial  
19 considerations that Carol outlined on Slide 15. I think I  
20 come down on the side of protecting the beneficiary here.

21           I did want to make several points, however. If  
22 we go this stay-based route, I think two important checks

1 need to be built into the system. The first is that  
2 although we won't have this incentive to stint at the  
3 episode level, there's still this incentive to stint within  
4 each of the stays. And so, for example, we're changing how  
5 we pay skilled nursing facilities from a per diem to a  
6 stay-based payment. If you go that route, there will be  
7 some sort of threshold, I imagine, you know, do they have  
8 this incentive right after they get past that threshold to  
9 then discharge the patient home? I think we really -- we  
10 want to make certain that those quality measures, that  
11 accountability is built into the system such that there's  
12 not this kind of stinting within a particular stay.

13           Then the second issue that will be really  
14 important to address is just this incentive to continue to  
15 create stays to get additional payments, and it's related,  
16 obviously, to the first stinting in that I end the stay  
17 early and send you to the next site of care from a SNF, for  
18 example, to a home health agency.

19           You had some great ideas earlier about how to  
20 build in some quality measures like Medicare spending per  
21 beneficiary. How do we build in other checks? Because I  
22 don't think we've done a good job to date in addressing

1 some of the multiple, for example, home health episodes  
2 that occur under the current payment system. I think we  
3 need to do better under this system.

4           A final comment, and this came up in a lot of the  
5 Commissioners' questions, is around value-based payment.  
6 Jon Perlin asked a great question around, well, how do we  
7 think about that initial site of care and whether or not  
8 it's appropriate? And I really think that's something that  
9 value-based payment is doing a really good job of  
10 addressing right now, at least the ACOs and thinking about  
11 not just limiting post-acute care use, but also thinking  
12 about kind of selection into a particular post-acute care  
13 setting. So I think this site-neutral payment has to be  
14 part of a bigger value-based payment approach, and I think  
15 both fitting this into ACOs will be really important as a  
16 first comment.

17           Second -- and this goes to Jon Christianson's  
18 comments around quality -- we need to pair this with really  
19 strong quality measurements, regardless of whether we go to  
20 stay-based or episode-based. But under a stay-based  
21 approach, building in a lot of those quality metrics and  
22 really strengthening post-acute care measures that work

1 across the different settings, I think right now we have  
2 the SNF value-based purchasing program. That's pretty  
3 limited. It's a single measure of readmissions. I don't  
4 think we've really built this out the way we've built out  
5 some of the other value-based payment programs for  
6 hospitals and other sectors.

7 A final point there is that we need to fit this  
8 into existing value-based payment models like ACOs, and we  
9 need to build a richer set of quality measures.

10 Thank you.

11 DR. CROSSON: Okay. Comments? Kathy, Brian,  
12 Warner.

13 MS. BUTO: So I would support beginning with the  
14 stay-based design. However, I also recognize -- and I  
15 guess it was really emphasized in some of the comments --  
16 that an episode-based approach has some real value in  
17 creating a different incentive in the system. And so what  
18 I would really like to say is -- and I think it was  
19 Jonathan who brought this up -- that although stay-based  
20 would be the initial step, I would really love to see some  
21 work be done on creating episode-based bundles that could  
22 be managed by the hospital for particular procedures that

1 are done frequently in Medicare where we think there are  
2 savings in the post-acute area, but the hospital has  
3 accountability for readmissions. So I think that's one  
4 source.

5 I actually think as we move to the ACO -- and I  
6 think somebody made the point. I think you made the point,  
7 Carol, that a lot of the savings ACOs have achieved are in  
8 the post-acute area. So, again, for selected services,  
9 again Round 1 or Phase 2, if the ACO could have more  
10 accountability for determining how to manage that episode-  
11 based payment, I think that might be a way to go. I don't  
12 think we're ready to do that, so I think stay-based makes a  
13 lot of sense with a lot of the parameters that David laid  
14 out.

15 DR. CROSSON: Brian.

16 DR. DeBUSK: First of all, as always, thank you.  
17 Excellent work. I want to be the second to apologize, with  
18 David pushing episodes and I was pushing episodes as well.  
19 I'm sorry.

20 [Laughter.]

21 DR. DeBUSK: But what I want to focus on is  
22 specifically Slide 16. You know, there are really two

1 dimensions to this issue. There's this philosophical issue  
2 around stays versus episodes. And then there's the  
3 mathematical issue, and I'm going to focus on the latter.

4           Your treatment on page 34 -- I guess that was an  
5 appendix or a text box -- where you talked about your  
6 analytic methods, you know, I was curious on how you would  
7 handle things like the home health adjuster, and I think  
8 adding the second one for blended -- there was a lot of  
9 rigor and thoroughness, and it was a well-thought-out  
10 approach to how you did the episodes and how you did the  
11 stays. Again, I want to congratulate you on that.

12           I was convinced -- I mean, after looking at it, I  
13 don't think mathematically episodes are practical or  
14 achievable right now. That doesn't mean we couldn't do  
15 them in the future. I really liked in the text -- I think  
16 on page 4 you referred to episodes as "theoretically  
17 pleasing."

18           [Laughter.]

19           DR. DeBUSK: I really enjoyed that comment. So  
20 my one contribution to this work would probably be that  
21 they are theoretically pleasing and mathematically  
22 unavailable at this time.

1 [Laughter.]

2 DR. DeBUSK: So I will refrain from the  
3 philosophical argument because until the math demonstrates  
4 that it's even possible, I'm not sure that we can go that  
5 dimension in that direction, anyway.

6 Thank you.

7 DR. CROSSON: So I would sum that up as  
8 theoretically exciting. Does that make sense?

9 [Laughter.]

10 DR. CROSSON: And, by the way, no more sitting  
11 together. Warner.

12 MR. THOMAS: So I agree, I think we ought to just  
13 stay with the stay-based design. A couple of comments,  
14 though.

15 I do think we should take this concept of the  
16 direction of patients back up. I think it's an important  
17 concept. I think we need to, with the appropriate  
18 information, guide patients to organizations that have  
19 higher and better quality measures and have better  
20 integration to the overall system. So I would encourage us  
21 to take that up again, because I think that's an important  
22 concept.

1           I also want to build off of one of Jonathan's  
2 points on the level of care. I think the reason we see  
3 people that gravitate into a higher level of care is  
4 because the economic model in skilled nursing is not really  
5 that effective. I think that's something we ought to be  
6 looking at. I think if there was a different economic  
7 model there, I think you'd see people use skilled nursing  
8 more than you'd see more skilled nursing beds. I think,  
9 you know, you've seen a plethora of skilled nursing beds  
10 basically go away over the past decade. They may come back  
11 now with ACO models, but I think that's been a big  
12 challenge.

13           I also would encourage us to not focus as much  
14 time and energy on reconstructing the post-acute  
15 reimbursement and put more time and energy in constructing  
16 the ACO model and creating the right incentive for the  
17 delivery system to get the patients to the right level of  
18 care and to manage it more effectively. I think we've seen  
19 initial results from the ACO, that they've done a good job  
20 there in managing that area. I think just to continue to  
21 reconfigure the payment mechanisms and the various areas of  
22 post-acute, I think this is a good chapter. But I think it

1 also identified that this is complicated, and it's probably  
2 going to be hard to have a policy or an approach that's  
3 going to essentially legislate or policy the solution. I  
4 think the care delivery system needs to drive the solution  
5 based upon what's best for that patient and create the  
6 right incentives for the whole entire delivery system  
7 versus each individual component of post-acute care.

8           So I would encourage us to spend our time going  
9 down that road versus trying to reconfigure the different  
10 components of post-acute care.

11           Then going back to Jaewon's comment on  
12 readmission penalties, you know, there really is -- there  
13 are no penalties in the post-acute area if they're not  
14 doing a good job and people bounce back into the acute-care  
15 world. And I do think having some or more robust penalties  
16 around, you know, value-based incentives in that area are  
17 important to get them incented to work together and also  
18 get them incented to work more directly with the acute-care  
19 portion of the delivery system to do a better job of  
20 coordinating care across the whole continuum.

21           So I would encourage us to put more of our  
22 efforts in some of those areas versus in the episode-based

1 design.

2 DR. CROSSON: Bruce, I saw your hand, then Paul,  
3 then Dana.

4 MR. PYENSON: Thank you very much. I support the  
5 stay-based approach, and one area that I think we might --  
6 after this area is closed, if we wanted to explore further,  
7 we might look into the practice pattern variations that  
8 lead to the regional variations in PAC use. What I've  
9 observed in Medicare data is that the regions with high  
10 inpatient utilization also have high SNF utilization and  
11 also high home health utilization. So the drivers of that  
12 seem to be a system of practice, and I think it's great to  
13 move to better and fairer and more equitable reimbursement  
14 structures. But to understand the drivers of our  
15 utilization as something that's not inherent in the walls  
16 of the SNF or in the home health agency, but something  
17 perhaps that's on a bigger, more comprehensive basis. I  
18 think if we do that we'll -- that's for the future. If we  
19 decide to do it, I would prefer going in that direction  
20 rather than trying to develop quality metrics, which I  
21 think other organizations are very capable of doing in --  
22 very necessary, but there's a number of outstanding quality

1 organizations that could explore what should be measured  
2 and how to do it.

3           So, overall, thank you very much for that. I  
4 think in retrospect, I think one of the questions I have or  
5 thoughts I have about an episode-based system is that  
6 episodes should probably be based on patients rather than  
7 site, and especially if the patient has a condition or  
8 that's perhaps a more sound basis for an episode, than  
9 saying here's a patient with a condition and happens to  
10 find themselves in a particular site.

11           So I think that's perhaps the reason why the  
12 inpatient DRG system actually has worked well, because it's  
13 on a more patient condition kind of focus. So just some  
14 thoughts there. So I disagree with Brian. I don't think  
15 this is intellectually interesting.

16           [Laughter.]

17           DR. CROSSON: Okay. Paul?

18           DR. PAUL GINSBURG: Yes, I agree with the  
19 perspective that at this point we should be going with a  
20 stay-based model. I think we can say that, you know, the  
21 combination of the evidence of extensive overuse in post-  
22 acute care and high rates of profitability creates a very

1 favorable environment for moving in this direction.

2 I suggest that we also say that, you know, a  
3 long-term goal or aspiration would be moving to episode-  
4 based payments, and pointing out how the experience with  
5 using stay-based will put us in a better position to move  
6 forward down the road, and that we should be thinking about  
7 getting prepared to move to an episode-based approach down  
8 the road.

9 DR. CROSSON: Thank you, Paul. Dana.

10 DR. SAFRAN: So I similarly support moving in the  
11 direction in the near term of stay-based approach and  
12 really support the point that Jon highlighted for us about  
13 needing to pair this with a robust quality measure set that  
14 has incentives attached to it.

15 I really like the point about how ACOs figure in  
16 here, and I think we've talked now and we're clear about  
17 how they figure in with respect to tamping down what could  
18 have been an individual for unnecessary volume, because I  
19 think we've seen in the ACO program -- and it's been  
20 referenced a few times today -- how, you know, hospitals in  
21 particular have become much smarter purchasers of post-  
22 acute care. So I think they'll be looking for post-acute

1 care settings that are good partners, as they are today,  
2 and those that don't take advantage by driving up volume  
3 will be part of that.

4 I also think that could help us with tamping down  
5 the incentive around increased handoffs that you point to  
6 as a possible downside of the stays, because I think  
7 hospitals will be looking for that, too.

8 So I think all in all, you know, we have a good  
9 mechanism in place to manage the potential downsides of  
10 stay-based, and that's a good direction to go while still  
11 exploring episodes to see if they would have value.

12 The one other thing I'll just put out there as  
13 something to consider is potentially having something built  
14 into our hospital value-based incentive program on the next  
15 round that holds a hospital accountable for the quality and  
16 performance in general of the post-acute care settings that  
17 they use. We found that really effective in my work at  
18 Blue Cross where were holding physician organizations  
19 accountable for the quality of the hospitals that they  
20 used, and it really created some pretty interesting shifts  
21 in referral patterns. So I think a similar dynamic could  
22 get created if you create some accountability on the

1 hospital side for who they're referring to for post-acute  
2 care.

3 DR. CROSSON: I wonder -- I don't disagree with  
4 that. I wonder if that then is tied into the issue that  
5 Warner brought up about, you know, the flexibility that  
6 hospitals have in terms of how they direct patient, which  
7 is another issue I think we need to come back to.

8 DR. SAFRAN: Yeah.

9 DR. CROSSON: Okay. Sue.

10 MS. THOMPSON: I'll be quick. I just want to  
11 underscore the opportunity I think we have uniquely to  
12 build on what we're learning in the ACOs, because I think  
13 we have access to ACOs who have indeed done what you  
14 articulated, Carol, and that is to see a reduction not only  
15 in the PMPM but in the quality scores as a result of doing  
16 just what you are describing, Dana, and that is building a  
17 network of post-acute providers who do meet the quality  
18 measures and deliver care based upon the network criteria.  
19 So there's just a lot to learn there that I think really  
20 will help us take the next step in this discussion. But,  
21 Carol, thank you. Great work.

22 DR. CROSSON: Jonathan.

1 DR. JAFFERY: A very quick follow-up to that. I  
2 agree with everything that has been said so far, and just  
3 to add, as we start to look at that and learn -- see what  
4 we can learn about what current ACOs have done in terms of  
5 partnering with post-acute entities, maybe making sure that  
6 we also try and figure out how different organizations have  
7 done different kinds of gain-sharing with those  
8 organizations, how they fit into -- you know, allowed some  
9 of those post-acute care settings to get back some of the  
10 shared savings and whether or not that has been an  
11 effective thing.

12 DR. CROSSON: Okay. Thank you very much. Good  
13 discussion. I think we have a direction, and I think we've  
14 had some additional thoughts which will be very helpful in  
15 rounding out the material that's finally prepared.

16 Carol, thank you once again for excellent work.

17 [Pause.]

18 DR. CROSSON: Okay. I think we're ready to move  
19 on to our final presentation for the March meeting, and  
20 that is going to be, I think what will be a final  
21 presentation of material for our mandated report on the  
22 impact of the dual-payment rate structure for long-term

1 care hospitals. And we've got Stephanie and Emma here, and  
2 Emma is going to begin. Thank you.

3 MS. ACHOLA: Good morning, today we will present  
4 the penultimate draft of the Commission's response to the  
5 Congressional mandate on changes in post-acute care and  
6 hospice services following the implementation of the dual  
7 payment rate structure for long-term care hospitals. Our  
8 objective today is to receive any final comments you may  
9 have since we will be publishing this information as a  
10 chapter in our June 2019 report to the Congress.

11 As you recall, we have discussed this topic  
12 several times over the course of this work cycle. In  
13 September, we discussed background information on the LTCH  
14 sector and provided you with the context for the mandate.  
15 In November, we presented our initial findings for the  
16 report, and we also provided information regarding payment  
17 adequacy in the LTCH sector in December and January.

18 Given the extent that we have previously  
19 discussed this material, our plan for today is to briefly  
20 review the payment changes made under the Pathway for SGR  
21 Reform Act of 2013, provide an overview of the mandate,  
22 present updated analyses through 2017, and finalize the

1 report for inclusion in the June 2019 report. Additional  
2 details regarding background and context were included in  
3 your mailing materials.

4           As you'll recall, The Pathway for SGR Reform Act  
5 established a dual-payment rate structure and therefore  
6 established patient-level criteria that determine payment  
7 levels. Cases that meet these criteria are paid the  
8 standard long-term care hospital prospective payment system  
9 rate, while those that do not meet the criteria are paid a  
10 lower site-neutral rate. The criteria for the standard  
11 LTCH PPS rate are as follows: patients must have an  
12 immediately preceding acute care hospital discharge and  
13 either spent three or more days in the ICU of the referring  
14 acute care hospital or receive prolonged mechanical  
15 ventilation in the LTCH.

16           Given the extent of this payment change, the  
17 Congress mandated that MedPAC examine the effects of the  
18 dual-payment rate structure on the growth in Medicare  
19 spending for services in LTCHs, different types of long-  
20 term care hospitals, the quality of care provided in LTCHs,  
21 and the use of post-acute and hospice care. The mandate  
22 further requested that the Commission assess the continued

1 need to apply the 25 percent threshold rule. However, CMS  
2 eliminated this rule in fiscal year 2019.

3 Now I will walk you through our approach to  
4 meeting the Commission's mandate. As you'll recall, we  
5 conducted a multi-pronged approach including a quantitative  
6 analysis of administrative data using claims and cost  
7 report data, and the provider of services file. We  
8 augmented this administrative data with information  
9 collected from site visits and telephone calls with LTCHs,  
10 referring acute care hospitals and skilled nursing  
11 facilities. We conducted site visits at 19 facilities in  
12 six states. Finally, we are also conducted telephone  
13 interviews with acute care hospital representatives in  
14 three additional markets.

15 We faced several analytic challenges in carrying  
16 out this work. First, because the dual payment rate policy  
17 is being phased-in over a four-year period, the policy is  
18 still only 50 percent implemented and our analyses will  
19 reflect this partial policy phase-in. Next, LTCH spending,  
20 use, and margins began to decrease prior to the  
21 implementation of the dual-payment rate structure, so we  
22 compared the rate of change in the years prior to the

1 policy implementation and the years after.

2           Lastly, LTCHs have relatively low volume of cases  
3 compared with the close to 5 million PAC admissions and  
4 episodes and 1.4 million hospice users. Therefore, it will  
5 be difficult to detect changes in the use of other PAC  
6 providers in the aggregate.

7           For certain analyses we focus on certain acute  
8 care hospital diagnoses that are more likely to be  
9 discharged to an LTCH and certain market areas based on  
10 their historical use of LTCHs. However, we urge caution in  
11 interpreting the data to attribute such changes to the  
12 implementation of the dual-payment rate structure given the  
13 limited time frame of the available data.

14           So starting with our interviews and sites visits.  
15 Generally, all of the facilities we spoke with reported the  
16 need to make operational changes in response to the  
17 implementation of the dual-payment rate structure. The  
18 degree to which these changes occurred varied facility to  
19 facility. Facilities that stopped admitting patients not  
20 meeting the criteria explained that payments under the  
21 blended rate were not adequate to cover their costs, and  
22 that focusing on cases that met criteria provided clear

1 guidance to referral sources. Interviewees stated their  
2 facilities expanded their referral regions and educated  
3 physicians and case managers in the acute care hospital on  
4 the LTCHs capabilities.

5           In contrast, some LTCHs interviewed continued to  
6 admit cases that did not meet criteria. Facilities  
7 reported several reasons for taking this approach,  
8 including maintaining relationships with referring acute  
9 care hospitals, providing a service to the community, and  
10 the belief that cases with short lengths of stay could be  
11 profitable under the blended rate.

12           Across facilities we spoke with there was  
13 consensus regarding an increase in patient acuity. As a  
14 result, staff at facilities interviewed reported the  
15 increased skills necessary at each staff level. For  
16 example, nurses were expected to be able to provide ICU-  
17 level care and received additional training, including  
18 critical care training. Facilities also reported  
19 increasing their capabilities adding bariatric beds, ICU  
20 beds, and telemetry services.

21           However, even with these admission and  
22 operational changes, staff members at several LTCHs

1 referenced declining occupancy rates and closures. To  
2 mitigate these declines, some facilities reported planning  
3 to repurpose beds. Another facility stopped staffing an  
4 entire floor, closing those beds to patients, while another  
5 reported reducing the number of beds it leased from its  
6 host acute care hospital. And now I will turn it over  
7 to Stephanie.

8 MS. CAMERON: The closures mentioned during our  
9 site visits and interviews are supported by our data  
10 analysis. Since the start of the dual-payment rate  
11 structure, over 50 facilities have closed, representing  
12 more than 10 percent of the industry. Most of these  
13 closures occurred in areas with other LTCHs and the  
14 remaining closures occurred where the closest LTCH was  
15 within about a two-hour drive.

16 Further, for-profit facilities comprised about 85  
17 percent of the closures. Facilities that closed tended to  
18 have a lower share of discharges that met the criteria,  
19 lower occupancy rates, lower Medicare margins, and higher  
20 standardized costs than facilities that remained open.

21 Associated with fewer LTCHs is reductions in  
22 volume and as you can see, the number of LTCH cases

1 declined starting in 2012. Starting with the blue portion  
2 of the bar chart, although difficult to discern, the volume  
3 of cases meeting the criteria decreased slightly from 2012  
4 to 2015, but starting in 2016 the volume of cases meeting  
5 the criteria began to increase slightly. In contrast,  
6 cases not meeting the criteria, the gray portion of the bar  
7 chart, declined more rapidly from 2015 to 2017 compared  
8 with prior years, as expected by the implementation of the  
9 dual-payment rate structure.

10 As a result of these two opposing trends, the  
11 share of LTCH discharges meeting the criteria has  
12 ultimately increased since 2012. Just over half of LTCH  
13 cases met the criteria prior to the implementation of new  
14 dual-payment rate structure; however, this share increased  
15 to about 64 percent in 2017.

16 As you will recall from January, in 2017, the  
17 aggregate Medicare margin fell to -2.2 percent, down from  
18 3.9 percent in 2016. However, the aggregate Medicare  
19 margin for LTCHs with more than 85 percent of Medicare  
20 cases meeting the criteria was 4.6 percent. This indicates  
21 that facilities with a high share of these cases can have  
22 positive financial performance under Medicare. Further, as

1 you'll recall, the margin for cases meeting the criteria  
2 based on a claims analysis remained higher at 5.8 percent  
3 in 2017.

4           Now quality. Not unexpectedly, given differences  
5 in patient severity, unadjusted rates of direct LTCH to  
6 acute care hospital readmissions, death in the LTCH, and  
7 death within 30 days of discharge from the LTCH varied,  
8 depending on whether or not the case met the criteria, but  
9 were generally stable over time. In 2017, for cases  
10 meeting the criteria, 10 percent were readmitted to the  
11 acute care hospital directly from the LTCH, 16 percent died  
12 in the LTCH, and another 13 percent died within 30 days of  
13 discharge from the LTCH. This means that, combined, close  
14 to 40 percent of LTCH cases meeting the criteria in 2017  
15 were readmitted or died within 30 days of LTCH discharge.  
16 By comparison, cases not meeting the criteria have lower  
17 rates of readmission and mortality.

18           Our mandate requested that we also assess the use  
19 of hospice care and post-acute care settings since the  
20 implementation of the dual-payment rate structure, so now  
21 we turn to that, starting with spending and supply.  
22 Spending for PAC grew slightly from 2012 through 2017;

1 however, the supply of PAC providers has remained stable.  
2 In contrast, hospice spending increased since 2012 in  
3 tandem with the number of hospice providers over this time  
4 period.

5           However, these aggregates do not necessarily  
6 reflect changes in ACH discharge pattern in response to the  
7 implementation of the dual-payment rate structure, given  
8 the relatively small volume of LTCH users. Therefore we  
9 consider changes in the share of discharges for acute care  
10 hospitals stays by ICU length of stay and by areas of the  
11 country with high and low historical LTCH use.

12           Here we have discharge patterns across PAC and  
13 hospice from 2015 to 2017. Over this time, as you can see,  
14 there has been little change in the share of acute care  
15 hospital discharges using each PAC and hospice setting, in  
16 aggregate. Discharge patterns, in total, have been  
17 relatively stable since the implementation of the dual-  
18 payment rate policy.

19           Because we didn't see much change in acute care  
20 hospital discharge patterns to PAC in aggregate, we  
21 consider the use of these services in historically high-  
22 LTCH use markets and historically low-LTCH use markets. As

1 you can see from the chart, the use of PAC and hospice are  
2 quite different in the high-LTCH use markets on the left-  
3 hand side of the chart compared with the low-LTCH use areas  
4 on the right-side. However, similar to the trends in total  
5 on the prior slides, we observe minimal changes from 2015  
6 through 2017, by type of market.

7           Lastly, we considered certain conditions that are  
8 more likely to use LTCH care from an acute care hospital.  
9 We find little change across low-LTCH use areas, so here  
10 I've provided changes based on areas with high LTCH use.  
11 As you might expect, the share of acute care hospital cases  
12 discharged to an LTCH increased for certain conditions that  
13 meet the criteria based on ventilator use, including MS-DRG  
14 004 as provided in the table.

15           Here we see a 4 percentage point increase in the  
16 share of live acute care hospital discharges that use LTCHs  
17 from 2015 to 2017. In contrast, the next two diagnoses are  
18 less likely to use an ICU for three days or longer and  
19 therefore, the decrease in the share of these conditions  
20 discharged to an LTCH is not surprising. For these  
21 conditions, we find slight increases in SNF use. However,  
22 I again want to urge caution in the interpretation of these

1 results given the limited data available to analyze to  
2 date. We've given you a lot of information today and  
3 over the course of this cycle. In summary, a relatively  
4 large number of facilities have closed; however, these  
5 closures have primarily occurred in areas of the country  
6 with multiple LTCHs and have had lower shares of cases that  
7 meet the criteria, lower occupancy, and higher costs  
8 compared with LTCHs that remained open. The volume of  
9 cases not meeting the criteria has decreased while the  
10 share of cases that meet the criteria in LTCHs has  
11 increased.

12 Additionally, LTCH financial performance under  
13 Medicare has decreased over time, but cases that meet the  
14 criteria continue to be profitable under Medicare. We were  
15 unable to detect consistent or significant changes across  
16 the available LTCH quality measures to date. Changes in  
17 the supply or use of other PAC and hospice providers have  
18 been minimal. Keep in mind, however, that LTCHs comprise a  
19 relatively small share of PAC and hospice use therefore it  
20 is difficult to observe the effect of any policy especially  
21 given its recent implementation, which limits our  
22 capabilities in interpreting any changes in the use of

1 other providers and in quality measures.

2           The changes in the LTCH setting we presented  
3 today are consistent with the policy objectives. These  
4 trends were expected, align with the Commission's goals of  
5 its March 2014 recommendation to the Congress, and are  
6 expected to continue as the policy is fully phased-in. We  
7 will continue to monitor trends in use across PAC and  
8 hospice, facility closures, and quality as data become  
9 available.

10           That concludes today's presentation. We look  
11 forward to your questions and final comments on the  
12 information we presented today. And as a reminder, this is  
13 the final presentation of the Commission's response to the  
14 Congressional mandate. This information will be included  
15 in the Commission's June 2019 Report to the Congress.

16           And with that, I turn it back to Jay.

17           DR. CROSSON: Thank you, Stephanie and Emma. We  
18 are open for clarifying questions. David.

19           DR. GRABOWSKI: Yeah. Thanks for this great  
20 work. I wanted to ask two questions. First, on page 18 in  
21 the text you have a sentence, and I'll just quote it:  
22 "Research on the value of care provided in LTCHs has been

1   undermine by difficulties controlling for selection and  
2   patient case mix." There is this paper, and you cited in  
3   your references, from Einav and colleagues that is an NBER  
4   working paper right now, and I assume will be published at  
5   some point. But they try to get at exactly this issue of  
6   selection and case mix by exploiting entry of LTCHs in a  
7   particular market, as a kind of a strategy.

8                   And I just wanted to get your thoughts on that  
9   paper. You cite it later, in a different context, but I  
10  think it could actually help with this text here maybe in  
11  explaining kind of the value LTCHs might bring relative to  
12  other settings. So your thoughts there.

13                   MS. CAMERON: Sure. So that study looked at  
14  markets that had an LTCH entry over a period of time. I  
15  believe that ended in 2012. I believe the data was 2008 --  
16  I might be wrong there -- but up until about 2012. And  
17  they looked at some pretty high-level quality metrics. One  
18  was mortality. They looked at time a patient, a  
19  beneficiary spent in the acute care hospital, the length of  
20  the entire episode, which included the acute care hospital  
21  stay plus post-acute. They looked at cost-sharing and I  
22  believe the use of SNF care.

1           And what they found was that spending for these  
2 episodes increased once an LTCH was opened in a market  
3 area. They found very little change in the length of the  
4 episode overall. They found substitution of LTCH use  
5 substituting for SNF care. But again, overall, they didn't  
6 find a lot of other change besides kind of that -- the  
7 site-of-care change, SNF to LTCH, and increases in  
8 spending.

9           I think one caveat, and I did want to be cautious  
10 about that, is the study did occur before this policy took  
11 place, and while they did do some -- they took into account  
12 patients that had a higher propensity for using LTCH care,  
13 which could be correlated with the patients that meet the  
14 criteria. It wasn't a one-for-one match, and that wasn't  
15 kind of how the propensity was identified.

16           So I think, David, you're right. I think what  
17 they found was LTCH added little to no value, and if  
18 anything, I think the punchline of that paper was they  
19 actually increased spending and waste, which was their kind  
20 of title, working title. And I think that that is  
21 absolutely correct. I think where, you know, I want to be  
22 cautious is that in recognizing that did not occur and the

1 data has not occurred since the slowing of growth in the  
2 LTCH industry and since the dual-payment rate structure  
3 began.

4 DR. GRABOWSKI: Just as a second question I  
5 wanted to get your opinion, either of you, on sort of  
6 linking this session with the prior one around site  
7 neutrality and payment. Here we have this sector that's  
8 different in a lot of ways. How does that fit in? We've  
9 gone to a lot of policy efforts to make certain the right  
10 individuals are receiving care in LTCH. Obviously, site  
11 neutrality is one way of hopefully ensuring that, or at  
12 least helping with that goal.

13 But I wanted to get your thoughts on how does  
14 this fit in? And maybe you no longer need the dual-payment  
15 rate structure once you have site neutrality, but what else  
16 do you need here, in this sector, to make certain that it's  
17 being used appropriately?

18 MS. CAMERON: So I think as we move towards a  
19 unified PAC-PPS I think you're absolutely right. The need  
20 for any dual-payment rate structure goes away. I think  
21 that, you know, as you saw in the paper on the stay-based  
22 and the updated approach there, that when we redefined what

1 it meant to be on a ventilator we saw that a vast majority,  
2 well over 95 percent of those cases, were being seen in an  
3 LTCH as we defined PAC. So if you look at all of the PAC  
4 settings, the LTCHs are by far seeing the vast, vast  
5 majority of those cases.

6 And so in the regression model the cost  
7 associated with majority LTCH care obviously captured, and  
8 so that cost is actually very heavily weighted towards  
9 LTCH. And so we would see, kind of depending on, you know,  
10 how the payment was set, but the cost are heavily, heavily  
11 weighted LTCH and would reflect that, presumably, in the  
12 ultimate payment.

13 And so, you know, in a lot of ways, again I think  
14 this is starting to identify a group of patients that are  
15 paid, you know, the LTCH rate, and as we move to a unified  
16 PAC-PPS, you're absolutely right. I think we do start  
17 thinking about more of site-neutral approach. And the  
18 patients that are able to be seen in a setting like a SNF,  
19 who I think a lot of us would consider being cases that  
20 don't meet the criteria today, would receive a reduction in  
21 payment. It would be a different metric. Right now it's a  
22 lesser of cost or an IPPS comparable rate. Obviously that

1 would be the rate that was indicated by kind of the  
2 regression and the cost.

3 I think LTCHs, one thing I will say, is I think a  
4 big portion of that transition for LTCHs is going to be the  
5 regulations. LTCH are certified as acute care hospitals.  
6 They have to meet a lot of those requirements. And as we  
7 move toward a unified PAC-PPS, you know, we have talked a  
8 lot about how important that regulatory piece is, and I  
9 think that is very true for LTCHs.

10 DR. CROSSON: Okay. I saw Pat and Kathy. Pat.

11 MS. WANG: In your observation of changes in  
12 supply of LTCHs and LTCH beds, did you, you know, whether  
13 qualitatively or quantitatively, observe differences in  
14 beneficiary access for those who met the criteria, for  
15 example, as LTCHs downsized the sort of non-qualified stays  
16 and focused on qualified stays in the new structure? Did  
17 you observe anything about occupancy, stable, up, down, in  
18 the remaining LTCHs? Any impact on wait times for  
19 beneficiaries who met the criteria and needed an LTCH bed,  
20 things of that nature?

21 MS. CAMERON: So from the quantitative data, we  
22 did not find much change in occupancy rates for the LTCHs

1 that have remained open. The data we used, as you'll  
2 recall, in our payment adequacy work when we looked at this  
3 was 2017, so, you know, here we are in 2019, and we will  
4 obviously continue to track on this because I think it's a  
5 really important point to keep an eye on.

6 We did not hear -- and I'll just step back and  
7 say the occupancies are hovering around 65 percent. So  
8 there are beds available. There is some seasonality to  
9 certain LTCHs in certain areas of the country. I think on  
10 especially kind of the east coast, flu season is a higher  
11 occupancy time for LTCHs compared to other parts of the  
12 year, and, you know, the mid-summer months are a lower  
13 occupancy time. But all in all, it's about 65 percent, and  
14 that's actually a very minimal down tick from where it was  
15 a couple years ago, but still in the ballpark. So we  
16 haven't seen any major changes there.

17 During our site visits, we did not hear from any  
18 hospital, referring hospital or from LTCHs themselves, of  
19 becoming too full to accept patients or that that  
20 beneficiary access was a concern. Again, I think as the  
21 policy becomes more fully phased in and the industry is  
22 settling out, we will obviously closely monitor this. But

1 we did not hear anything of that level of negativity for  
2 beneficiary access.

3 DR. MATHEWS: And just to add to that, Stephanie,  
4 if we go back to Slide 10, you do see a certain stability  
5 in the number of cases that meet the criteria that are  
6 being admitted over time at the same time that there is a  
7 reduction in cases that don't meet the criteria. So to the  
8 extent there are reductions in the non-criteria cases, that  
9 is going to positively impact ability of patients who do  
10 meet the criteria to get int.

11 DR. SAFRAN: On this point [off microphone]?

12 DR. CROSSON: Okay.

13 DR. SAFRAN: Did you look specifically at rural  
14 to see if that held true there? Because some of the data  
15 in Table 3 just made me have that -- in the paper made we  
16 have that question about rural was different?

17 MS. CAMERON: One of the difficulties is there  
18 are so few rural LTCHs that one change in one rural LTCH  
19 could draw us to conclusions that we may or may not be  
20 comfortable with. Rural LTCHs typically actually have a  
21 lower share of patients meeting the criteria, and part of  
22 that is a volume issue. You gain referrals from hospitals

1 within, you know, a 20-mile-ish radius on average, but  
2 there's obviously a much larger referral zone, up to two  
3 hours. For rural areas, having the number of acute-care  
4 hospitals drawing volume is a much more difficult  
5 threshold.

6 So what we do know is that the rural LTCHs do  
7 have a higher share of cases not meeting the criteria, but  
8 I have been concerned about really digging too deep because  
9 there are so few of them and drawing industry conclusions  
10 on a very small number is something I'm wary of doing.

11 DR. CROSSON: Kathy.

12 MS. BUTO: So I think the idea behind the report  
13 is really interesting, which is to say what happens when  
14 LTCHs concentrate more of patients who meet the criteria.  
15 It continues to strike me that a lot of patients, based on  
16 your data, are patients who, if there were no LTCH option,  
17 might be hospice patients. But, in fact, as you move to  
18 the dual payment system, I mean, LTCHs are going after more  
19 of those patients, sort of the high-intensity, very frail  
20 patients who may die within a short period of time.

21 So I'm wondering whether you saw any -- and you  
22 probably didn't look at this because there's so few LTCHs,

1 but any differences in the characteristics of LTCH patients  
2 who meet the criteria and hospice patients? Are hospice  
3 patients overwhelmingly cancer patients? Which wouldn't be  
4 LTCH patients. They're both in the similar situation where  
5 they're quite vulnerable, frail patients, and I wondered if  
6 you see any characteristics where you might say without  
7 LTCHs some of these patients or a larger number of them  
8 might be hospice patients.

9 MS. CAMERON: I think that's a good and  
10 challenging question to answer. LTCHs are required under  
11 law to maintain an average length of stay of 25 days or  
12 longer, and they do need to take that into consideration  
13 when they admit patients. And so they are not -- they do  
14 not want to admit a patient that is not expected to live  
15 post-discharge. You know, they're providing acute and  
16 rehabilitative care to a very sick group of beneficiaries.  
17 And in wanting to provide that rehabilitation, that  
18 includes a live discharge. And so I think, you know,  
19 theoretically there are some things we might be able to  
20 look at. I didn't do that here. And maybe we could talk  
21 after and think about that. But, you know, it is a  
22 different population. These LTCHs want -- the patients

1 that go there and the families of patients that go there  
2 are pursuing a curative care track, and they are interested  
3 in rehabilitation and ultimate discharge from a facility  
4 being alive. When one enrolls in hospice, that's not the  
5 expectation, and so, you know, there are two very different  
6 populations in a way, kind of in tracks.

7           Now, that said, I think we have heard in the past  
8 that some beneficiaries end up going to an LTCH after an  
9 acute-care hospital stay not understanding the road they  
10 have ahead of them, and it's only after the extremely acute  
11 phase of the illness occurs in that, you know, five-,  
12 seven-day acute-care hospital stay, they're discharged to  
13 the LTCH, and everyone exhales. It's the exhale after the  
14 emergency situation and the reactionary mode where there is  
15 some question of is this the path we want to be on. And we  
16 have heard that for some. It hasn't been the track they  
17 wanted to be on, and that's unfortunate that conversations  
18 of end-of-life care did not occur in the hospital, and that  
19 expectation wasn't set earlier in the course of treatment.  
20 And it puts LTCHs and LTCH caregivers in a very difficult  
21 spot as well.

22           MS. BUTO: Thanks. I wouldn't ask you to go back

1 and do any more analysis here, but it strikes me as exactly  
2 the case that people talk about, which is the last six  
3 months of life being a time for many people of the most  
4 expensive care, and LTCH is a very expensive setting. So  
5 it just struck me that there is this -- a little bit of a  
6 disconnect, as you say, and conversations that should  
7 happen sooner.

8 Thank you.

9 DR. CROSSON: Karen.

10 DR. DeSALVO: Kathy, I'm glad that you raised  
11 that, because I'm still stuck on this Figure 5, which Kathy  
12 actually talked about at the last meeting, too, which is  
13 that between a third and 40 percent of admissions for all  
14 cases -- you know, depending on criteria, either experience  
15 mortality in a narrow window or go back in the hospital.

16 And so I wonder if, thinking forward for the next  
17 generation of work, there is an opportunity to bring in,  
18 for example, the beneficiary and caregiver voice and some  
19 of the qualitative work about their expectation management  
20 and how they were spoken to even in the acute-care setting  
21 in the hospital, and then thinking about strategies that  
22 would really encourage and drive end-of-life conversations

1 or palliative care conversations in the acute side of the  
2 hospital before people end up in an LTCH, which maybe is  
3 where the family didn't really understand what that was  
4 going to be about and what it would be like.

5           And maybe your specific question is did we -- in  
6 the qualitative work, I didn't see that we formally spoke  
7 to families and caregivers, so we can't include any of that  
8 perspective in the chapter?

9           MS. CAMERON: We spoke with two patients --

10          DR. DeSALVO: Okay.

11          MS. CAMERON: -- and their families at one of the  
12 LTCHs we visited, and they were very happy with the  
13 outcomes and the care they received and live very full  
14 lives currently.

15           We did not speak with families of beneficiaries  
16 who died in the LTCH or kind of within that 30 days that  
17 you're referencing. That could be something we consider  
18 kind of for future work, if that's a direction we want to  
19 go in.

20           There was within the past couple months an  
21 article that did talk about kind of life after the ICU, and  
22 I thought that, you know, there are some corollaries

1 between that article, and it was -- I can't remember. I  
2 want to say it was either New York Magazine or it was in  
3 kind of an everyday publication, talking about the stress  
4 and the trauma that being in these very, very high  
5 intensity settings provides, taking a step away from LTCH a  
6 little bit but talking about the ICU, and that it's a very  
7 long process of what recovery is and understanding kind of  
8 how do we define recovery and how does one recover and what  
9 does that mean to be fully recovered, both from, you know,  
10 your physical and your mental state following ICU use. And  
11 that is far out of the scope of this paper, but I think it  
12 touches upon some of the issues you're bringing up and  
13 thinking about, you know, long-time patient satisfaction  
14 and family satisfaction.

15 DR. DeSALVO: And expectation management and  
16 clarity about what recovery would look like, et cetera. So  
17 maybe later, maybe in the future we can start to think  
18 about some policy directions that would encourage that even  
19 further.

20 Thank you.

21 DR. CROSSON: Pat.

22 MS. WANG: This is a really interesting

1 conversation, and I just want to -- there's a reason that  
2 hospice is not part of the PAC PPS. Hospice is a different  
3 thing. And, you know, everything that -- the questions  
4 that Kathy raised and, Karen, your point is all a good  
5 direction to pursue.

6 I guess that I would just think that we should be  
7 a little bit cautious about sort of a slide from -- I mean,  
8 you know, a of people die in the hospital, too. You don't  
9 expect that when they're sick and they go to the hospital  
10 that maybe they should be counseled to go to hospice  
11 instead. And I think whether it's LTCH or under the PAC  
12 PPS, an equivalent setting to take care of people who are  
13 acutely ill and do hope to recover -- I mean, these are  
14 licensed as hospitals. In the future version in the PAC  
15 PPS they will be licensed as something to take care of  
16 patients who are this critically ill. We should just be a  
17 little cautious about assuming that that is an automatic  
18 slide to hospice, because I really think they're two  
19 completely different things. It doesn't take away from the  
20 importance of counseling and expectation management, but  
21 it's very hard at that stage in somebody's illness to  
22 really manage expectations of a family, and also the

1 patient who thinks that they're going to walk out of there.

2 DR. DeSALVO: Thanks for that clarity. I didn't  
3 mean to imply that you could substitute one for the other,  
4 but I do think that we would owe it to beneficiary to make  
5 sure that we heard what their experiences were like and  
6 also understood if they were getting all of the options  
7 presented to them.

8 DR. CROSSON: Okay. Jonathan and then Marge.

9 DR. JAFFERY: So sort of on this same topic, and  
10 I do think this is a really important, interesting  
11 discussion, and I'm still struggling with where do LTCHs  
12 fit in. Are they really part of the post-acute-care space,  
13 or are they part of the acute-care space, and how does that  
14 make sense?

15 Maybe for the next -- again, I think this report  
16 is great for right now. I think maybe as part of the next  
17 stage analysis, there might be some other information that  
18 we can get at in terms of prognosticating a little bit who  
19 of the patients who are going -- who meet criteria, who are  
20 going to the LTCH, end up in that 30 or 40 percent of  
21 people who don't do well. You showed some very stable  
22 information for patients in the criteria that the 30

1 percent of them die within the stay or 30 days after. But,  
2 you know, thinking about that idea of counseling in the  
3 acute-care setting or even the early stage of the LTCH  
4 stay, that might start to think about, well, who are the  
5 right patients that should go to palliative care or  
6 hospice. If a family hears that 30 percent of people are  
7 going to die in that time frame, a lot of them will say,  
8 well, that means 70 percent won't. But if they hear, well,  
9 in my certain situation it's actually 75 percent or 80  
10 percent, that may provide for some different kind of  
11 conversations. So I don't know if there's enough data to  
12 look at that down the road.

13 MS. CAMERON: I think what's difficult is, you  
14 know, that's a conversation that most likely occurs between  
15 a patient and the family and a social worker or a  
16 physician. And finding that data and when it occurs in an  
17 acute-care hospital is just something I don't know we are  
18 able to understand.

19 DR. JAFFERY: I guess what I -- if there's data  
20 that we could sort out that says what sort of conditions  
21 certain ages, certainly particular diagnoses that may or  
22 may not lead to a higher mortality, as a tool for the

1 physician and the social worker and a team to have the  
2 conversation with the family.

3 MS. CAMERON: I see, so thinking about kind of  
4 the unadjusted quality measures I showed up on the screen  
5 and that are in your Figure 5, but thinking about those  
6 potentially by certain diagnostic groups, you know, what  
7 does this look like for the ventilator patients, what does  
8 this look like for patients with other categories of  
9 illness.

10 DR. JAFFERY: Right. It's still a conversation,  
11 and some patients and families will say, well, if it's a 5  
12 percent chance, that's better than 0, and so I want to do  
13 everything I can, but just giving people the opportunity to  
14 have as much information as they can.

15 DR. CROSSON: Marge.

16 MS. MARJORIE GINSBURG: Nice work, Stephanie.  
17 This is great. I'm looking at Slide 11, which shows the  
18 difference between the for-profit and nonprofit. This is  
19 really a stark difference, and I guess I have a couple  
20 questions.

21 One, were you taken aback as much as I was about  
22 the different metrics here between those two? And I'm very

1 concerned about it, and I realize this is not about for-  
2 profit/nonprofit, but it does give one pause. And it makes  
3 me worried that it's more likely that nonprofit  
4 institutions will close shop eventually with these kinds of  
5 figures persisting.

6 So I'm curious about what your take was on this  
7 and whether this registers any concern on your part about  
8 what this means for the future.

9 MS. CAMERON: So we've been seeing this trend for  
10 quite some time and the variation in for-profit/nonprofit  
11 LTCHs. Over really the past five or more years, they began  
12 to diverge quite a bit. And one of the things to keep in  
13 mind is, you know, the for-profit and nonprofit facilities  
14 may have some different practice patterns in terms of their  
15 length of stay, in terms of their costs, in terms of their  
16 ability to control costs; and that, you know, for Medicare  
17 cases, while there is a negative margin, which is quite  
18 substantial when you look at kind of the overall across all  
19 LTCHs negative 13 percent, they still maintain -- you know,  
20 they still have other patient populations, and so this is,  
21 you know, thinking about their capability to control costs  
22 in their nonprofit environment. And so it doesn't seem as

1    though they are controlling them as well as the for-profit  
2    facilities.

3                   DR. CROSSON:   Jon.

4                   DR. PERLIN:   I'm confused.   On page 9, you have  
5    85 percent of the facilities that closed were for-profit,  
6    facilities that closed, and they have, among other things,  
7    higher standardized costs.   So it's likely that there were  
8    other efficiencies in terms of the care since --

9                   MS. CAMERON:   So I think we need to be cautious a  
10   little bit here of kind of how we are triangulating the  
11   facilities that closed with kind of the overall for-profit  
12   facilities.   I understand, you know, for the overall for-  
13   profit facilities, the standardized costs tend to be lower.  
14   However, for the group that closed, they were higher, and  
15   they don't necessarily look like the rest of the for-  
16   profits.   So I just do want to give some caution on  
17   triangulating this is based on 50 facilities, which isn't -  
18   - I'd say it's not a small number, but it's not necessarily  
19   representative of the rest of the ones that remained opened  
20   that we're talking about here.

21                   DR. CROSSON:   Okay.   We just completed Round 1.5,  
22   so we're going to move to a conclusion, and David is going

1 to bring us home.

2 DR. GRABOWSKI: Great. Thanks, Jay, and thanks  
3 again for a great chapter and presentation. I know we've  
4 been through this material several times so I'll be  
5 relatively brief.

6 I think a big focus among policymakers has been  
7 sort of determining what is a long-term care hospital and  
8 who should it be for. And, Jonathan, I was really struck  
9 by your comment, because I had something very similar  
10 written down here -- are they a hospital or are they a  
11 post-acute care provider? Both? Neither? Are they  
12 somewhere in between? When I've visited LTCHs they don't  
13 feel like other institutional post-acute care providers,  
14 like skilled nursing facilities or inpatient rehab, yet  
15 they also don't feel like a hospital.

16 And so -- and I think if you look around the  
17 country in areas where beneficiaries don't have access to  
18 an LTCH, we see this tension. Some end up staying in the  
19 inpatient hospital longer, some end up going to a skilled  
20 nursing facility that has built this infrastructure to  
21 really provide this type of service. So they're sort of a  
22 hospital and they're sort of a post-acute care provider.

1           Policymakers have gone through all these steps to  
2 make certain that the appropriate patients are being  
3 admitted to LTCHs. We saw this payment adjustment for  
4 short stay cases and we saw this 25 percent threshold rule,  
5 we saw the moratoria, and now this dual-payment rate  
6 structure. So all of these policy efforts just to make  
7 certain the appropriate individuals are getting services  
8 here.

9           I came away from your chapter believing the dual-  
10 payment rate structure is generally working towards  
11 ensuring that individuals who meet the criteria are being  
12 admitted to LTCHs and those who don't meet the criteria are  
13 beginning to find care elsewhere. So I think that's a good  
14 development, and based on your work I didn't see any  
15 adverse consequences.

16           So I think so far, so good. I do believe,  
17 however, we have more work to do with LTCHs, and this is  
18 one of the real reasons I'm glad we're moving towards a  
19 site-neutral payment system, because I think it's really  
20 hard to do something site-specific here. I think you  
21 really need to think about LTCHs in the bigger picture.  
22 And so I'm really glad we're moving towards site-neutral

1 payment in post-acute care.

2           The final point, once again, is this is another  
3 reason I'm really glad that we're moving towards value-  
4 based payment and ACOs because I think having a larger at-  
5 risk entity thinking about the value of these services is  
6 really important, and if they're offering value those at-  
7 risk entities will direct beneficiaries to these services.  
8 If they're not, they won't. And I really think that's  
9 important going forward because it's been really hard to  
10 regulate, with all these different steps, that the  
11 appropriate individuals get services here, and I think we  
12 can do this in a better way and also make certain that  
13 these services are adding value for the program and for the  
14 beneficiaries. Thanks.

15           DR. CROSSON: Thank you, David. So I would like  
16 to invite, you know, further suggestions to help Stephanie  
17 and Emma prepare the final report, if we have not already  
18 covered them. Jon.

19           DR. CHRISTIANSON: I guess I don't have any. I  
20 think my reading of the chapter is that we -- and the  
21 Congressional mandate -- is that we've fulfilled it with  
22 this chapter. And I think the comments that I hear David

1 making and others are, in the future, if we want to go  
2 forward with more work in this area here's what we might  
3 want to do.

4           But my own opinion is I don't think we need to go  
5 forward with more work between now and when this needs to  
6 be wrapped up, and I'm very comfortable having it in the  
7 June report.

8           DR. CROSSON: Okay. And I'd just like to add a  
9 couple of points here. First of all, I think there's -- I  
10 don't want to overstate this, but I think there's a certain  
11 reason for celebration here. I mean, here we have examined  
12 a policy that, in part, at least, originated here at the  
13 Commission, and up to this point at least it seems to have  
14 worked -- worked as intended, worked to the benefit of the  
15 program and potentially, as well, to beneficiaries, and  
16 arguably without obvious untoward consequences. And that  
17 doesn't happen often in a process of development and  
18 execution of policy, particularly in health care. So I  
19 think that's worthwhile to note in passing.

20           The second thing is it didn't come up in the  
21 presentation but just for clarity here, in the document and  
22 in the final report we will respond to that portion of the

1 mandate that asked us to comment on the need for  
2 continuation of the 25 percent threshold rule, even though  
3 that has been suspended by CMS. Nevertheless, we have done  
4 work on that before and it does appear in the report.

5           With that, Emma and Stephanie, thank you very  
6 much for the work and the presentation, and we look forward  
7 to seeing the final report.

8           With the end of the material today we now have  
9 time for a public comment period. If there is anyone who  
10 would like to comment on the work before the Commission  
11 come forward. I'll ask you in a minute to identify  
12 yourself and any organization or institution that you are  
13 affiliated with. We would ask you to keep your comments to  
14 approximately two minutes. When this light comes back on  
15 the two minutes will have expired.

16           MR. KOENIG: All right. Thank you. I'm Lane  
17 Koenig. I'm Director of Policy and Research for the  
18 National Association of Long-Term Hospitals.

19           I think the discussion on long-term care  
20 hospitals has been very helpful. I just wanted to make a  
21 couple of points. So one is there is a paper that recently  
22 came out, and I'll make sure Stephanie has it, that looked

1 at quality of life after -- on a ventilator in an LTCH.  
2 And the upshot is that -- because this is a big gap in what  
3 we know about quality of life after that, and the results,  
4 I think, were a bit surprising, I think you'll find  
5 surprising. Eighty-five percent of people who were weaned  
6 off the ventilator said they would do it again if they had  
7 the chance to do it, and quality of life was improved for  
8 those who survived and physical function and things like  
9 that. So I'll share that with Stephanie and make sure she  
10 sees that.

11 The other thing, too, just to mention, on the  
12 NBER paper, so if the NBER paper is a not-peer-reviewed  
13 paper and is going to be in the chapter I want to make sure  
14 that peer-reviewed papers that have been published on LTCHs  
15 are actually in the chapter.

16 A couple of things on the NBER paper. Actually,  
17 they looked back to 1998, so their period that they were  
18 looking at was 1998 to 2014. As Stephanie said, they  
19 identified the effects based on entry of the LTCH into the  
20 market. Most entry of LTCHs into the market, because of  
21 the moratorium and other things, happened prior to 2008.  
22 So basically they're identifying their effects largely

1 based on a period from 1998 to 2007. The population of  
2 LTCHs have changed, actually, significantly since then.

3 And then there are two peer-reviewed papers, one  
4 came out in 2015, that I was an author on, and another one  
5 that just came out that I was also a co-author on. The  
6 first one was published in Medical Care in 2015, and it  
7 showed some positive effects of LTCH for certain cases who  
8 spent three more days in the ICU or had multiple organ  
9 failure.

10 The other paper that just came out last month  
11 looked at the impact of the new criteria on severe wound  
12 cases. And the paper is kind of an interesting take. You  
13 know, I can say that because I'm an author on it, I guess,  
14 so I'm biased. But it looked at the change in severe wound  
15 cases, what happened to those cases after criteria, and  
16 what their outcomes were. And so I suggest that you sort  
17 of look at that.

18 The one thing that we found is we didn't find,  
19 for that population, any significant savings to the  
20 Medicare program as a result of the new criteria, and for  
21 certain cases that have a high propensity to go to an LTCH  
22 we found that severe wound cases had higher readmissions

1 and reasons for readmissions for sepsis, which might  
2 explain the lack of savings in that population.

3           So anyhow, I'll make sure the MedPAC staff has  
4 that and can share it with you all. Thank you.

5           DR. CROSSON: Thank you. Seeing no one else at  
6 the microphone, this concludes the March meeting. We will  
7 reconvene in April.

8           Thank you very much, everyone. Safe travels.

9           [Whereupon, at 11:20 a.m., the meeting was  
10 adjourned.]

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