MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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Thursday, October 4, 2018
9:58 a.m.

COMMISSIONERS PRESENT:

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1 P R O C E E D I N G S

2 [9:58 a.m.]

3 DR. CROSSON: I would like to welcome our guests
4 to this October meeting of MedPAC. This morning we are
5 going to return to an issue that the Commission has
6 discussed before which is of great concern and interest to
7 the Nation, and that has to do with the epidemic of
8 opioids, and particularly opioid overdoses and deaths as a
9 consequence to that.

10 We're going to have two discussions. The first
11 one is going to be a context-setting discussion to set the
12 Commission up for the second discussion, which has to do
13 with the mandated report to the Congress.

14 So we have Shinobu and Rachel here, and, Shinobu,
15 are you starting? Okay.

16 MS. SUZUKI: Good morning. Today Rachel and I
17 are here to provide you with information on opioid use in
18 Part D. This work is in response to Commissioner interest
19 and updates our earlier work from a few years ago looking
20 at opioid use and polypharmacy. The session is intended as
21 informational, but we are interested in hearing from
22 Commissioners about future direction for work on this

1 topic.

2 We'll start the presentation with background
3 information that provides context about use of opioids by
4 Medicare beneficiaries. We'll present updated data on the
5 patterns of opioid use in Part D. And we'll conclude by
6 describing steps CMS and plan sponsors are taking to
7 monitor opioid use and manage overuse and misuse.

8 Opioids such as hydrocodone and oxycodone are
9 commonly prescribed for both acute and chronic pain, but
10 they can also bring serious harm when misused. Here's a
11 quick summary of the context in which opioids have become
12 commonly prescribed to Medicare beneficiaries. Use of
13 opioids to treat non-cancer pain became widespread during
14 the 1990s. A couple of things appear to have contributed
15 to this change. First, new extended-release formulations
16 were approved in the 90s, and some manufacturers began to
17 aggressively market them as being less prone to misuse.
18 There was also a growing sense that pain treatment was
19 inadequate, and support for using opioids for chronic pain
20 grew among clinicians. But clinical guidelines around
21 opioid use were unclear, and clinicians faced ambiguity
22 about what constituted safe prescribing.

1 Increase in the use of opioids for chronic pain
2 coincided with a very concerning nationwide increase in
3 opioid overdose deaths. CDC reported that in 2016, there
4 were over 40,000 deaths due to opioid overdose, and at
5 least 17,000 were from prescription opioids. The benefits
6 and risks of opioids are especially apparent in the
7 Medicare population because of higher illness burdens which
8 may make them more likely to experience pain. But side
9 effects of opioids can interfere with other treatments.
10 In addition, because the elderly patients are
11 more likely to have reduced kidney and liver functions,
12 there is higher risk of toxicity and harm, even with a
13 lower dosage. Multiple government reports by OIG and GAO
14 have found evidence of potential opioid overuse, misuse,
15 and fraud and abuse in Part D.
16 To address the ambiguity around safe prescribing
17 of opioids, in 2016 CDC came out with a guideline for
18 prescribing opioids for chronic pain. The guideline states
19 that non-pharmacologic therapy and non-opioid pharmacologic
20 therapy are preferred. It also noted that long-term opioid
21 use often begins with treatment for acute pain and,
22 therefore, CDC recommended that when opioids are used for

1 acute pain, clinicians should prescribe the lowest
2 effective dosage for the shortest duration needed --
3 typically three days or less and rarely more than seven
4 days.
5 However, the guideline does not preclude the use
6 of opioids for patients with chronic pain. If a clinician
7 determines that benefits outweigh risks of harm, the
8 guideline recommends using the lowest effective dosage and
9 carefully reassessing benefits and risks when increasing
10 dosages. The CDC guideline generally discourages
11 clinicians from increasing dosages and urges them to use
12 additional caution when initiating opioids for patients age
13 65 and older.
14 The chart on the left shows the trend in opioid
15 use per 1,000 -- on the top -- compared with the use of
16 non-opioid analgesics per 1,000 -- shown at the bottom --
17 for 2007 through 2016. The top line shows that the use of
18 opioids per 1,000 peaked around 2010 to 2012 and then
19 decreased by about 18 percent between 2012 and 2016.
20 During the same period, the use of non-opioid analgesics
21 per 1,000 remained pretty much unchanged. While the
22 decline is good news, opioid use in Part D continues to be

1 widespread, with nearly one-third of enrollees filling at
2 least one opioid prescription in a given year. Most opioid
3 use was unrelated to cancer or hospice care. And in 2016,
4 gross spending on opioids totaled $4.1 billion, putting
5 them among the therapeutic classes with the highest
6 spending in Part D.
7 There is, however, growing recognition that
8 opioid use varies widely. Some patients need only a few
9 days' supply for post-surgery pain while others need
10 monthly fills for intractable pain. This figure depicts
11 the variation in use among opioid users in 2012, around the
12 time we saw peak use of opioids in Part D. The vertical
13 axis shows the variation in the average MME per day, and
14 the horizontal axis measures the number of days' supply.
15 Among beneficiaries in stand-alone PDPs with at least one
16 opioid prescription in 2012, about 78 percent had an
17 average daily dose of 50 MME or less. A cluster in the
18 upper left shows beneficiaries with low-intensity use --
19 those with 50 MME per day or less and treatment lasting
20 three months or less. About 40 percent had low-intensity
21 use.
22 In the lower right corner are high-intensity

1 users -- those with a higher average dose, and treatment
2 lasting more than three months. About 17 percent had high-
3 intensity use. This variation in intensity of use is
4 important in understanding opioid-related adverse drug
5 events, or ADEs, which we will turn to next.
6 This chart shows the incidence of opioid-related
7 ADEs among those who used opioids in 2012. We looked at a
8 very narrow definition of opioid-related ADEs and included
9 only diagnosis codes specifying poisoning by opioid in
10 inpatient and outpatient claims, including emergency
11 department visits that resulted in inpatient stays.
12 Overall incidence of opioid-related ADEs was 0.6 percent,
13 or six ADEs per 1,000 opioid users. But as you can see by
14 the blue and gray bars, high-intensity users, shown in
15 gray, had a much higher rate of ADEs -- nearly seven times
16 that of low-intensity users. Certain demographic and
17 clinical characteristics appeared to be associated with the
18 risk of experiencing opioid-related ADEs. We show some of
19 them here on the chart, for example, being under age 65,
20 receiving Part D's low-income subsidy, taking more drugs,
21 and obtaining opioids from multiple prescribers. But as
22 you can see across all of the subgroups, high-intensity use

1 of opioids is consistently associated with a higher
2 incidence of opioid-related ADEs. For example, among
3 opioid users with ten or more unique drugs, incidence of
4 ADEs among high-intensity users was more than six times
5 that of low-intensity users.
6 DR. SCHMIDT: ADEs related to opioid use are
7 evidence of actual harm that has occurred. But, in
8 addition, we've seen patterns in Part D data that suggest
9 much broader potential for harm. The key reason is
10 polypharmacy -- when beneficiaries use multiple drugs.
11 Medicines can interact with opioids and magnify effects
12 such as respiratory depression. We looked at Part D
13 enrollees who filled at least one opioid prescription in
14 2015, excluding those in hospice or being treated for
15 cancer. On average, those beneficiaries used nearly six
16 opioid prescriptions during the year. When we compared
17 them to enrollees who had no opioid prescriptions, on
18 average those with opioids filled more prescriptions for
19 all drugs -- an average of 70 compared to 40 -- and used
20 drugs from ten different therapeutic classes, compared with
21 five. Also, 45 percent of enrollees with opioid
22 prescriptions also filled prescriptions for benzodiazepines

1 or gabapentin -- drugs that, when used concurrently,
2 increase the risk of opioid-related death. When we ranked
3 the Part D enrollees by opioid spending and looked at the
4 top 5 percent, they filled on average 22 opioid
5 prescriptions during the year with average opioid spending
6 of over $3,700; 75 percent of those top enrollees were also
7 filling concurrent prescriptions for benzodiazepines or
8 gabapentin. These patterns are concerning signs of
9 potential harm to beneficiaries.
10 In 2013, CMS added new requirements for Part D
11 plan sponsors around managing opioid overuse. Sponsors had
12 to review claims to identify enrollees who were at high
13 risk of opioid abuse or misuse, monitor for high cumulative
14 dosages across all a patient's prescriptions, and plans
15 could use safety edits or notifications to pharmacists to
16 check with the patient's prescriber.
17 Also in 2013, CMS started its Overutilization
18 Monitoring System to monitor whether plan sponsors were
19 complying with opioid policy. The OMS uses claims to
20 identify patients who seem to be exhibiting "shopping
21 behavior" by having many providers. It also gives plans
22 opportunities to provide information to prescribers that

1 could help to coordinate patient care. Each quarter, the
2 OMS notifies plan sponsors about their enrollees who look
3 like they could be at high risk. The sponsor has 30 days
4 to reach out to prescribers to make sure they're aware the
5 patient sought opioids from several providers, check
6 whether the dosage was intended, and then report back to
7 CMS.
8 Beginning in 2019, plan sponsors will have new
9 authority to limit certain at-risk beneficiaries' access to
10 frequently abused drugs, which I'll describe more in a
11 minute. CMS also monitors opioid use through quality
12 measures and patient safety reports to plan sponsors.
13 Shinobu showed you earlier that there are
14 different patterns of opioid use, so a one-size-fits-all
15 approach to managing opioid prescriptions is not
16 appropriate. For 2019, CMS suggests that plan sponsors use
17 a tailored approach. For patients newly prescribed an
18 opioid, after surgery, for example, plans must limit the
19 quantity dispensed to no more than a seven-day supply. For
20 enrollees that are at high risk of abusing opioids, plans
21 will have authority to limit access through a drug
22 management program, but must follow a process that I'll

1 tell you about on the next slide. That process is
2 integrated with the OMS. For other beneficiaries who are
3 chronic users of opioids but whom the plan has not found to
4 be at risk, CMS expects plan sponsors to notify the
5 pharmacist to do a safety check with the prescriber when
6 the enrollee's cumulative dosage reaches 90 MME or more.
7 CMS permits plans to put limits on prescription fills at
8 cumulative dosages of 200 MME or higher. CMS also expects
9 plan sponsors to alert the pharmacist when an enrollee has
10 duplicative opioid prescriptions or takes certain other
11 drugs concurrently like benzodiazepines.
12 Beginning in 2019, plans may set up drug
13 management programs to manage benefits of enrollees who the
14 plan finds to be at risk of abusing certain drugs like
15 opioids. The plan has to use clinical criteria for
16 defining who is potentially at risk and then review past
17 claims. Beneficiaries in hospice, long-term care, or being
18 treated for cancer are exempt. The plan must conduct case
19 management, that is, reach out to prescribers to see if
20 there are clinical factors that warrant the cumulative
21 dosage. There's a formal notification process to the
22 beneficiary and prescribers, and the enrollee can appeal if

1 the plan finds that they are at risk. After these steps,
2 the plan sponsor may use a pharmacy lock-in or require the
3 beneficiary to use one or a few designated pharmacies to
4 fill their opioid prescriptions. Plans may also put
5 restrictions on the beneficiary's fills or lock them into
6 seeking prescriptions from one or a few prescribers, but
7 only after several documented attempts to reach the
8 prescribers and agreement from at least one of them. Plan
9 sponsors must review whether the clinical criteria continue
10 to apply to the beneficiary and end their at-risk status if
11 the criteria no longer apply. Normally, enrollees who
12 receive Part D's low-income subsidy may change plans once
13 per quarter in 2019. However, if an LIS enrollee's plan
14 finds them to be at risk, then the beneficiary may not use
15 their quarterly special enrollment period.
16 CMS also has a separate effort that focuses on
17 providers. Under contract with CMS, the national benefit
18 integrity Medicare drug integrity contractor, or MEDIC,
19 analyzes prescription data and conducts investigations to
20 identify providers who may be committing fraud and abuse.
21 For example, the MEDIC might see a pattern of claims that
22 suggests a provider may be prescribing opioids

1 inappropriately or operating a pill mill. The contractor
2 may review medical records, conduct site visits and
3 background checks, and interview beneficiaries to
4 investigate cases. If warranted, the MEDIC may refer the
5 case to CMS, plan sponsors, and law enforcement. The HHS
6 Office of Inspector General says that the MEDIC contractor
7 has identified thousands of leads in recent years, but the
8 OIG couldn't evaluate the effectiveness of the MEDIC
9 because they don't know what actions plan sponsors took
10 based on those leads.
11 Another approach CMS will use beginning in 2019
12 is to place certain prescribers on a preclusion list --
13 meaning the prescriber has been revoked from Medicare for
14 engaging in behavior that is detrimental to the best
15 interests of the Medicare program. Part D plan sponsors
16 must reject pharmacy claims written by prescribers who are
17 on the preclusion list.
18 In summary, our analysis of claims suggests that
19 prescription opioid use continues to be widespread among
20 Part D enrollees. Prescription patterns raise concerns
21 about broad risk to enrollees associated with polypharmacy
22 and high use of opioids. CMS has required Part D plan

1 sponsors to take steps to manage opioid use for the past
2 five years, and in 2019, sponsors will have new authority
3 to restrict access to frequently abused drugs like opioids
4 for certain at-risk beneficiaries.
5 And now we're happy to take your questions.
6 DR. CROSSON: Thank you, Shinobu and Rachel.
7 Very nice context and level setting presentation.
8 For this presentation we are going to have one
9 round only, which would include questions and brief
10 comments, starting with Jonathan.
11 DR. JAFFERY: Thank you for that summary. So,
12 clearly, there has been a lot of attention on the behalf of
13 prescribers in terms of being concerned about past and
14 current behavior about overprescribing. But I think we're
15 hearing -- or at least I am hearing lots of anecdotes about
16 people who may be appropriate for opioids now not getting
17 them, particularly folks with cancer and in hospice. And
18 so any analysis about trends in prescribing patterns for
19 those groups?
20 MS. SUZUKI: Our analysis has focused on non-
21 cancer, non-hospice care patients. But when we look at the
22 overall use, the share -- well, first of all, cancer and

1 hospice patients are excluded from these management tools
2 that plans are using, and we don't see any drop necessarily
3 for cancer and hospice patients using opioids. We haven't
4 looked closely at the quantity, but I think, in general,
5 people seem to be getting their drug based on trends.
6 DR. SCHMIDT: To answer directly, we haven't
7 looked at specific diagnoses like sickle cell anemia or
8 spinal cord injuries or things like that where you'd expect
9 intractable pain and maybe opioid long-term use has been
10 used and might be more appropriate.
11 I think CMS recognizes that there are those
12 patients out there, and that's why they're arguing for a
13 more tailored sort of approach. And we can get into this
14 more a bit later perhaps, but looking at formularies and
15 Part D plans, it looks as though the high-dosage, extended-
16 release kinds of formulations are not showing up on plans -
17 - not a lot of plans are covering those directly. So some
18 of those patients may need to seek out exceptions to get
19 coverage for those. There are some stand-alone drug plans
20 having that, but not a whole lot.
21 DR. CROSSON: Jaewon.
22 DR. RYU: Yeah. I had a question on Figure 2.

1 It shows that the prescriptions per thousand for opiates
2 has been decreasing over the last -- I don't know -- five
3 years or so, but elsewhere you mention that the death rate
4 for beneficiaries from opiate overdose has climbed and in
5 fact increased fastest among all age groups. Any insight
6 into how that disconnect kind of reconciles?
7 DR. SCHMIDT: Well, I think it just maybe speaks
8 to the magnitude of -- or the degree to which they are
9 being prescribed in this population now and have been.
10 So even though maybe it's cut back some, it's
11 still one in three. It's still a lot of people, and so,
12 again, with the risk of polypharmacy interactions with
13 other things that folks are taking, there's still quite a
14 risk out there.
15 DR. RYU: Yeah. It just seems like the decrease
16 in utilization rate would correlate with the decrease in
17 death rate, but I just thought that was kind of bizarre.
18 The other question was around any insight into
19 what the precipitating event is. So you remove cancer; you
20 remove hospice. But are these in a postoperative? Are
21 these ER visits that create that first encounter with
22 opiates that then triggers the downstream utilization? Do

1 we have any kind of evaluation or information on that
2 front?
3 MS. SUZUKI: So we have not looked specifically
4 into the triggering event.
5 We have looked at diagnosis codes for people who
6 do use opioids in the Part D program. A lot of them seem
7 to have psychiatric conditions. Some of the high users,
8 over half of them, reported some sort of psychiatrist
9 conditions, like depression and bipolar.
10 There are rheumatoid arthritis-type conditions
11 that are higher. You'll see more prevalence among the
12 opioid users compared to non-users.
13 I think there is some neurological conditions
14 that also show up more among the users compared to non-
15 users of opioids.
16 DR. CROSSON: Yes. Dana.
17 DR. SAFRAN: Thanks. This is really interesting
18 and I'm timely work.
19 I had two questions. One is on page 9, and I
20 think you have the figure. I guess it is Figure 1 in the
21 report. I think you had it in your slides too, where you
22 have the different quadrants low-intensity use. Yeah,

1 that.

2 So what was striking to me about this figure was,

3 at the very top, the high percentage of beneficiaries who

4 even while on a lower average daily Medicaid are on that

5 for a long time. I just wonder what we know about that

6 issue because we sort of call out high-intensity users, and

7 we're sort of focused there. But my eye gets caught by

8 that, being on a low dose for a long time. Who are they,

9 and what do we know about their outcomes? So I just wanted

10 to ask about that.

11 Then I will just throw out my second question and

12 listen to your response.

13 My second question is whether we are able to,

14 with the data we have or whether we know of others, maybe

15 academics or elsewhere, who are doing modeling to help us.

16 We should be able to use data to get a pretty good

17 predictive sense of who are the people who are most at

18 risk. What are the factors that really put somebody are

19 risk, beyond some of the things we're talking about here?

20 That could really be used to guide prescribers.

21 So I'm just curious whether, A, we think we have

22 data like that, that we could do some of that advanced

1 analytics to do predictive modeling or do we know of folks
2 who are doing it. It seems important.
3 DR. CROSSON: Dana, just to be clear, on your
4 first point, you're talking about the northeast corner of
5 the slide there; is that right?
6 DR. SAFRAN: No. I'm talking about sort of the
7 north middle west, the dark part where it's a sizable
8 percentage, over 1.61 percent of overall opioid users who
9 are on zero to 20 Medicaid, but for at least half a year.
10 DR. CROSSON: I see, okay. All right. Not the
11 long-term users in terms of nearly a year.
12 DR. SAFRAN: No.
13 DR. CROSSON: But somewhere in the middle there.
14 DR. SAFRAN: Yeah, yeah.
15 DR. CROSSON: Okay, thanks.
16 Sorry. Go ahead.
17 MS. SUZUKI: So on your first question about the
18 low-dose, long-term users, we don't have a demographics for
19 that cell separately from the others, but I think in
20 general, low intensity -- opioid users tend to be under 65,
21 low-income subsidy, disabled, have more conditions than
22 other populations. They may be in one of the conditions

1 where you require chronic pain treatment rather than short-
2 term acute pain. But we don't know for sure whether that's
3 the right demographic.
4 DR. SCHMIDT: And on your second question, in the
5 course of putting together some research on this and been
6 approached by private-sector consultants who have the sort
7 of analytic skills that you're speaking to, they're doing
8 predictive modeling now for all kinds of providers to try
9 and help with prescribing behavior or kind of guide the
10 inpatient-to-outpatient transition better.
11 And they're looking at things like past dependent
12 substance abuse, socioeconomic status, disability, those
13 kinds of factors.
14 But, in addition, for the Medicare population,
15 again, let's look at polypharmacy concerns because of the
16 older body's inability to clear meds as quickly as someone
17 younger.
18 DR. CROSSON: All right. Thank you.
19 So I had Brian, Amy, and Kathy; is that right?
20 Okay. Brian.
21 DR. DeBUSK: First of all, thank you for a really
22 well-written chapter. It is sort of thought provoking and

1 alarming.

2 I had two questions. First of all, is there a
3 precedent for something like this happening? Have there
4 been other drugs in the past that have gotten away from us
5 or gotten out of hand that had to be pulled back in, or is
6 this truly new territory? If we go back even 10, 20, 30
7 years?

8 DR. SCHMIDT: I'm going to look around the table
9 to other folks to see if they can think of any. I can't.

10 DR. DeBUSK: This is truly uncharted territory.

11 DR. PERLIN: Opioids. At the turn of the
12 century, in fact, the opioid epidemic, we pulled it back
13 once before worldwide.

14 DR. DeBUSK: Oh, I was thinking morphine post-
15 Civil War, but --

16 [Laughter.]

17 DR. PERLIN: Exactly.

18 DR. CROSSON: Well, cocaine as well.

19 DR. DeBUSK: Okay. Well, again, I just wondered
20 if there were some examples. Maybe we could learn.

21 But the other question I had is, Are there some
22 more radical ideas that maybe we could explore that you've

1 explored that maybe didn't make it into the chapter, even
2 more restrictive or more radical ideas on how we could
3 address the crisis?
4 DR. SCHMIDT: Well, I think this is a situation
5 where there's a balance to be had. There are patients who
6 maybe have been receiving opioids for a long time. They
7 have a high tolerance. Maybe they have physical and
8 psychological dependence, and so to do something dramatic
9 could have some serious consequences on their health.
10 At the same time, you don't want too much
11 prescribing going on because there's potential for abuse
12 and overdose and diversion, those sorts of factors.
13 So this is a difficult path to walk to make sure
14 you're allowing high dosages out there where it might be
15 important, but trying to pull back generally where it's
16 causing public harm.
17 DR. DeBUSK: Again, thank you for that, but when
18 I read the chapter, I guess my clarifying question would
19 be, What we saw in the meeting materials, was that sort of
20 the middle of the road of the policy options, where maybe
21 you clipped some of the higher or the more radical ideas,
22 or have we inventoried those? I mean, do we have a pretty

1 good feel for what those ideas would be?

2 DR. MATHEWS: If I could take a stab at that

3 Brian. I think that the material that we've presented here

4 is largely informational. We're looking at trends. We're

5 looking at some of the actions that CMS has taken to

6 monitor and provide appropriate feedback to prescribers and

7 provide information to pharmacies that again might be

8 conveyed to prescribers. But we are not talking Commission

9 policy at this point.

10 If you have ideas you'd want us to pursue, by all

11 means, you're free to articulate those, but this is a

12 largely informational discussion.

13 DR. CROSSON: Amy.

14 MS. BRICKER: Thanks for the chapter and

15 something that I'm personally very, very passionate about.

16 A couple questions. Do we know how many high

17 opioid utilizers age into the Medicare program each year?

18 DR. SCHMIDT: No, we don't at this point. No.

19 MS. BRICKER: So, likely, without knowing, I'm

20 just going to take a guess. Because the system has grossly

21 failed this population on the commercial sector, this

22 program is inheriting, I think, this burden, and it is

1 incumbent upon us to begin to solve it and address it in a
2 real way. So I'll hold that one on some ideas there.
3 The preclusion list that you noted for '19 and
4 then the requirement of pharmacy claim to be rejected, are
5 those prescribers still being reimbursed by Medicare for
6 their physician services, for getting paid for the office
7 visit, even though they're on this list as a bad actor? Do
8 you know?
9 DR. SCHMIDT: I need to verify this answer, but
10 my sense is no. I think that they are on the reenrollment
11 bar for Medicare, so I think at this point, no.
12 MS. BRICKER: Okay. So they have been excluded
13 from the Medicare program entirely, this 800 physicians.
14 So I don't know if this is common knowledge, but
15 120 Vicodin costs $25. So to reject a claim at pharmacy
16 just means that we lost track of it. It doesn't mean that
17 the patient walked away without it. So I just want to
18 emphasize that.
19 It's incumbent upon, I believe, us to begin to
20 either -- I believe through a stick, not a carrot, to begin
21 to change the rhetoric around this topic. There's such a
22 stigma around addiction, and what struck me as -- in the

1 chapter we are going to talk about later today around
2 psychiatric services, the very small percent of Medicare
3 beneficiaries that are seeking addiction treatment, it's
4 tiny.
5 One in three are getting an opioid prescription,
6 and yes, I know not a third of the population is addicted
7 to opioids. But it's a very high number in this
8 population, and yet they are not seeking treatment. Why
9 aren't they seeking treatment?
10 We have got to take this as a public service
11 announcement. "Wear your seat belt," that worked. We've
12 got to take this on I think in a more bold way and to pull
13 out those prescribers, those that are continuing to -- this
14 is a revenue stream. Once you understand who will
15 prescribe for you, that becomes something that the
16 communities rely on, and it's really hard for physicians to
17 walk that back. So I would encourage us to do more.
18 I know that we're going to talk about this in the
19 next section also, and Jon Perlin sits on the National
20 Academy of Medicine. There are many, many groups that are
21 studying this, and so I think we should learn from those
22 and take what's working and then expand upon that. But

1 there's just really not enough that we could do here. We
2 are not the only country in pain, and yet it's a
3 disproportionate amount of opioid prescriptions that are
4 dispensed and utilized in this country. And so we've got
5 to figure out how to begin to do the right thing for these
6 beneficiaries.
7 We are at an alarming rate. Seeing them age into
8 this population would be my guess. So I would just urge us
9 to be bold here.
10 DR. CROSSON: Thank you.
11 Amy. We've got Kathy and Warner and Sue.
12 MS. BUTO: You may have covered this, but I was
13 wondering if we can differentiate beneficiaries of both the
14 high- and low-intensity users by MAPD and PDP, both in
15 terms of enrollment. So do we see a disproportionate in
16 enrollment and say the PDP versus the MAPD and their
17 utilization? So can we make that distinction?
18 MS. SUZUKI: So for those 2012 analysis, this was
19 part of an adverse drug event analysis, so we had to limit
20 the analysis to PDP enrollees, so we have claims for the
21 A/B service. So this is all PDPs.
22 But in terms of MAPDs versus PDPs, the

1 utilization generally is not terribly different. Both
2 users on average took about five to six opioid
3 prescriptions. They also had about the same mean number of
4 days supplied per prescription.
5 Maybe there is a slightly smaller share of MAPD
6 enrollees who had the very high use, like the top 5
7 percent, but in general, they were very similar.
8 DR. SCHMIDT: But among all opioid prescriptions,
9 there are more in PDPs, more of those enrollees taking
10 opioids are in PDPs, because it's correlated with LIS
11 status, disability, those sorts of things.
12 MS. BUTO: I also wondered if it was correlated
13 with inpatient versus outpatient, fewer opioid
14 prescriptions that we can, I guess, identify that are
15 bundled into the DRG on discharge.
16 Anyway, we can come back to that later.
17 DR. CROSSON: Okay. So I have Warner, Sue, and
18 Bruce.
19 Just to be clear, we're going to have time for
20 additional input after the next presentation as well.
21 Warner.
22 MR. THOMAS: I'll be real quick. Have we looked

1 at the usage on beneficiaries that are over 65 versus
2 beneficiaries that are disabled? Do we make a distinction
3 there, or do we see any differences in the utilization?
4 MS. SUZUKI: So we haven't done that specific
5 analysis, but we do see that under-65 population is over
6 represented in the highest use group. So that's the one
7 where we saw an average 22 prescriptions per year compared
8 with 5 to 6 per year for the rest of the population.
9 MR. THOMAS: And is that a significant enough
10 population to skew all the numbers or not?
11 MS. SUZUKI: I'll have to go back and look.
12 I know that LIS, which also has high share that's
13 disabled, they accounted for about two-thirds, roughly, of
14 the population that was in the highest use group.
15 MR. THOMAS: Just a last comment, and it really
16 kind of speaks to the language.
17 I would just encourage us, going to Amy's point,
18 to have more stronger language, more urgency in the chapter
19 around the importance of this issue. I know there's a more
20 informational chapter, but I just think continuing to raise
21 the awareness, I just don't think we're doing enough. So I
22 would hope that we could build that into this chapter going

1 forward.

2 DR. CROSSON: Sue.

3 MS. THOMPSON: And I'll be quick. I really want

4 to underscore what Warner just said and in support of Amy's

5 comments.

6 I remember the days of when accrediting bodies,

7 reviewers were critical of providers and are skimping in

8 adequately managing pain, and a movement towards pain is

9 what the patients says it is and how we through that

10 narrative were able to, I mean, move 180 degrees in terms

11 of the liberal use of this drug or these drugs.

12 So my question becomes, Does it become a matter

13 of a new narrative around moving back to some center place?

14 Because, certainly, pain is real, but what's the middle

15 ground? The power of that narrative surely shifted us.

16 I am very curious about what education are we

17 assuring that our providers have around pay management.

18 What's that minimum understanding?

19 With that, I just want to underscore a strong

20 narrative here because it certainly worked in the opposite

21 direction.

22 DR. CROSSON: I think it's a good point, Sue, and

1 I remember that too. We had this in California, but in
2 other parts of the country where physicians were being sued
3 not for malpractice, but for elder abuse, which, of course,
4 in most jurisdictions was not covered by malpractice
5 insurance. That was one of the precipitating events that
6 you described, which brought about, on the part of
7 physicians, I think the notion that they were at risk if
8 they did not liberally, more liberally anyway, provide
9 opioids.
10 I think in part -- not in total, but in part
11 contributed to where we are right now. And I think as a
12 consequence of where we are now, I think policies need to
13 be directed in a balanced way to stop this epidemic, but
14 also not deprive individuals who legitimately need pain
15 relief from those services.
16 Bruce.
17 DR. PYENSON: Thank you very much for a lot of
18 great information.
19 My question is, Do you have any insight or data
20 on how formulary design in Part D might influence or either
21 attract the selection of members or prescribing patterns in
22 particular with brand, higher-intensity opioids versus

1 other opioids?

2 DR. SCHMIDT: Well, as I alluded to earlier, we

3 haven't done a look over time at formularies, but I've been

4 spending some quality time with the plan finder over the

5 past few days. Since then, new information has just come

6 up for 2019 plans.

7 At least for looking at branded, extended-

8 release, high-dosage OxyContin, for example, there's a

9 handful of PDPs that have that on formulary, and most MAPDs

10 do not appear to have it on formulary.

11 All of the plans seem to have low-dosage or

12 immediate-release formulations of opioids.

13 So there may be some strategy there to simply not

14 cover the higher-dosage and extended-release versions of

15 drugs, which means that people who have been taking those

16 will probably need to seek exceptions to their prescriber

17 and the plan.

18 DR. CROSSON: Okay. Again, thank you, Rachel and

19 Shinobu, for an excellent context chapter.

20 We will now move on to the second presentation

21 for this morning, which is on a similar topic and will

22 introduce us to some mandated work by Congress.

1 [Pause.]

2 DR. CROSSON: Okay. So Jennifer is going to take
3 us through this set of questions, including a congressional
4 mandate, which asks whether certain Medicare payment
5 systems may be influencing the overuse of opioids.
6 Jennifer?

7 MS. PODULKA: Thank you.

8 So as you've heard, Commissioners have expressed
9 an interest in continuing to explore Medicare
10 beneficiaries' use of opioids and current efforts to
11 influence physicians' prescribing patterns. In addition,
12 recently passed legislation includes a mandate for the
13 Commission to report on opioid issues in inpatient and
14 outpatient hospital settings.

15 The SUPPORT for Patients and Communities Act
16 calls on MedPAC to report to the Congress by March of 2019
17 on three items:

18 First, a description of how the Medicare program
19 pays for pain management treatments, both opioid and non-
20 opioid pain management alternatives, in both the inpatient
21 and outpatient hospital settings;

22 Second, the identification of incentives and

1 adverse incentives under the hospital inpatient and
2 outpatient prospective payment systems for prescribing
3 opioid and non-opioid treatments, and recommendations as
4 the Commission deems appropriate for addressing these;
5 And, third, a description of how opioid use is
6 tracked and monitored through Medicare claims data and
7 other mechanisms and the identification of any areas in
8 which further data and methods are needed for improving
9 understanding of opioid use.
10 On the first item, Medicare uses bundled payments
11 to pay for pain management drugs and other goods and
12 services in both the inpatient and outpatient settings.
13 They're applied somewhat differently in the two settings.
14 The inpatient prospective payment system, or IPPS, assigns
15 days to categories depending on patients' conditions and
16 sets payment bundles that reflect the average cost of
17 providing all goods and services, including drugs that are
18 supplied during the stay.
19 The outpatient prospective payment system groups
20 services into categories on the basis of clinical and cost
21 similarity and sets payment bundles to cover the costs of
22 providing directly related and integral goods and services

1 along with the primary service.

2 Additional goods and services are either paid

3 separately or not paid by the outpatient prospective

4 payment system. And you may remember in prior reports and

5 presentation we have described situations where outpatient

6 drugs are usually self-administered or separately payable

7 or paid on pass-through status, but none of these rules

8 apply to pain drugs in the outpatient hospital setting.

9 So, to sum up, the IPPS payment is fairly

10 straightforward, but the OPPS payment is not, so we'll dig

11 into that one.

12 Pain drugs in the outpatient setting may be paid

13 under Part B or Part D or not paid by Medicare at all.

14 Determining which is a bit tricky, so we'll walk through

15 this flow chart.

16 The first question shown in the top left diamond

17 starts with: Is the drug for pain? Drugs that are not are

18 outside the scope of our study today. If the answer to the

19 first question is yes, we move along the top to the diamond

20 shape that asks the second question: Is the drug directly

21 related and integral to a procedure or treatment and

22 required to be provided to a patient in order for a

1 hospital to perform the procedure or treatment? CMS has
2 affirmed in multiple rules that post-surgical pain
3 management drugs are directly related and integral.
4 So following the yes across the top to the box
5 that indicates that in these situations pain drugs are paid
6 under Part B as part of the OPPS bundled payment.
7 But pain drugs can be used in outpatient settings
8 for other reasons. Rather than being directly related to a
9 procedure or treatment, pain drugs can be the treatment all
10 by themselves, for example, when a patient goes to the ED
11 with an injury and pain. In these cases, Part D doesn't
12 pay for the drug, and the hospital usually charges the
13 patient. If the beneficiary has a Part D drug plan, the
14 plan might pay for the drug if it is included in the plan's
15 formulary and the hospital's pharmacy participates with the
16 plan. But many don't.
17 And one last note before moving on. CMS'
18 guidance about determining how drugs are paid for in
19 outpatient hospital settings is directed to the MACs, or
20 Medicare administrative contractors. In practice, this
21 means that implementation of these rules is up to the
22 discretion of the individual MACs, so there may be

1 variation across geographic regions.

2 The second item from the legislative language
3 asks us to identify incentives and adverse incentives under
4 the hospital inpatient and outpatient prospective payment
5 systems for prescribing opioids and non-opioids. So this
6 study will focus on these financial incentives, but we
7 recognize that there are also patient-specific and clinical
8 factors that guide prescribers' pain drug choices.

9 The inpatient and outpatient prospective payment
10 system payment bundles are designed to give hospitals a
11 financial incentive to select the lowest-cost goods and
12 services possible. This incentive is balanced by
13 Medicare's quality measurement and reporting programs,
14 along with providers' clinical expertise and
15 professionalism. Thus, these balanced incentives ideally
16 result in high-quality outcomes for patients at the best
17 prices for beneficiaries and other taxpayers.

18 To better understand the extent to which there
19 might be a financial incentive that influences opioid
20 prescribing, we have begun an analysis of the difference in
21 prices between opioid and non-opioid drugs commonly used in
22 the inpatient and outpatient hospital settings. And I'll

1 note that we are also looking into options about non-drug
2 alternatives.
3 This analysis, however, has a key caveat. We do
4 not know the actual prices that hospitals paid for these
5 drugs as hospitals do not report their drug acquisition
6 costs. Average sales prices, which are weighted averages
7 of manufacturers' sales prices for a drug for all
8 purchasers net of price adjustments, are not available to
9 us for many of the opioid and non-opioid drugs in our
10 study. In lieu of these, we will attempt to examine list
11 prices that may be publicly available, such as wholesale
12 acquisition cost and average wholesale price.
13 We acknowledge that if we use these prices, they
14 will represent an upper bound, but the relative differences
15 between the two categories of drugs should be informative.
16 And we plan to present on this topic at a second meeting
17 and hope to have results from the analysis to share with
18 you to inform your discussion.
19 On the third item from the mandate, as you just
20 heard in detail in Shinobu and Rachel's presentation, CMS
21 tracks opioid use through data available in the Part D
22 program. To briefly review, CMS monitors opioid use in

1 Part D in multiple ways, and there are three categories
2 that might be most relevant to Parts A and B.
3 First, the Overutilization Monitoring System
4 shares feedback securely with Part D plan sponsors and
5 ensures that they implement opioid overutilization policies
6 effectively.
7 Second, CMS uses quality measures to track trends
8 in opioid overuse across the Medicare Part D program and
9 drive performance improvement among plan sponsors. These
10 include publicly available display measures and
11 confidential patient safety reports that are sent to plan
12 sponsors.
13 And, third, CMS makes data on clinicians' opioid
14 prescribing patterns publicly available on the website
15 through the Medicare Part D opioid prescribing mapping tool
16 that shows comparisons at various geographic levels.
17 All three efforts rely on prescription drug
18 event, or PDE, data, which are a summary record that
19 prescription drug plan sponsors must submit every time an
20 enrollee fills a prescription under Medicare Part D. The
21 PDE data are not the same as individual drug claim
22 transactions, but are summary extracts using CMS-defined

1 standard fields. The distinction is important, and I'll
2 come back to it in a bit.
3 And, finally, the agency does not operate opioid
4 tracking programs in Part A and Part B.
5 So this brings us to the question: Given
6 concerns about the opioid crisis, should CMS track opioid
7 use in hospital inpatient and outpatient settings? And if
8 yes, what lessons learned from CMS' tracking of opioid use
9 in Part D should be applied to similar efforts in Part A
10 and Part B?
11 Reasons for undertaking a tracking program
12 include the severity of the opioid epidemic, the gap in
13 knowledge about the degree to which Medicare beneficiaries
14 are exposed to opioids while in the hospital, and the
15 opportunity for program oversight of hospitals' use of
16 opioids versus non-opioids.
17 On the pro side, I'll note that CDC's
18 recommendation to limit opioids for acute pain to three
19 days or less clearly has implications for opioid use in the
20 inpatient setting where the average length of stay for
21 Medicare fee-for-service beneficiaries in 2016 was four and
22 a half days. The recommendation may also play a role in

1 the outpatient setting given that patients may begin an
2 opioid course during their outpatient visit and then
3 complete the course at home.
4 Balanced against these reasons for tracking in A
5 and B are the current lack of claims and other data
6 infrastructure to support a tracking program and questions
7 about how to interpret the appropriateness of opioid
8 prescriptions identified by a tracking program.
9 If Medicare were to undertake an opioid
10 monitoring program in Parts A and B, there are structural
11 differences from the Part D program that would require
12 adaptation of current tracking efforts. In Part D,
13 Medicare relies on plan sponsors to report PDE data
14 summarizing the claims and to use the analytic results
15 along with their own data to implement drug management
16 programs. On the Parts A and B side, there are no
17 equivalent entities to fill this role.
18 Next, Parts A and B claims mostly do not include
19 compliance information on pain management drugs. CMS could
20 take steps to require hospitals to include the information
21 on claims, and then some entity, such as MACs or another
22 contractor, would need to extract the opioid data from the

1 claims for analysis.
2 Alternatively, prescribing clinicians or
3 hospitals could be required to report summary information -
4 - similar to the PDE data -- about pain management drugs.
5 Another key difference from Part D is that once
6 any Parts A and B opioid use data are analyzed,
7 policymakers would need to determine to whom and how the
8 results should be communicated. Are hospitals, individual
9 prescribing physicians, or both the right recipients? In
10 Part D, plan sponsors fill this feedback role and are
11 expected to educate and communicate with prescribers about
12 plan policies. Policymakers would need to determine what
13 entity in Parts A and B should communicate analytic results
14 and what, if any, additional steps beyond communication and
15 education should be taken.
16 So there are undoubtedly additional issues to
17 work through, but I'll stop there for now, and please let
18 me know if you have any questions on the material in either
19 the paper or presentation; also, if there are additional
20 items that you would like us to explore before we revisit
21 this study at the January meeting; and a reminder that the
22 final product here will be a chapter in our upcoming March

1 report.

2 Thank you.

3 DR. CROSSON: Thank you, Jennifer. Very nice.

4 We'll have clarifying questions. I see Pat,

5 Brian. We'll move down this way.

6 MS. WANG: Thank you so much for this report,

7 which dovetails nicely with the presentation that we just

8 heard.

9 On Slide 3, when you outline the three items and

10 the work plan that you have, which is very well thought

11 out, in Item 2, incentives for prescribing opioids and non-

12 opioid alternatives, are you considering including or is it

13 part of the scope of work to examine the adequacy or

14 feasibility of Medicare payment for non-opioid pain

15 treatments, alternative therapies, whether it be

16 acupuncture or biofeedback or some of the other things that

17 people are trying to substitute for opioid utilization?

18 You know, I think it might be -- I don't know how developed

19 that field of alternative pain management is, but to the

20 extent that it exists, I would just suggest it to be

21 included in the analysis of payment systems and, you know,

22 whether there are treatments that could be available that

1 are not adequately paid for now by Medicare.

2 And then the second question I had was just
3 really a small one, just in terms of how you plan to kind
4 of understand what is going on in the hospital setting and
5 how that might affect this problem. If somebody leaves an
6 inpatient setting with an opioid prescription that may
7 trigger one of the alarm bells from the Part D -- that
8 would show up in the Part D analysis when the member went
9 and filled the prescription, is it possible to know what
10 portion of the problematic prescriptions are originating
11 from an inpatient hospital discharge? Would that be
12 another information point to sort of say there's a hot spot
13 here that needs to be looked at because it seems like
14 prescribing patterns upon departure from the hospital or
15 hospital formularies themselves, that it might be a way of
16 -- it might be an area of further exploration, just another
17 data point.

18 MS. PODULKA: We can check on both of those. We
19 have had some initial discussions about some of the
20 additional replacements such as acupuncture, so we can
21 include some discussion. We are probably lacking some data
22 sources, if we are talking about payment or cost for

1 providing these services.

2 And then there could be mechanisms for comparing
3 Part D scripts filled for opioids and tracking
4 longitudinally back for those beneficiaries. I don't know
5 that we're going to have the scope for this study, but it's
6 something that you might want to consider for CMS' scope in
7 the future.

8 DR. MATHEWS: Yeah, Pat, I would concur with
9 Jennifer's answer there. What we're trying to do is
10 balance, you know, the scope that we could potentially do
11 with the timeline that we've been asked to report out on.
12 So just in order to get through the work and be responsive
13 to the mandate, our initial take is to scope the work
14 fairly narrowly. But as Jennifer said, as resources
15 permit, we would be happy to explore these other potential
16 issues that you want to put on the table.

17 DR. CROSSON: Yes, I was going to ask the same
18 question. This is a summary of the mandate here, but it's
19 how Medicare pays for opioids and non-opioid alternatives.
20 The question I think on the table is: Does that include
21 how Medicare doesn't pay for the alternatives? And that's
22 kind of the boundary you're talking about.

1 DR. MATHEWS: Right.

2 DR. CROSSON: Okay. Brian.

3 DR. DeBUSK: Thank you for a really well written
4 chapter. I had a clarifying question on Chart 10, where
5 you talk about Part A and B claims don't include
6 information on the Part A and B drug use. And you alluded
7 a little bit to this in the presentation, but is there a
8 vehicle that we could incorporate this concept into, for
9 example, the hospital-acquired condition program or
10 something like that? Is there an existing vehicle that we
11 could incorporate these types of measurements into? Does
12 anything come to mind?

13 MS. PODULKA: I had not a considered hospital-
14 acquired conditions program. We have had internal
15 discussions and we have spoken with CMS about, you know,
16 how quickly or how readily could these data be collected
17 and analyzed. The short answer is it's not overnight.
18 There's nothing immediately available that comes to mind
19 for us or the CMS group that was tremendously helpful in
20 discussing this with us. So if we were or if CMS were to
21 begin collecting the data, there is some ramp-up time to
22 get that set up.

1 DR. DeBUSK: Consensually, wouldn't an opioid
2 addiction originating from a surgery be a hospital-acquired
3 condition?
4 MS. PODULKA: Yes.
5 DR. CROSSON: Okay. Amy and Paul, and then we'll
6 come over here.
7 MS. BRICKER: You made the point about the CDC
8 recommendation on three days and how an average inpatient
9 stay is four and a half days, and that was a complexity or
10 a consideration. I actually found that to be a good thing.
11 so the patient, if we were to recommend or to encourage
12 hospitals to maintain that three days, they still have a
13 day and a half with the patient, or more, to help them
14 manage, you know, their pain in a different way versus
15 exiting them and saying, "Go take a Tylenol."
16 So I think it actually might be an opportunity,
17 but I wanted to understand if I'm missing something there.
18 MS. PODULKA: No, not at all. I think you're
19 raising a very good point. And we're not suggesting that
20 we tip into not using opioids within the inpatient. I
21 personally would think if there's a time to get opioids,
22 it's in the hospital following a major surgery when the

1 nursing staff is there to supervise and check on you and
2 make sure you don't go into respiratory depression. It's
3 that there's this question of, you know, might the first
4 introduction to opioids happen not with your community
5 physician and your community pharmacy, but might it have
6 started within the hospital, either inpatient or
7 outpatient? And we don't have the data to have eyes on
8 that necessarily right now.
9 MS. BRICKER: Okay.
10 DR. CROSSON: Paul.
11 DR. PAUL GINSBURG: Jennifer, on page 17, what
12 you sent out, you're talking about the situations where
13 patients are prescribed both opioids and drugs which are
14 dangerous when taken in conjunction with opioids. Is there
15 any information about the degree to which these situations
16 are coming from the same doctor or from different doctors
17 and it's more of a -- is it more of a coordination issue or
18 more of a physician issue?
19 MS. PODULKA: With the gabapentin and
20 benzodiazepines, that's something I will have to check on
21 and get back to you.
22 DR. PYENSON: Okay.

1 DR. CROSSON: Kathy.

2 MS. BUTO: I just wanted to go back to Pat's

3 point and make sure I understand. Are you saying that

4 there isn't a way to track Part D opioid prescriptions back

5 to a discharge, hospital discharge? It just strikes me

6 that's an important link that we ought to be able to make.

7 Did you say that, or did I just mishear it that way?

8 MS. PODULKA: Right now, the data don't

9 necessarily -- one could do a study and track back and say

10 there is a Part D script filled at a retail community

11 pharmacy and look back and say that beneficiary was

12 recently discharged from the hospital.

13 MS. BUTO: But right now, we don't have the data.

14 MS. PODULKA: Right.

15 MS. BUTO: And so we also don't know what

16 proportion of the issue arises from a hospital discharge

17 versus in community Part D prescription, if I'm hearing you

18 correctly --

19 MS. PODULKA: Correct.

20 MS. BUTO: -- since we don't know that.

21 Thank you.

22 DR. CROSSON: Questions?

1 Jonathan.
2 DR. JAFFERY: So this may actually relate a
3 little bit to Paul's question or inform that, but you
4 mentioned a couple times in the report and in today's
5 presentation around track, prescribing, prescriptions and
6 patterns at the hospital level or perhaps at the
7 prescribing physician level. I just wonder, thinking about
8 inpatient care, which spans days, you have different
9 physicians who cover, and the prescribing physician --
10 quote/unquote, "prescribing physician" may not always be
11 the person who prescribed.
12
13 So I don't know if you have any thoughts or
14 concerns about that or how you would manage that or if
15 maybe that pushes you towards thinking about it at the
16 hospital level rather than at that prescribing physician
17 level.
18 MS. PODULKA: We had thoughts and discussions,
19 and hence, we raised it as a question.
20 I don't have a solution. I can certainly
21 envision that there's a management team in many inpatient
22 settings where there's an anesthesiologist and other

1 physicians who are managing the drugs, and it might be more
2 of a one- or two-physician team on an outpatient visit.
3 I don't know if you need the same response or
4 different responses, and I'm sorry I don't have an answer
5 for you.
6 DR. CROSSON: Okay. Thank you.
7 So we're going to proceed with the discussion
8 now, the point of which is to help Jennifer prepare for the
9 second presentation in January. Because of the timeline
10 that we receive, it will be our last opportunity to bring
11 our thoughts together and to help the staff prepare the
12 final report to the Congress.
13 We have Jon Perlin here who has been working in
14 this area and will start off the discussion.
15 DR. PERLIN: Thanks, Jay.
16 Let me thank Jennifer as well as Shinobu, Rachel,
17 and the MedPAC staff for really terrific insight on this on
18 a critically important topic.
19 It is a critically important topic, but you've
20 been asked a difficult question, difficult because the
21 answer to that question may not be through the means that
22 were identified in the question to achieve the answer that

1 I think Congress is seeking. And I think that's the sort
2 of conundrum that we need to work out here a little bit.
3 By way of preface, Jay mentioned I have been
4 working in this area. Actually, earlier, you said, "Jon
5 has experience with opioids." So, to qualify that --
6 [Laughter.]
7 DR. PERLIN: -- my Ph.D. is molecular
8 neuropharmacology, the obvious course to health
9 administration, but more importantly, of late I've been
10 working with the National Academy of Medicine's Action
11 Collaborative on combating the U.S. opioid epidemic, the
12 main thrust of this effort.
13 I think there will be great resources and linkage
14 to working on your question that has to do with really four
15 or five groups of activities -- pain management, prevention
16 of overuse disorders, treatment of overuse disorders, and
17 then things associated with that, community resources, the
18 stigmatization, both of patients as well as providers in
19 this space, and some of the complexities of therapy, which
20 really do get at one of the issue I'll talk about
21 specifically and comparing opioid to non-opioid or
22 alternatives to traditional opioid therapy and further

1 research that's necessary.

2 I think to contextualize, this point about the

3 hospital being the starting point or medical encounters

4 being the starting point is really important because when

5 we talk about the opioid epidemic, we're really talking

6 about a sequence of three epidemics, the first of which was

7 with the promulgation of these synthetic opiates, which is

8 why they're called opioids, and a belief that they perhaps

9 were not as addictive.

10 There was an escalation in the use of these, and

11 that led to an awful lot of overuse, dependence, and

12 addiction, all of the untoward outcomes.

13 In turn, that led -- and I'll explain why in a

14 moment -- to a heroin epidemic and more recently to a third

15 epidemic, predominantly imported synthetic opioids, very

16 high-potency opioids like fentanyl.

17 The reason I make this point is that 70 percent

18 of the people who overdose and die from opioids actually

19 had their start with a prescribed opioid, which is why it's

20 so important to trace back both to patients who graduate

21 into the Medicare programs as well as patients who initiate

22 opioids in the Medicare program, and this notion that

1 health care encounter, especially as Brian indicated the
2 hospital is gateway, is tremendously important because as
3 your work and what you've highlighted shows so eloquently
4 in the data is that there is an absolute correlation with
5 the duration of exposure and the intensity of exposure.
6 So those data points in terms of answering
7 Congress' question are tremendously important and helpful.
8 The question is, How do you get that most easily, and how
9 do the incentives that Congress also asked you to opine on
10 operate?
11 As we all know, there are multiple categories of
12 incentives. There are both financial incentives, which is
13 one question, but in this particular area, as the
14 clarifying questions of both the first and second
15 presentation brought out, there are also other incentives,
16 including quality measures and experience measures. And
17 there has been concern that some of the HCAHPS measures
18 have driven in the interest of both meeting and a desire to
19 ameliorate pain, but also patient satisfaction have driven
20 potentially excessive prescribing.
21 It's interesting. I looked up the specific
22 language of the measures, and they've been changed, but the

1 change or nuance in the way they operate toward the
2 incentives may be informative to your conversation's
3 nonfinancial incentives.
4 The former pay management domain had three
5 questions. During this hospital stay, did you need
6 medicine for pain? New pain management question. During
7 this hospital stay, did you have any pain?
8 Second question. During this hospital stay, how
9 often was your pain well controlled? New question. During
10 this hospital stay, how often did hospital staff talk with
11 you about how much pain you had?
12 Third question. During this hospital stay, how
13 often did the hospital staff do everything they could to
14 help you with your pain, do everything they could?
15 Important and best answer in HCAHPS was always. During
16 this hospital stay -- new question -- how often did
17 hospital staff talk with you about how to treat your pain?
18 What's interesting is that I'm not sure -- and I
19 think further research needs to be done -- whether this
20 completely ameliorates the implicit incentive toward
21 prescribing for pain. Certainly, it addresses management
22 pain.

1 What I can tell you from the health services
2 research is that it changes these questions from drivers of
3 overall satisfaction to drivers of nurse communication as a
4 secondary factor. So just note that in terms of the
5 nonfinancial incentives.
6 In terms of this particular question of tracking,
7 there's an implicit assumption -- or an explicit
8 assumption, actually, the bundled payment which includes
9 the payment for pain management, including drugs for pain
10 management, would be driven by the lowest cost. After I
11 stipulate that that could be, I have to note that there may
12 be other factors as well, such as the implicit incentives
13 for pain remediation, as I mentioned, under HCAHPS and that
14 they in fact may work intent.
15 So you have this conundrum where you need to
16 analyze and assess the cost as a driver, but that's
17 challenging for the reasons, some of which you noted, that
18 the costs of the drivers are bundled. And unlike Part D
19 and elements of Part B, there is not a tollgate that
20 collects the data at every encounter. So to other points,
21 how do you get the data that really answers the question
22 that it appears that Congress is interested in?

1 Second, you note that the cost of the drugs are
2 obfuscated by very arcane purchasing process, so proxies
3 for the cost of those drugs aren't clear. But I would
4 actually say, even more importantly, the alternative drugs
5 may not be exact therapeutic substitutes.
6 It's kind of like comparing the past completion
7 rate for a quarterback with the ERA of a pitcher. They're
8 both measures of sports, but they're different sports. And
9 here, the problem is that different classes -- the closest
10 may be non-steroidals, but there are also anti-
11 inflammatories. There's a gabapentin that really relieves
12 certain sorts of nerve pain. There are topical
13 anesthetics. There are injectable anesthetics that bundle
14 with the procedure, as Pat mentioned, very viable
15 alternatives or nontraditional approaches. They're not
16 necessarily captured even with modifiers.
17 One of the most important alternatives is
18 complicated by the arcane law and regulation around its
19 administration, and that's the mixed agonist,
20 buprenorphine, which offers some analgesia and blocks the
21 euphoric effect. And that has a set of training
22 requirements for a prescription that make it very, very

1 complicated.

2 So I'm going to come back to that as an important

3 point because I think your work can actually be even more

4 informative than just combating. I think if you play the

5 data right, you can also get insights to what's working in

6 terms of better outcomes for Medicare beneficiaries.

7 To this question of how do you get to an answer

8 that's not confounded by the factors I just mentioned and

9 other factors such as, frankly, the supply and the

10 effectiveness of regulatory requirements, potential adverse

11 effects of some other alternatives -- ketamine as an

12 example, antipsychotics as an example -- you've still got

13 the fundamental question. Should CMS monitor opioid use?

14 I think it would be irresponsible for anyone to

15 suggest other than an emphatic yes in terms of answer yes

16 on that, but it leaves you with a question. If you can't

17 disentangle that monitoring through the Part A mechanisms

18 and it would create undue burden to put mechanisms there,

19 what are your other proxies?

20 So here are some suggestions since there is not

21 an overutilization monitoring system equivalent from Part D

22 in the hospital.

1 I think opining on the prescription drug
2 monitoring program and consistency state to state would
3 give you some insight into prescribers and the quantity of
4 prescriptions that are being written for Medicare
5 beneficiaries.
6 Second, there is not only the post-marketing
7 surveillance system, which as you note in the report is
8 voluntary, but the Sentinel system actually accrues data
9 from provider organizations. And you can actually send
10 questions into it so you can look at patterns of use.
11 Now, it's not encyclopedic because it doesn't
12 include all providers, but it can give you directionally
13 correct information as to what the trends are among
14 beneficiaries. And it now, including alignment with
15 insurers, has over 100 million individuals, many of whom
16 are obviously not Medicare beneficiaries, but many of whom
17 in fact would be.
18 Jay, unless you think there's some Tennessee
19 conspiracy, I don't think Brian and I talked about this.
20 But this notion of a hospital-acquired condition is I think
21 one of the ways of getting a handle on adverse outcomes,
22 particularly since this phenomenon of overuse, dependence,

1 and even addiction often starts with the exposure and the
2 health care environment.
3 My team and I actually have a Health Affairs blog
4 that we'll enter into the record here, "A Case for
5 Confronting Long-Term Opioid Use as a Hospital-Acquired
6 Condition." In it, we find actually looking at some data
7 that 5 to 15 percent of those individuals with use
8 disorders post-hospitalization started almost with
9 predicable excess duration, excess dose, and I think the
10 scary part is that there are subsets of individuals who
11 started with single exposures as well.
12 So I think it's something, if we look at that, we
13 could drive not only curbing overuse of opioids, but
14 actually moving toward alternatives that serve Medicare
15 beneficiaries even more effectively.
16 Finally, as we think about the remainder of the
17 questions that you've been asked, I think we need more
18 sensitive and specific measures. Clearly, the measures
19 that you indicated -- high dose, multiple prescribers, both
20 high dose and multiple prescribers, and concurrent
21 administrations with other potentially addictive drugs --
22 are good measures.

1 But I think we need to go further into that.
2 Those measures -- and this is why I am suggesting the
3 prescription drug monitoring program -- need to be a
4 transparent byproduct of care, not an add-on to the care
5 process, and you just don't have the tools in Part A that
6 you got for Part B and Part D.
7 Second, good measures could provide insights into
8 alternatives and better outcomes. That's, I think, a
9 recommendation for the Sentinel database, and I think you
10 have additional tools that have been alluded to, such as
11 your geographic mapping of hot spots of prescribing that
12 would allow a different sort of investigation into the
13 liability.
14 Let me conclude where I began, which is that I
15 think you've got a critically important question. I think
16 you've got directionally good guidance in terms of what you
17 need to answer, but I think the specific pointing to trying
18 to replicate the measurement systems that applies on Part D
19 to the inpatient won't work for any number of reasons that
20 I've outlined and would suggest that you provide feedback
21 that directs toward some of the alternatives, including
22 other sources of data, prescription drug monitoring

1 program, and potentially Sentinel and consideration of
2 overuse disorders among Medicare beneficiaries and some
3 window post-hospitalization or post the index event where
4 those drugs are prescribed as a safety even, a safety
5 failure, and either a hospital-acquired condition or a
6 care-acquired condition.
7 Thanks.
8 DR. CROSSON: Thank you, Jon.
9 Let me just ask you. So you've pointed out the
10 problem of confounding variables, particularly the
11 potential or actual incentives created by hospitals seeking
12 to perform well no HCAHPS. So I don't have an answer here,
13 but can you think of a way or an approach that the staff
14 could use to try to tease those apart, or is there any way?
15 DR. PERLIN: This is a tough one because I think
16 pain still needs to be addressed, and at the heart of that
17 is how do you separate incentives for addressing pain from
18 incentives that lead to overuse or a particular modality of
19 pain therapy.
20 I think further health services research may be
21 necessary there. Let me ponder that.
22 I would certainly welcome input from my

1 colleagues on that question.

2 DR. CROSSON: Jim.

3 DR. MATHEWS: One other additional clarifying

4 question. So we're happy to pursue this notion of

5 considering opioid addiction as a hospital-acquired

6 condition, but I have a question. At what point can you

7 define addiction, and for what duration of time would a

8 hospital need to track a patient on a post-operative basis

9 in order to ascertain addiction?

10 DR. DeBUSK: In theory, wouldn't it be in the

11 Part D claim? I mean, if I see a claim or a hospital

12 discharge and then I follow that claim for 30, 60, 90 days,

13 and they're still filling 100 MMEs a day, I mean, it should

14 be right there in the data, shouldn't it?

15 DR. PERLIN: I think that's the nidus of a

16 surveillance system because I was thinking about the same

17 question: How do you operationalize this concept? I think

18 there are probably clusters of diagnoses that shouldn't be

19 associated with chronic use of opioids, and so right there

20 is one sort of data clue.

21 Second, here's the challenge. I think

22 operationalizing. It may not be in the same calendar year.

1 It may be for patients who have service in January that you
2 can track later in the year, but in December may not be the
3 end of that calendar year. So I think you need some sort
4 of rolling marker of that, but associating particular
5 diagnoses with prescriptions in excess of what would be
6 predicted for that diagnosis might be a means of
7 operationalizing.
8 I think Karen wants to weigh in on that.
9 DR. DeSALVO: Yeah. As the Commission has talked
10 about hospital-acquired conditions and having that drive
11 behavior and the delivery system to assess for conditions
12 on entry into the hospital, one potential positive impact
13 of a model like this would be a heightened questioning upon
14 admission to the hospital and a checking perhaps of the
15 PDMP to look for prior prescriptions. So it might improve
16 processes up front to identify whether someone is at risk
17 for addiction.
18 DR. CROSSON: Okay. So now we'll continue with
19 the discussion, and I'm trying to think where I've started.
20 But I can't remember anywhere.
21 All right. Kathy.
22 MS. BUTO: So I think we probably all can agree

1 that our goal is appropriate pain management but reducing
2 unnecessary use and long-term addiction and abuse as part
3 of whatever Medicare policy we recommend.
4 We want hospitals and physicians to have the
5 flexibility but within some parameters that we've been
6 struggling with and accountability.
7 I think part of the paper that I found the most -
8 - I guess the area where we've already identified we need
9 to do some additional work is inpatient hospital in
10 particular. That the DRG bundle, as I see it -- and I
11 think as Jon pointed out -- it does encourage cost
12 effectiveness but not appropriate use.
13 So I don't think we can just say DRG bundle, that
14 sort of takes care of the issue of incentive, because I
15 don't think it gets at the incentives that drive
16 inappropriate use. It might get at cost incentives.
17 I really think it's important, even if we don't
18 have time to do it in this go-round for the report, to
19 point out how much we need to develop data that allows
20 Medicare to differentiate between a hospital inpatient
21 stay-generated opioid use and potentially overuse versus
22 outpatient prescription because I don't think we can get at

1 the issue even of hospital-acquired condition until we know
2 better what that difference is. So that can be done
3 concurrently with trying to look at either HACs as a way of
4 getting at this or other aspects of value-based purchasing
5 that could provide at least an initial handle on what's
6 going on with prescribing related to either surgeries or
7 other MS-DRGs.
8 I think it's really hard to come up with
9 benchmarks. I started thinking about this whole thing of
10 the tournament model, et cetera.
11 I think one place to start would be if we could
12 find out which MS-DRGs have associated with them the
13 prescription of opioids.
14 So I'm thinking that's going to be some of the
15 major surgeries, like bypass surgery and so on, but I don't
16 think we know. We need to know more about what those are,
17 and it's possible you could develop some intermediate
18 benchmarks related to the extent to which opioids are
19 prescribed in relation to those particular diagnoses.
20 I think you could then figure out -- you might
21 then be able to have the data to look at long-term
22 addiction, but it seems to me, at least initially, we'd

1 want to see which ones are generating opioid prescriptions
2 that start in the hospital and then maybe are continued
3 through Part D.
4 It just strikes me that we may need to kind of go
5 stepwise into the measurement area just to figure out
6 what's going on, and I think that will help a lot.
7 DR. CROSSON: Thank you. Bruce.
8 MR. PYENSON: Thank you very much, Jennifer. I
9 noted on page 18 that there's mention of some of the
10 benefits that Medicare Advantage plans can cover as outside
11 of fee-for-service, and I believe one of those is
12 acupuncture that you mentioned. I believe it's not covered
13 by fee-for-service Medicare. And it struck me that because
14 this is such -- the topic we're addressing here is such an
15 important topic that just a caution that we don't expand
16 Medicare coverage to things that Medicare should not cover.
17 There's all sorts of advertised solutions to pain. Placebo
18 effect is important, of course. But as our concern over
19 this is substantial, we need to also keep in mind that
20 there's for sure interests that would like to see expanded
21 Medicare coverage, and in particular, it's not just things
22 like perhaps acupuncture. There's novel therapies that

1 perhaps would like to receive an add-on payment through the
2 DRG system, and there's medical devices.
3 So I just want to note my view that we need to
4 make sure that that doesn't sneak into this very serious
5 problem.
6 DR. CROSSON: Thank you. Karen.
7 DR. DeSALVO: I'll just add to the call that this
8 is extremely important and we should have visibility into
9 everywhere that we can be of help.
10 I want to just acknowledge this multiple
11 incentives issue and just bring a little bit of frame
12 around that. This issue of the HCAHPS question came up a
13 lot historically. It was recently changed. There may be
14 some pre- and post-data that would be informative, though
15 it's going to be heavily confounded by all of the other
16 efforts that are happening. But that work is probably not
17 done, meaning that there were some other suggestions about
18 phraseology for those questions that were not taken up by
19 the prior administration. So perhaps there's some
20 assistance you could get from some physician groups and
21 others who had strong ideas, including our current Surgeon
22 General, who had a lot of ideas about this when he was in

1 Indiana.

2 The other incentive has to do -- and, by the way,
3 that may be perceptional, but it's a very strongly held
4 feeling in the physician community. The safety issues I
5 think are really strong, and I appreciate you raising them
6 in the chapter, and I think it's an important consideration
7 on the inpatient setting.

8 I don't know where to put the bundle around these
9 alternative therapies. There's an evidence base that's
10 emerging but not terribly strong. The administration has
11 been doing a lot of work in this space, along with others,
12 so you might look to what the CDC and the Office of the
13 Assistant Secretary have done. In 2016 there was a report
14 on managing chronic pain and another subsequent report, so
15 they've been doing some assessment there.

16 I just want to make this final point, which maybe
17 is likely out of scope here, though it hasn't been raised
18 yet as a point and is worth thinking about going forward.
19 A lot of the effort to address the opioid challenge in this
20 country is related to the supply side and to medical
21 treatment as the option. Clearly, as Jon well articulated,
22 there's a demand side. Whether and how it begins, when you

1 shut off the supply of prescription opioids, some people
2 then find other ways to self-medicate. And to Amy's point,
3 we're seeing this particularly in those who are about to
4 age into Medicare and middle-aged folks and in people who
5 live in rural America particularly impacted. So for those
6 future beneficiaries, I think thinking about not just the
7 supply side but why is it that there is such a demand for
8 self-medication and that leads you to things like social
9 isolation and some of the social determinants of health
10 where -- and to recovery programs, et cetera. So that's
11 beyond perhaps the scope of this, but I hope at some point
12 we can think about what the Medicare program can be doing
13 to support those kinds of systems as well.
14 Thank you.
15 DR. CROSSON: Warner.
16 MR. THOMAS: Just a couple of comments.
17 One, I think it's a great topic and a great
18 chapter. I'm not sure what is identified in ambulatory
19 quality measures around the tracking and utilization of
20 opioid drugs, but I think that would be something to think
21 about as well, especially as we think of ACOs and, you
22 know, kind of looking at ambulatory measures. I would

1 encourage us to think about that.

2 Karen and I were also talking about just the
3 impact of post-acute care. Have we looked at utilization
4 in a post-acute setting and how that plays into this?
5 There really wasn't a lot of discussion around that, and
6 I'm not sure -- that may not even be an issue, but it may
7 just be something we take a look at.

8 And then, finally, I know we have and I know
9 there are other organizations around the country that have
10 these functional restoration programs, which essentially
11 is, you know, a 45- or 60- or 90-day process to get people
12 off of opioids. And, you know, I think thinking about
13 whether there should be -- I'm not sure what the Medicare
14 reimbursement is there, but perhaps that's something that
15 should be taken up and thought about as a way to really in
16 a more comprehensive -- and this is a combination of
17 therapy, you know, weaning people off the drugs,
18 potentially some other types of pain control options.
19 We've had tremendous success with it; I know other
20 organizations have as well. And so we may want to think
21 about this as what's the Medicare reimbursement model for
22 this. I think it's something that's actually paid out-of-

1 pocket now, so it may be something you want to consider and
2 think about.
3 DR. CROSSON: Jonathan.
4 DR. JAFFERY: Thanks, Jay, and this is a great
5 discussion as I track the Madison, Wisconsin, chief of
6 police report on a monthly basis of opioid overdoses and
7 watch it be a straight rise. It's hard not to really be
8 shocked and start to think we need to be creative and do
9 what we can.
10 Maybe building on Karen's last point and thinking
11 about how to bring some things in scope, this demand side
12 idea, Amy mentioned, pointed out the barrier of stigma to
13 getting treatment, but there's also a prescribing of --
14 and, Jon, you touched on this -- the prescribing of
15 medication-assisted treatment, which is really seen as a
16 very big barrier. So any of us who have tried to get our
17 physicians to get the waiver recognize that barrier, and
18 some of it is time and some of it is money. But there has
19 actually been some interesting studies that look at
20 additional barriers, even amongst individuals who have
21 already gotten the waivers. There's a reluctance to use
22 those to prescribe or to prescribe for many patients. And

1 there has actually been some analysis of what those
2 barriers are, and it really seems like the things that --
3 the fixable things that really rise to the top are around
4 support for the prescribers, because they need the
5 counseling support and they need the other things that are
6 maybe a little bit outside the scope of their normal
7 practice, but still I think solidly within health care.
8 And so I know we've talked a lot about attending
9 to payment around prescribing patterns, but there might be
10 some room for thinking about how do we support physicians
11 and support practices to not only get the waivers, but then
12 also actually prescribe, and I think we can look to
13 Vermont's hub-and-spoke model as the one that jumps out as
14 being the most developed, the one that other States are
15 trying to replicate to varying degrees of success, and has
16 had a lot of success in increasing the access to
17 medication-assisted treatment.
18 DR. CROSSON: Okay. Thank you.
19 So here we'll start with Paul.
20 DR. PAUL GINSBURG: Yeah, presumably a major
21 motivation for Congress asking for this report was a
22 concern that there were situations that non-opioid

1 alternatives to opioids are more expensive, and that's the
2 basis of your plans to look at the price data. It hasn't
3 come up in our discussion at all yet, and I was wondering,
4 you know, what were the anecdotes that got Congress
5 concerned about this? And how likely is it that we're
6 going to find that this is a real issue?
7 DR. MATTHEWS: So I'm not sure we want to kind of
8 pre-anticipate our findings once we obtain the data. So in
9 terms of the likelihood that we will find something or, you
10 know, what anecdotes might have motivated the Congress to
11 ask these questions, I would prefer to hold off until we
12 actually have something to come back to you with.
13 DR. CROSSON: Amy.
14 MS. BRICKER: In wild support of tracking this in
15 Medicare A and B population, I appreciated the idea that
16 was -- you know, it centered around hospital-acquired
17 condition. I think it's going to be difficult to determine
18 and would look to Jon and others to inform at what point is
19 there a problem, in fact? And then how is that then
20 tracked back? I think that would be certainly a debate
21 amongst the stakeholders that, you know, essentially would
22 be impacted by this. But I think it's a worthwhile

1 conversation.

2 I think there's been such a focus so far today

3 around prevention of, you know, starting a naive patient

4 presumably on an opioid and then, you know, therefore,

5 preventing addiction. I think we've got -- building on

6 what Karen mentioned a moment ago around intensifying the

7 conversation or putting a stronger requirement around

8 questioning patients around their current utilization of an

9 opioid and the likelihood that they, in fact, you know, are

10 drug seeking or in an addictive state, or the

11 predisposition of a patient to addiction. And it's not

12 about then putting -- you know, refusing to treat and, oh,

13 you're just here because you're seeking a narcotic -- which

14 is typically what happens. Those people just get pushed

15 back out of an ER or what have you -- but embracing them,

16 okay, you're here, you're in the right place, and we're

17 going to get you help, and trying to lean into that,

18 because what absolutely happens -- and if you don't believe

19 it, go to any rural community in America. They will find a

20 resource, and it is heroin or fentanyl or the combination

21 of both.

22 And so I implore us to think about, of course,

1 preventing but also starting to swing the pendulum back the
2 other way around we have an issue and the hospital systems
3 and the communities are best readied or have the ability to
4 start to address the issue with the right level of
5 resources.
6 The other thing that I find fascinating is we
7 haven't even talked about the manufacturers and what role
8 does the pharmaceutical manufacturer play in this. I could
9 envision a tax like we put on cigarettes, but paid by
10 manufacturers. They're benefitting. You want to know who
11 benefits from this? They benefit from where we are today.
12 No one else is benefitting from this crisis but
13 manufacturers of these products. So what role do they
14 play? Could they be, you know, forced to stop promoting
15 product but educating physicians about the risks
16 associated? Should they be using their dollars to fund,
17 you know, substance abuse education prevention treatment?
18 That's where I would like to see this go. I realize that's
19 provocative and likely not something that this Commission
20 has the stomach for, but I would encourage us to think more
21 boldly around, you know, where did this start, who's
22 profiting, who's benefitting, and at the expense of, of

1 course, our beneficiaries and America at large. So thanks.

2 DR. CROSSON: Thank you. Brian.

3 DR. DeBUSK: First of all, I'm really glad to see

4 us working on this really important subject. It's probably

5 overdue that we do more work here.

6 What I want to mention, in the next round of work

7 if we could focus on tailoring some solutions, and I know

8 the work spoke to this. This one-size-fits-all model

9 doesn't work. I am hoping that we can identify some

10 tranches of beneficiaries, for example, degenerative spin

11 patients or post-traumatic osteoarthritis patients where we

12 could almost bucket the high-use beneficiaries and develop

13 some very specific tracks to try to address them, because I

14 think you're almost going to be treating a series of

15 conditions here, not just opioid use in general. And,

16 again, I could tell in the reading materials that's, I

17 think, the direction you're taking us. But I hope we

18 really build out that direction and look at those specific

19 conditions and try to identify them and develop policy

20 around some of the specific ones.

21 The other thing I would want to encourage, I

22 really liked in the reading material the pharmacy lock-in,

1 the prescriber lock-in. A lot of those conventional tools
2 I think are great. I hope we explore this hospital-
3 acquired condition idea a little bit more. But also, to
4 Amy's point, I hope that we can at least look at some of
5 the more radical ideas that are out there. You know, tough
6 to watch sometimes, but I hope just for the sake of
7 completeness that we can look at those and have them out on
8 the table.
9 And then the final thing -- and this was
10 something Warner mentioned -- just like we're looking at
11 the cost of opioid versus non-opioid therapies and trying
12 to figure out where the financial incentives are, I would
13 love to see the financial -- almost a pro forma, let's say
14 I'm a primary care physician and I do have someone on 120
15 MMEs a day. What would it look like if I tried to wean
16 them through just E&M visits or through -- you know, I'd
17 love just to see is it a financial disaster for me? I
18 mean, what does it really look like? And is there some
19 type of incentive that you could give me, almost a CPT code
20 I could bill. Let's say I do walk you down over 90 days or
21 180 days. Would we consider a CPT code that I could bill
22 that has a lump sum payment as a result, you know, sort of

1 an end cap or an end to that series of E&M visits.

2 DR. CROSSON: Thank you.

3 Further commentary? Jaewon.

4 DR. RYU: I think on that last point, I think you
5 are on to something, Brian, because as I think through the
6 prescribing behavior, whether it is the hospitalist
7 inpatient team or the emergency medicine physician, I'm not
8 sure financial individuals -- I think we need more
9 information to figure out whether and to what extent that
10 plays a factor in what they do. But I think there's a
11 simplicity and an ease, I think there's a length-of-stay
12 dynamic. It's easier to go ahead and prescribe something
13 to get someone home and there's a length of stay played
14 both inpatient and in the ED that's at play there. And I
15 think unless we recognize that it's actually more resource-
16 intensive to address the problem correctly, I think this is
17 really tough to get after, because there's always going to
18 be that efficiency length-of-stay dynamic that sort of
19 introduced yet another incentive beyond the financial ones.
20 And creating a counter-incentive, so to speak, by
21 reimbursing the level of resource allocation that you would
22 need to address the problem accurately or comprehensively,

1 I think that's got to be part of the solution.

2 DR. DeBUSK: Again, to your point, we're trapped

3 by venue. We can't look at the bigger picture here. And,

4 you know, then a final thought. Maybe you fund the new CPT

5 code with penalties from the hospital-acquired condition

6 program. Just a thought.

7 DR. CROSSON: Jon, do you want to make a last

8 comment?

9 DR. PERLIN: Sure. Well, thanks. I really

10 appreciate the terrific conversation. I think we're in

11 emphatic agreement around the importance of this issue and

12 tremendous work that you've done and the need to monitor

13 and the complexities.

14 You know, I think we also have agreement that

15 some of the tools that were offered may not be tools to

16 answer the question that's really asked, implied. We go a

17 little afield of that.

18 I think the other thing that scares us both in

19 the area of prevention as well as -- I'm glad we got to the

20 conversation of treatment as well -- is that we guide by

21 the evidence. And when you actually look at the evidence

22 for treatment, the area that really is a clear leader is

1 what we refer to as medication-assisted therapy, which is a
2 horrible term. It's kind of like "food-assisted lunch."
3 [Laughter.]
4 DR. PERLIN: Not that I'm hungry, but the problem
5 with that treatment is it implies that the medication is
6 adjunctive. And the medication is actually if you look at
7 any of the dates on recidivism, it is medication that's
8 associated with actually the recovery or the abstinence
9 from the addictive -- more addictive drugs. And it's
10 associated positively with survival -- in the health
11 services research literature, it's associated with survival
12 in older patients, i.e., the Medicare beneficiaries.
13 And so I would hope that we'd also take a
14 proactive stance noting that consistency with the evidence
15 would be the facilitation of the appropriate means of
16 therapy. I think it's worth noting the undue regulation
17 around training for the prescription of buprenorphine in
18 particular, and the complexity of getting patients
19 evidence-based therapy in that regard, and that actually
20 implies, I think, another set of measures for tracking,
21 which is -- you know, I realize some of these are process,
22 but the percent of beneficiaries who actually have

1 evidence-based approaches to the overuse disorders.

2 Thanks.

3 DR. CROSSON: Thank you.

4 Okay. Good discussion. Jennifer, I hope that's

5 helpful to you, and we look forward to hearing from you

6 again in January.

7 That ends the presentation portion of the morning

8 session. We now have time for questions from our guests.

9 If there are any members of the audience who would like to

10 make a comment, now is the time to step forward to the

11 microphone so we can see who you are.

12 [No response.]

13 DR. CROSSON: Okay. I'm not seeing anybody, so

14 we are adjourned until 1 o'clock.

15 [Whereupon, at 11:43 a.m., the meeting was

16 recessed, to reconvene at 1:00 p.m., this same day.]

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1 AFTERNOON SESSION

2 [1:00 p.m.]

3 DR. CROSSON: Okay. I think we can sit down

4 here. We've got -- wait one minute here.

5 [Pause.]

6 DR. CROSSON: Okay. Well, we're almost

7 assembled, but I think we need to start.

8 So we're going to begin the afternoon with a

9 topic that we've been talking about for some time, which

10 has to do with concerns about primary care workforce

11 availability, now and in the future, for Medicare

12 beneficiaries. And today we're going to talk about payment

13 policies for advanced practice registered nurses and

14 physician assistants. And we've got Brian and Kate here,

15 and who's going to start? Brian is going to start out.

16 Thank you.

17 MR. O'DONNELL: Good afternoon. In this session

18 we'll discuss Medicare's policies surrounding APRNs and

19 PAs. This work is in response to Commissioner interest

20 conveyed during our January 2018 meeting on rebalancing the

21 physician fee schedule. Specifically, Paul, you asked us

22 to look into a practice known as "incident to" billing.

1 Amy, you asked what Medicare knows regarding the
2 specialties in which APRNs and PAs practice. And Brian,
3 Sue, and Jon, you discussed issues related to APRNs' and
4 PAs' increasing roles in delivering primary care.
5 This presentation will address these topics, but
6 before we get into them I'd like to thank Carolyn San
7 Soucie for her assistance with this project.
8 This slide lays out a roadmap for our discussion
9 today.
10 Given that the Commission has not directly
11 addressed this topic in a few years, we'll first go through
12 several slides of background material. We'll then discuss
13 our analyses on Medicare billing trends and the prevalence
14 of "incident to" billing. Finally, we'll discuss two
15 policy options for the Commission to consider.
16 MS. BLONIARZ: Okay. Starting with definitions,
17 the term APRN groups together four categories of advanced
18 practice nurses that can bill Medicare directly: nurse
19 practitioner, certified registered nurse anesthetists,
20 clinical nurse specialists, and certified nurse midwives.
21 All APRNs must be credentialed as registered
22 nurses and complete additional education and training, most

1 commonly a master's degree. They are licensed by the state
2 to practice, and the state may impose certain additional
3 requirements for their practice.
4 PAs take a similar path. They must graduate from
5 a physician assistant program, which is generally a post-
6 baccalaureate master's. PA education includes a clinical
7 rotation, and then the state licenses them to practice.
8 The requirements that states impose on APRN and
9 PA practice is referred to as scope of practice, and it
10 affects APRN and PA ability to diagnose, treat, and refer
11 patients and their ability to prescribe medications, order
12 services, and interpret tests. Their requirements vary by
13 type of credential, and for NPs, specifically, a little
14 less than half the states allow NPs to practice the full
15 suite of medical care consistent with their education and
16 training without significant constraints or limitations.
17 Sixteen states impose a moderate level of
18 oversight, such as counter-signatures of medical records or
19 chart review. Twelve states have more significant
20 constraints, either requiring ongoing direct supervision or
21 restricting prescribing. And the trend has been, over
22 time, for states to increase the scope of practice for

1 these providers.

2 One area of interest, that Jon asked us to look
3 into, is comparing NP and PA care to care delivered by
4 physicians on the basis of quality, cost, and patient
5 experience. Although this is a well-studied area of health
6 policy, there are limitations to the research, given the
7 small number of randomized studies, the limitations of
8 claims data, including "incident to" billing, small sample
9 sizes, and short follow-up.

10 Overall, for the services they provide in common,
11 the evidence appears to be that NPs and PAs provide roughly
12 equivalent care in terms of quality and patient experience.

13 For cost, the evidence is more mixed. Some
14 insurers, including Medicare, pay a discounted rate for NP
15 or PA care billed directly. But NP or PA care could also
16 affect total episode costs or utilization through
17 differential effects on downstream services, such as
18 imaging and tests, additional follow-up visits,
19 hospitalizations, or emergency department visits. And a
20 few studies have found higher ordering if diagnostic
21 imaging among NPs and PAs than for physicians, but others
22 have not.

1 Turning to the practice specialty of APRNs and
2 PAs, there is scantier information about their current
3 practice specialties than for physicians and less
4 uniformity in credentialing. In addition, APRNs and PAs
5 may be more likely to work across different fields during
6 their career than physicians.
7 But turning to the specialties in which NPs and
8 PAs appear to practice, two point-in-time estimates are
9 that about half of NPs work in primary care and 27 percent
10 of PAs work in primary care. Shares of primary care NPs
11 and PAs both appear to have declined over time.
12 With respect to what Medicare knows, the system
13 that providers use to enroll in and bill the Medicare
14 program and be paid for their services classifies all NPs
15 and one specialty and all PAs as one specialty.
16 Medicare covers nearly all medically necessary
17 services provided by NPs, CNSs, and PAs under Part B of the
18 program, as long as the service is delivered in compliance
19 with state law. There are a few limits on what NPs and PAs
20 can order or certify the need for certain types of
21 services, and a particular example is that only physicians
22 can order home health.

1 In terms of billing and payment, APRNs and PAs
2 may either bill Medicare directly, using their own provider
3 number, or bill "incident to" a physician service, meaning
4 that the physician bills for the service that the APRN or
5 PA provided, and there is a payment differential for direct
6 and "incident to" billing.
7 This slide walks through the two methods of
8 billing, using NP services as an example. Down the left
9 side of the graphic is if the NP billed Medicare directly.
10 They would report their own provider number and meet a
11 general requirement for collaboration with a physician, or
12 meet a state requirement if it is stricter, and the NP
13 would be paid directly at 85 percent of the fee schedule
14 amount.
15 On the right side shows the process for billing
16 for the NP service "incident to" the physician service.
17 The physician's ID would be on the claim and the physician
18 and NP would need to meet the "incident to" requirements
19 for direct supervision, and the payment would be 100
20 percent of the fee schedule amount.
21 "Incident to" billing is only permitted in the
22 physician office and cannot be used for new patients nor

1 for existing patients with a new problem. In those
2 circumstances, the NP would have to bill directly. I'll
3 turn it to Brian to go through the data work and policy
4 implications.
5 MR. O'DONNELL: So as Kate mentioned, we are
6 going to switch gears and talk about some of our analyses
7 regarding the billing patterns for APRNs and PAs. Before
8 we get into the numbers, one thing to keep in mind is that
9 the billing statistics we'll present generally
10 underestimate the services APRNs and PAs actually provided
11 because of "incident to" billing.
12 Having said that, this slide looks at allowed
13 charges billed by APRNs and PAs in 2010 and 2016. As you
14 can see, total allowed charges billed by APRNs and PAs grew
15 rapidly over the period, more than doubling from roughly
16 $3.1 billion to $6.5 billion.
17 NPs and PAs represented a large majority of all
18 allowed charges billed by this group of clinicians and
19 their allowed charges also grew quickly. NPs' billings
20 increased by 158 percent over this time, and PAs' billings
21 increased by 118 percent.
22 Just to put these growth rates in context a bit,

1 the number of Part B fee-for-service beneficiaries has
2 grown by about 5 percent over the same time period and
3 Medicare spending on the physician fee schedule has grown
4 by about 13 percent over the same period.
5 In your mailing materials, we show that NP and PA
6 billings are concentrated in E&M services, so this next
7 slide drills down on the number E&M office visits billed by
8 APRNs and PAs, primary care physicians, or specialists,
9 from 2010 to 2016.
10 Over this period, the number of E&M office visits
11 billed by APRNs and PAs increased from 11 million to 28
12 million, an increase of 149 percent.
13 This rapid increase is consistent with the
14 overall growth in allowed charges I mentioned earlier and
15 the growth in the number of APRNs and PAs billing Medicare,
16 which I did not discuss today but is included in your
17 mailing materials.
18 Before I leave this slide, there are a few other
19 trends worth noting. First, the total growth in visits and
20 visits billed by specialists have grown by amounts roughly
21 similar to the growth in the number of Part B fee-for-
22 service beneficiaries. However, the number of visits

1 billed by primary care physicians has declined by 13
2 percent over the same period. This suggests that APRNs and
3 PAs could be billing for visits that were once billed by
4 physicians, especially in primary care.
5 So the next few slides deal with "incident to"
6 billing.
7 A service that is performed by an NP or PA and
8 billed under Medicare's "incident to" rules appears, in the
9 claims data, as though a physician performed the service.
10 This means that Medicare's "incident to" rules obscure the
11 number of services actually furnished by NPs and PAs.
12 Given the rapidly expanding supply of NPs and
13 PAs, Medicare's "incident to" rules could apply to an
14 increasing number of services. However, existing research
15 on the prevalence of "incident to" billing is limited.
16 Therefore, we conducted original analyses to try to give
17 the Commission a rough sense of the prevalence of "incident
18 to" billing.
19 The analysis I'll walk through today estimates
20 the prevalence of "incident to" billing for E&M office
21 visits.
22 This slide shows the percent of E&M office visits

1 billed by NPs in physician offices and in hospital
2 outpatient departments, HOPDs. For established patients,
3 the right hand side of the figure, NPs billed a much higher
4 share of visits in HOPDs, the blue bar, than in physician
5 offices, the green bar.
6 For established patients, NPs must bill under
7 their own NPI in HOPDs but can bill under a physician's NPI
8 in the physician office setting, so the difference we see
9 between the bars could reflect NPs billing under
10 physicians' NPIs in the office setting.
11 In contrast, for new patients, the left-hand side
12 of the figure, NPs must bill under their own NPIs in both
13 settings, and as you can see, NPs billed only a slightly
14 higher share of office visits in HOPDs than in physician
15 offices.
16 Given the minimal differences between HOPDs and
17 physician offices for new patients, where we think the
18 billing data accurately reflects who performed the visit,
19 we conclude that most of the difference between the green
20 and blue bars for established patients is due to "incident
21 to" billing.
22 So based on this conclusion, we estimate that

1 approximately 40 percent of E&M office visits NPs performed
2 for established patients in physician offices were likely
3 billed "incident to" in 2016. This means that for every
4 100 such visits NPs performed, we think roughly that 40
5 appear in the claims data as though they were performed by
6 a physician.
7 We also conducted the same analysis for PAs and
8 conclude that roughly 30 percent of such visits by PAs were
9 likely billed "incident to" in 2016.
10 To put these numbers in context, we think that
11 the rates of "incident to" billing for NPs and PAs mean
12 that roughly 5 percent of all E&M office visits billed by
13 physicians were likely performed by an NP or PA in 2016.
14 The next two slides provide an overview of two
15 policy options for the Commission to consider. Both policy
16 options are designed to improve the information the
17 Medicare program has on such clinicians.
18 The first policy option is eliminating "incident
19 to" billing for APRNs and PAs. This means that APRNs and
20 PAs would be required to bill under their own NPI when they
21 furnish a service to a Medicare beneficiary.
22 Requiring direct billing could have several

1 implications, including reducing Medicare and beneficiary
2 expenditures, as all services currently billed "incident
3 to" and paid standard fee schedule rates would be paid at
4 85 percent of those rates; improving fee schedule
5 valuations by enhancing the program's ability to detect
6 potentially overvalued services; enhancing program
7 integrity by narrowing a rule that Medicare currently has a
8 limited capacity to enforce; and improving the ability of
9 policymakers to directly compare the care furnished by
10 APRNs, PAs, and physicians.
11 The second policy option is improving Medicare's
12 specialty designations for APRNs and PAs. Under this
13 option, APRNs and PAs could be required to self-select a
14 specialty in which they practice when they enroll in
15 Medicare and then update that information regularly.
16 Refined specialty categories would help Medicare
17 identify primary care clinicians because assuming that all
18 NPs and PAs provide primary care, as is sometimes done, is
19 imprecise, as roughly three-quarters of PAs and half of NPs
20 do not predominantly provide primary care.
21 This brings us to your discussion. After
22 answering any clarifying questions, we would like the

1 Commission's feedback on any analyses you would like us to
2 conduct or any additional material you would like us to
3 include in future iterations of this work. We would also
4 like the Commission's feedback on the two policy options.
5 With that, I turn it back to Jay and look forward
6 to the discussion.
7 DR. CROSSON: Thanks very much, Brian and Kate.
8 I am going to start off with one question. It was in the
9 chapter mentioned, but could you review for us, to the best
10 of your knowledge, what the original intention of "incident
11 to" billing was supposed to be?
12 MR. O'DONNELL: Right. So when we started on
13 this project we went out and asked folks that question, and
14 we heard this refrain constantly, that, you know, the
15 "incident to" regulations were not intended to cover APRN
16 and PA services. And so we'd say, "Well, what does that
17 mean?" and we kind of got fuzzy responses.
18 And so what we did was we went back and looked at
19 the origins of the "incident to" rule, and it came into
20 being with the Medicare program. So in terms of coverage,
21 in the original 1965 act, you know, physician services were
22 covered and also services provided "incident to" those

1 physician services. And so we went back and looked when
2 NPs and PAs were created as entities, or specialties, and
3 the first programs were created in 1965, with the first
4 graduating classes a few years after that.
5 So based on that conclusion, we say in the paper
6 that we don't think rule was intended to cover NP and PA
7 services, originally intended, because they didn't exist at
8 the time it was written. And so I think that what that
9 leaves is that, you know, services provided by kind of non-
10 licensed folks or lower-end folks than NPs and PAs. I
11 think that was the original intent when this was written.
12 DR. CROSSON: Good. Thanks very much. Other
13 clarifying questions? Sue.
14 MS. THOMPSON: Thank you. Important chapter and
15 one that leads nicely into the next discussion on primary
16 care.
17 So looking at the state scope of practice laws,
18 is there anything about the fact that there's great
19 variation across the country, state to state, in terms of
20 the autonomy of these categories of workers, that impact
21 recommendation number one?
22 MS. BLONIARZ: So I don't think that this would

1 affect -- scope of practice would affect this
2 recommendation. In most -- in all states, NPs and PAs are
3 permitted to bill any insurer or be credentialed, and what
4 we think, with "incident to" is that it's adding on a layer
5 of kind of supervision that doesn't, you know, it doesn't
6 replace state law, and in some ways it's more restrictive
7 than some state laws.
8 And so I think, if anything, it would probably be
9 the reverse. It's kind of there's a financial incentive to
10 bill "incident to." Once that's no longer there,
11 physicians and NPs and PAs would not have to meet the kind
12 of direct supervision requirements, but whatever state law
13 was still in place, you know, would govern kind of their
14 practice.
15 MS. THOMPSON: Thank you.
16 DR. PAUL GINSBURG: If I could add something, I
17 am under the impression -- you may tell me I'm wrong --
18 that the scope of practice issues and controversies mostly
19 come up with independently practicing, usually, NPs. PAs
20 tend not to practice independently.
21 But that for the most part, I think for those
22 employed by physicians, they can do whatever the physician

1 asks them to do, and I don't think the laws interfere with
2 that.
3 So, in a sense, the actual variation in practice
4 is probably less significant than what appears on the basis
5 of the laws.
6 DR. CROSSON: Further questions. Over here, I've
7 got Kathy, Dana, Pat. Kathy, Dana, Pat.
8 MS. BUTO: So I wondered whether we have an idea
9 of why the growth in NPs is faster or more than the growth
10 and the number of PAs. Is there a difference in scope of
11 practice? Is that your sense between the two, even from
12 state to state? Or what makes one more attractive than the
13 other is what I'm trying to get at.
14 MS. BONIARZ: Yeah. So there is differences
15 state to state in terms of scope of practice, and what we
16 kind of tried to convey in the paper is that PA scope of
17 practice, PA state law often defers to the physician and
18 says the physician -- a physician that's in a collaborative
19 or supervisory arrangement with a PA would kind of define
20 what services that PA would provide and what circumstances,
21 whereas a state's scope of practice laws for NPs is a
22 little more prescriptive in terms of saying an NP must have

1 an established relationship with a physician. They may
2 have specific practice protocols. They may have more
3 restrictions around prescribing, particularly for
4 controlled substances.
5 But I would also add kind of to the point you
6 were asking about. The orientation of both specialties is
7 a little different. NPs, generally, their education and
8 training historically has been a little more focused on
9 them kind of fitting into an independent practice, whereas
10 a PA has always been historically kind of part of a
11 physician team.
12 And what that's meant in practice is that some
13 settings, like retail clinics, see more benefit from hiring
14 NPs because they are directly diagnosing, treating, and
15 prescribing.
16 MS. BUTO: That's really helpful.
17 So I'm hearing more flexibility for the PA but
18 always in relation to a physician supervision or
19 relationship, where NPs can actually set up independently -
20 -
21 MS. BONIARZ: Right.
22 MS. BUTO: -- under certain circumstances.

1 MS. BONIARZ: And the one caveat I want to make
2 is that that is recently changing on the PA side, and I
3 think Brian included some material in the paper about their
4 optimal team practice, which is a little bit -- I would say
5 moving a little bit farther away from kind of that
6 physician-headed model.
7 MR. O'DONNELL: That's right.
8 and I would say to support that is that the
9 trends in NPs and PAs, it hasn't always been that NPs were
10 growing faster. If you looked at a previous decade, there
11 was some evidence that PAs were growing faster. And that
12 was the period of time when physician billing was growing
13 much faster. And then around 2010, when you see docs being
14 employed by hospital systems, the NPs started to grow
15 faster.
16 DR. CROSSON: Okay. I've got Dana, Pat, and I
17 think I saw Karen.
18 Dana.
19 DR. SAFRAN: Thanks, Jay.
20 I just have two questions. One is back on the
21 issue of differences in state scope of practice laws.
22 Apology if I missed this, but has there been any

1 research? You talked about the research around looking at
2 quality of care, cost of care, patient experience too,
3 relative to physicians. But has there been any research to
4 see at the state level for the states that have more
5 liberal or more strict scope of practice laws, how those
6 quality and patient experience and cost parameters play
7 out?
8 MS. BONIARZ: Yeah. We did look at that, and
9 there's a fair bit of data, a fair bit of research on is
10 there something different about the states that have made
11 changes to scope of practice, then kind of looking at time
12 trends.
13 DR. SAFRAN: Yeah.
14 MS. BONIARZ: I would say that, again, it's kind
15 of mixed, and it's very -- I would say the research is a
16 little dependent on what your priors are.
17 Some of the states that have enacted scope-of-
18 practice changes are systematically different than ones
19 that didn't, and I think I would say there's kind of
20 evidence on both sides there. And I wouldn't say that any
21 of the evidence is super strong in one direction or
22 another.

1 DR. SAFRAN: I'd be really interested to see some
2 of that data because I think there's a lot in there,
3 understanding any problems that have to be dealt with.
4 My second question is on Slide 10, and it's in
5 the first two rows there. Do we have any insight or could
6 we from the data as to whether the increase that we see in
7 the first line and the tradeoff being made in physician
8 visits has anything to do with ACOs looking to not do
9 incident billing and make the most out of the budgets that
10 they're given by using folks to the top of their license
11 and not billing that extra 15 percent? Any insight on
12 that?
13 MR. O'DONNELL: Unfortunately, I think the answer
14 is no. I think we saw this trend where we saw the decline
15 for PCPs and APRNs, and we wanted to highlight it, but we
16 talked internally. We think there's two or three different
17 possible explanations -- and I guess maybe four now -- that
18 we hadn't thought of.
19 So it could be just kind of a billing versus a
20 performing issue as to where there's differential trends
21 and incident to billing, so it just looks like PCPs are
22 going -- it could be that PCPs are doing different

1 services, so the distribution of services have changed, or
2 it could be that they're doing less. And I think at this
3 point, we haven't explored past what you see right here.
4 DR. SAFRAN: Yeah. So I think that would be an
5 important thing to look into, and you probably have the
6 data that would allow you to look to see. Do you see
7 different patterns inside of ACOs versus elsewhere?
8 DR. CROSSON: Pat.
9 MS. WANG: Thanks.
10 I was wondering if I could just focus on Slide
11 13, the conclusion that 40 percent of E&M office visits,
12 blah-blah-blah. I just want to make sure I understand
13 this.
14 So I guess focusing on the NPs, because I do
15 think PA services are a little bit different, but just
16 focusing on NPs, is it clear that the visit that -- here
17 suggests there's a substitution of the physician billing
18 when somebody has actually performed the service.
19 Number one, it really is very distinct, like the
20 NP has actually performed independently an entire visit. I
21 mean, this sort of suggests the doc had nothing to do with
22 it, but they're billing for it, anyway, as opposed to the

1 physician maybe having had some involvement in that visit.
2 And I guess that I'm a little confused here because whether
3 or not the scope of practice differentials among states may
4 effect that -- I guess the question is, Is this 40 percent
5 cleanly -- this is the work of the NP, but it's being
6 billed as incident to the doc?

7 MR. O'DONNELL: Yes. So I think there's at least
8 a couple issues there. One is that the numbers that we
9 present aren't clean because the data don't indicate --
10 there's not a flag on the data that says this is an
11 "incident to" claim. It's all hidden. This is a research
12 endeavor to try to give you a sense of the magnitude. So
13 that's one thing.

14 The second thing is you referred to is this just
15 an NP versus an NP and a doc collaboration. In the
16 physician office setting, if there is that collaboration,
17 they can bill it "incident to."

18 For instance, in the hospital outpatient
19 department, there's rules around what they call split
20 visits or shared visits. So when we made this estimate,
21 the kind of baseline that we are looking at -- and that's
22 NPs and HOPDs -- that already excludes split visits or

1 shared visits. So I think that it kind of accounts for
2 that. So I'm not sure that's driving that issue.
3 MS. WANG: Okay. It's just --
4 MS. BONIARZ: Actually, I can answer just, I
5 think, the point about whether it interacts with state
6 scope of practice.
7 I will say as far as I can recall, no states have
8 scope of practice for NPs or PAs that is as high as direct
9 supervision under the Medicare "incident to" rules. It's
10 less oversight than that, so that's actually kind of the
11 highest bar.
12 MS. WANG: I guess policy option 1, which would
13 be to eliminate "incident to" billing -- I may be
14 misunderstanding the thrust here -- is with the potential
15 of saving Medicare money. It kind of suggests that that NP
16 really is performing -- maybe the physician is doing more
17 than we think because it is kind of a collaborative.
18 I'm a little confused by the suggestion there
19 because maybe the NP is doing a certain amount of work, but
20 the physician is also doing a certain amount of work for
21 that same patient and that's why the --
22 MR. O'DONNELL: Right.

1 And I think your point is valid. There's a chunk
2 of services that NP furnish, right? A portion of that,
3 they might be performing independently, whether you think
4 it's simple sprains or colds or what have you. Then there
5 is another portion where there's likely collaborative care.
6 Maybe these are complex patients, things of that nature.
7 So for the first chunk of visits, we do think
8 that if you require direct billing, there will be savings
9 because their NPIs will appear on the claim.
10 Now, for that second chunk -- and we don't know
11 the distribution between the two chunks, but for that
12 second chunk, if you were to require direct billing, you'd
13 have to have a wraparound policy saying if the NP performed
14 51 percent of the visit, then their NPI would appear on the
15 claim, or if a doc did 51 percent, their NPI would appear
16 on the claim.
17 The HOPD already has a rule similar to that, and
18 the rule is that if a physician performs a substantial
19 portion of the visit, then their NPI appears on the claims.
20 MS. WANG: Okay. Gotcha.
21 And then the final question I had, do you know
22 how malpractice expense is handled when NPs are employed by

1 physicians in their offices? And how does that show up in
2 the fee schedule calculation? Do they have to carry their
3 own malpractice insurance?
4 MS. BONIARZ: They do, yes.
5 MS. WANG: Okay. And so if they're employed by
6 physician office, is it likely that the physician office is
7 paying for that malpractice? How does that work?
8 MS. BONIARZ: I'm not sure, if they were
9 salaried, if that would be part of their compensation, but
10 they are required to carry their own malpractice. And then
11 from the Medicare side, it's considered direct practice
12 expense.
13 DR. CROSSON: Okay. I've got Karen and then Amy.
14 DR. DeSALVO: It's not a Round 1, but it's a
15 point on to Pat, which is one of the expenses for the
16 physicians who are collaborating physicians is malpractice
17 and linkage to licensure. So there is some added cost also
18 for the physicians.
19 With the caveat that -- first of all, thank you,
20 guys. This is really thought-provoking and kind of drives
21 me to some of the questions you're hearing about team-based
22 care, which is where we've been pushing primary care and

1 inpatient care and ERs and how this might not -- this kind
2 of analysis in thinking and some of the recommendations
3 might go against that kind of a move, but nonetheless, it's
4 good to understand the practice patterns.
5 I wondered if -- maybe I missed it in the
6 chapter, but if we understood how these kinds of chart
7 billings look for other payers outside of Medicare to
8 understand that these trends are reflected in Medicaid and
9 the commercial marketplace -- and you're shaking your head
10 vigorously as if you are six steps ahead.
11 MR. O'DONNELL: Yeah. So we have a survey in the
12 field right now looking at private payer policies --
13 DR. DeSALVO: Okay. That's what you were --
14 MR. O'DONNELL: for "incident to" billing, and it
15 does over time -- it seems like private payers have moved
16 more in the direction of requiring direct billing or at
17 least allowing direct billing for NPs and PAs.
18 So we have some examples. I think we cite
19 Montana Blues in the paper, and we have some examples like
20 that.
21 DR. DeSALVO: Thank you. Yes. That as well as
22 I'm trying to understand if there's a practice pattern that

1 reflects a big increase in NPs billing in the way that
2 we've seen in the data and a decline in primary care
3 physicians. Is the pattern similar, not just the rules?
4 MS. BONIARZ: I know on the Medicaid side,
5 there's been growth in NP and PAs, both in billing and in
6 volume, but I don't know about other --
7 DR. DeSALVO: For me, I'm asking because if it's
8 something about "incident to" that's special to Medicare,
9 but we see the pattern even where payers are not using that
10 kind of a model, maybe it's not the "incident to," but
11 something else about what's happening in the clinical
12 environment.
13 And I had a question on Slide 12 to make sure I'm
14 understanding this right, which is -- so this is hospital
15 outpatient departments, which means they have got a
16 facility fee associated with this also that the hospitals
17 are billing?
18 And so I wonder if there's any way to tease out -
19 - I don't know if it's possible, but how much of this is a
20 business decision on the part of hospitals that are
21 employing primary care because they can also charge a
22 facility fee. So the growth in NP employment and use in

1 outpatient setting is a lower salary expense, but then
2 still, it doesn't hurt them on the reimbursement, even if
3 it's only 85 percent, that if they can bill. Does that
4 make sense?
5 MR. O'DONNELL: So I'm not sure I tracked that
6 question entirely, but certainly -- so in the OPD, you're
7 prohibited from billing "incident to," right?
8 DR. DeSALVO: Okay.
9 MR. O'DONNELL: But they do get --
10 DR. DeSALVO: So I can understand that.
11 MR. O'DONNELL: Yeah. Sorry.
12 DR. DeSALVO: All right. That's perfect. Thank
13 you.
14 DR. CROSSON: Amy.
15 MS. BRICKER: Just so I am ensuring that I am not
16 oversimplifying, is there any other contractor or advantage
17 to "incident to" outside the financial?
18 MR. O'DONNELL: So for folks like RNs and LPNs
19 who provide services in physician offices who can't bill
20 Medicare directly, that's the only manner in which they can
21 be reimbursed for those services.
22 But for APRNs and PAs who can bill directly, I

1 think there was a little bit of a stretch for us to find
2 any other benefits.
3 MS. BRICKER: Okay. And then the 85 versus --
4 the 15 percent delta, 85 versus 100 percent, can you
5 quantify that? If it's 5 percent of E&M are actually NPs
6 or PAs and if "incident to" billing were not allowed, what
7 is the cost, the savings to the program?
8 MR. O'DONNELL: So we have calculated that, and I
9 don't want to give an exact point estimate, but it's a few
10 hundred million dollars a year, we think. In the ball
11 park.
12 MS. BRICKER: Okay. We might then think about
13 that in the next chapter around consideration for primary
14 care. So maybe we can link it. These are very correlated,
15 yes.
16 Thanks.
17 DR. CROSSON: Okay. Sue, one more question.
18 Jaewon, is your hand up?
19 DR. RYU: Yeah.
20 DR. CROSSON: Sue.
21 MS. THOMPSON: I'm trying to recall, and I'm not
22 remembering. Do we have any information about any

1 compliance to "incident to" billing that we know of from a
2 standpoint -- oh, you're looking at me like you wish I
3 hadn't asked that.
4 MR. O'DONNELL: No. So we talked to a few
5 medical directors, and I think the ability to enforce these
6 rules are quite limited.
7 DR. CROSSON: Jaewon.
8 DR. RYU: A couple questions around the job
9 market. I think going back to -- I think it was Slide 10
10 or 12, the one with the chart showing the negative, that
11 one. How much of that is driven by supply changes, primary
12 care physician availability? Any sense of that?
13 MR. O'DONNELL: Yeah. So I think one of the
14 reasons we thought this was particularly interesting is
15 that what Ariel is going to tell you is that the number,
16 the raw number of primary care physicians that have been
17 billing Medicare has actually been going up slightly over
18 time. So you see an increasing number, and then you see
19 them doing 13 percent fewer office visits. So there's a
20 dissonance there that I can't really explain at this point,
21 but --
22 DR. RYU: And those unique billers, are they

1 billing in a meaningful way, meaning part-time work versus
2 what seems to be full-time engagement?
3 MR. O'DONNELL: Right. And that was part of --
4 if we go the next step, if you guys want us to explore
5 that, that's one of the first things we're going to do, is
6 to say, "Okay. Are they billing more? Are they billing" -
7 - "Is it just a minimal level? What does the distribution
8 look like?"
9 DR. RYU: And then on a related point, I think
10 you mentioned in the send-out materials that it was
11 anticipated that this would not have an impact on the job
12 market necessarily because the salary differential between
13 advanced practitioners and physicians are still significant
14 enough to create rationale.
15 I guess the question is are there other dynamics
16 -- and I don't know the answer to this. But are there
17 other dynamics that would suggest the business case, so to
18 speak, of employing advanced practitioners weakens with the
19 15 percent delta and the payment?
20 MR. O'DONNELL: So I can't think of any off the
21 top of my head, but we talked to folks who work at medical
22 schools for PAs. And we asked them, "What does your

1 application rate look like?" and they said they're getting
2 applications from a lot of people. They have to deny a lot
3 of folks.
4 So there seems to be a desire to go into PA
5 school or NP school, and so when we look at the employer
6 market, folks have continued to speculate that at a certain
7 point, there might be a glut. You might have a leveling
8 off of interest, but that is why we put the statistic in
9 about the increasing salaries. I just don't see it right
10 at this point.
11 DR. CROSSON: Okay. I'm sorry. Warner.
12 MR. THOMAS: Just one comment kind of tied to
13 that. I think where we see the workforce challenges is
14 actually more in the nursing area, because we've seen
15 nurses that are, you know, progressing to be nurse
16 practitioners. I think that creates more pressure, and I
17 think that will discontinue as we see an escalation in this
18 profession and will create more challenges in the nursing
19 world.
20 DR. PAUL GINSBURG: If I can make a comment on
21 this. I suspect that because of the incidence of billing
22 rule, this is probably pulling up salaries of NPs and PAs

1 artificially, and in a sense -- which might actually be a
2 problem not only spending too much money, but in a sense
3 challenging the RN markets as people are pulled out of the
4 RN market. So I wouldn't have any qualms about not paying
5 too much and getting fewer NPs or PAs in the process.
6 DR. CROSSON: Okay. So we're going to move on to
7 the discussion. Put up the last slide. We're going to
8 talk about requests for additional information -- we've
9 already heard some -- but then ask for Commissioners'
10 perspective on the incident-to billing options that were --
11 well, the incident-to billing option or the other specialty
12 designation option that were on the table. So sue is going
13 to begin the discussion.
14 MS. THOMPSON: Well, again, thank you. I think
15 this is an incredibly important topic and one that we
16 likely haven't spent enough time on, and it's a component
17 of our health care workforce that is growing, and it's been
18 growing, and we haven't talked about it since 2014, I
19 think. So I think it's all connected.
20 I think the comment that Warner just made about
21 the impacts that the APRN opportunity is having on our
22 registered nursing workforce is profound. And, yeah, we

1 push a balloon here, and it comes out there. So I cannot
2 overstate the importance I feel that we focus on the work
3 of nurse practitioners and PAs and how they contribute to
4 solving for providing care to our Medicare beneficiaries.
5 My perspective comes from a rural perspective in
6 this country where we are very, very dependent on and value
7 very much our nurse practitioners who, within the state of
8 Iowa, have a scope of practice that allows for independence
9 practice. But from a system where I work, we employ a
10 goodly number, and many of these nurse practitioners work
11 in clinics serving rural communities without a physician in
12 the clinic. So they are practicing quite independently.
13 Likewise, PAs plan an important role as well but
14 also, you know, from my experience work very much in tandem
15 with a physician specialist for the most part.
16 I want to go on record saying that I would
17 support eliminating the incident-to billing if for no other
18 reason, to be quite honest, is to create some dollars for,
19 as I think Amy began to suggest, the next chapter, but also
20 to clean up the data. I think one of the biggest
21 challenges we have as we look to understand attribution is
22 who was actually putting hands on that patient. And this

1 incident-to component blurs the data. And I think, again,
2 for no other reason than if we could just get our data to
3 clean up, there's good reason to continue exploring that
4 recommendation.
5 Also, in terms of the component about the
6 specialty designation, I do think we didn't spend a lot of
7 time talking about that in our discussion. I think there's
8 value. And as I would hope we continue to understand the
9 value and put increasing value on understanding the role
10 that APRNs and PAs play in our working complement, that at
11 the same time with increasing that value we also increase
12 the responsibility and accountability for appropriate
13 education, because I think if there's a prejudice out
14 there, and even in an environment where we use nurse
15 practitioners a great deal, it is that they don't have the
16 same education. They haven't put the hours of residency
17 that a physician has invested. And so with that, I just
18 think there's a complementary set of accountabilities that
19 we would want to attend to in this conversation. And I
20 think I would go on record saying this is a very important
21 group of individuals that provide a lot of access to care,
22 particularly in rural parts of our country. And in terms

1 of assuring that we provide the same quality of care, that
2 we clean up the data so that we can confidently put forth
3 data that assures us that our beneficiaries are receiving a
4 complementary level of care.
5 DR. CROSSON: Thank you, Sue. Very clear.
6 I think I had a right-table bias this morning, so
7 I am going to have a left-table bias and start with Paul.
8 DR. PAUL GINSBURG: I'm really very glad you did
9 this project, and you did a great job. And I'm
10 enthusiastic in supporting both recommendations, and the
11 way I would explain it is that to me incident-to billing is
12 a relic of the Medicare of the late 1960s where the program
13 was completely passive. It just wanted to pay bills for
14 whatever was going on. And we have a different Medicare
15 today. We have a Medicare that's more accountable, that's
16 more interested in quality issues, that wants to know
17 what's going on in the program.
18 I first ran into the incident-to issue really as
19 a researcher, seeing that there was just a big black thing
20 that I couldn't see through because of this ability. So to
21 me that's the virtue of the specialty designations, so we
22 have a much better sense of what's happening in the

1 Medicare program. It makes certain policies feasible that
2 wouldn't have been feasible otherwise, making use of
3 specialty designations.
4 I think for the incident-to billing, it is
5 leading to overpayment, and some incentives that we
6 probably don't understand, which, if we did, we probably
7 wouldn't like what they're incenting.
8 DR. CROSSON: Thank you. Amy.
9 MS. BRICKER: Also supportive of prohibiting
10 incident-to billing, but want to think about redeploying
11 those dollars back to the physician. I don't know that --
12 I had assumed that it wasn't necessarily an upside for the
13 actual nurse practicing, but instead the larger practice,
14 that they're generating additional revenues associated with
15 incident-to billing, and not necessarily flowing down to
16 the nurse practitioner him- or herself.
17 So, clearly, this policy is a takeaway from, you
18 know, general revenues of those practices, and we're all
19 very attuned to the decline in primary care. And so, you
20 know, I'm not typically in favor of, you know, when we find
21 opportunities for savings, redeploying that. But I think
22 in this case, given the specialty or the general practice

1 of primary care, we may want to consider that. How then
2 you identify those practices -- I mean, does everyone get a
3 bump equally? I don't know. Do we instead ask for folks
4 to identify themselves as, yes, this is part of my practice
5 and this is a takeaway, so then is there a way for them to
6 begin monitoring? Did they, in fact, stop doing it if you
7 said that it's difficult to monitor or to ensure that this
8 is no longer occurring?
9 So, I don't know, things we still need to flesh
10 out, but I think that there's value in that and in
11 identifying specialties of those nurse practitioners,
12 because for no other reason, I thought it was interesting
13 and a good point you made around it's quite easy for these
14 folks to switch specialties. You don't see that -- and the
15 physician, of course, is readily -- and so then the quality
16 of the care that's provided if you go from general practice
17 to some other specialty and outcomes associated so in favor
18 of both.
19 Thanks.
20 DR. CROSSON: Brian.
21 DR. DeBUSK: Great chapter, really nice work.
22 I'm glad we're addressing this.

1 I think eliminating the incident-to billing I
2 think is an obvious thing. I think it's great that we're
3 exploring this now, and I fully support that, as well as
4 having them specify their specialty designation and
5 updating -- and, again, I'm very much in favor of that.
6 The thing I want to focus on, though -- and
7 Warner touched on it and Paul touched on it -- we need to
8 pay close attention to the economic and time arbitrage here
9 between a nurse practitioner -- you're probably talking
10 about 24 months postgraduate, probably $35,000; a PA, which
11 is 27 months, probably $72,000, $75,000; and then compare
12 that to, say, a primary care physician. You look at what
13 they're going to spend and the time they're going to
14 invest, there's a lot of economic and time arbitrage there.
15 And, again, to Warner and Paul's point, you're
16 pulling nurses out of the field into this new -- again,
17 it's an economically beneficial place to be. We can't
18 argue against what they're doing. They're making a good
19 decision. But there's another issue, and this is slightly
20 beyond the scope of this chapter, but this is going to roll
21 right over into the discussion we have here in a few
22 minutes on primary care. What are you going to do as these

1 mid-levels get independent practice autonomy? We're
2 sitting at 22, 23 states now. I noticed the reading
3 materials didn't really talk about the momentum, but
4 there's really good momentum. I mean, we could be having
5 this conversation next year, and it would be 35. I
6 wouldn't be surprised -- or at least 30.
7 So when you look at that and you look at these
8 degree completion programs that are available -- and I
9 don't know if you guys have had a chance to explore that
10 yet, but, you know, there are now doctorates in nursing
11 practice. There are now PA programs where they complete a
12 doctorate. These are terminally degreed people. These
13 degrees confer the title of "doctor." Now, they aren't a
14 licensed physician, but what do you do with this
15 combination of terminal degrees being conferred and
16 independent practice autonomy? This is something we need
17 to keep our eye on because there will be people running
18 around with the title or at least calling themselves
19 "doctor," practicing medicine with independent practice
20 autonomy, and it could further undermine some of the issues
21 that we're having with primary care physicians and further
22 implode the primary care pipeline.

1 DR. CROSSON: Okay. Pat, Dana, and Jon.
2 MS. WANG: Again, I think that this picks up on
3 some of the comments that people have made, but just to
4 draw it down, if incident-to billing is eliminated, then
5 there does, I think, have to be a next step of work of
6 determining what the appropriate fee schedule is for NPs
7 and PAs. Eighty-five percent is completely arbitrary, and,
8 you know, it does suggest that the RUC or somebody like
9 that is going to have to determine what the appropriate fee
10 schedule level is. You know, people -- you know, the point
11 that Brian was just making, there is the work that NPs in
12 particular do to provide primary care is really, really
13 essential. But 85 percent of physician, given what they
14 train and what they're expected to do, seems pretty
15 arbitrary. So I'd just put a marker down on that, and it
16 will have financial implications all the way around.
17 The other thing is that this has -- and I guess
18 we'll roll into the next chapter discussion. It has big
19 implications, I think, for the -- after I read this, I kind
20 of felt like, well, I don't even know what to make of the
21 predictions of oversupply/undersupply of primary care
22 physicians if, in fact, a primary care physician's work is

1 actually -- it is team-based and it is kind of -- they are
2 extending beyond, you know, the FTE physician in the office
3 because they do have NPs and PAs. I just think it has
4 implications for kind of backing into -- well, maybe the
5 physician fee schedule for primary care as it exists today
6 is sufficient because there's all this incident-to billing,
7 and economically they've made it work. You know, once you
8 start separating everybody into their own little silo of
9 billing and so forth, it does -- I think it raises
10 additional challenges for determining appropriate, you
11 know, levels for the physician fee schedule for the pure
12 primary care doc for their own work. And maybe it is just
13 a matter of, you know, spreading around the money that's in
14 there and kind of allocating it more precisely. This is
15 the fee schedule for an NP; this is the fee schedule for a
16 primary care doctor. But I just want to -- you know, I
17 think there are a lot of implications to going down this
18 route, which, you know, for Sue's comments, I agree, it's
19 too murky right now. It would be good to know more without
20 undermining the good that comes right now of these quasi-
21 teams that seem to be operating to provide primary care
22 effectively.

1 DR. CROSSON: Dana.
2 DR. SAFRAN: Thanks. So I'm also in support of
3 both of the recommendations, and I won't add a lot to what
4 has already been said other than that, you know, I think
5 that -- I take the points that are being made about concern
6 that, you know, is 85 percent of fee schedule actually
7 going to turn out to be too much by some measure or
8 creating problems in the nursing workforce?
9 On the other hand, from where I am sitting and
10 thinking about it, you know, with all that we're trying to
11 accomplish through payment reform, delivery system reform,
12 getting folks practicing at the top of their license, I --
13 you know, to me this looks like a 15 percent saving by
14 having a workforce that's perfectly capable of doing what
15 for years we've relied on somebody with a physician's
16 credential to do that they may not need to be doing, and
17 that, in fact, the more we're trying to focus health care
18 on issues that extend beyond the four walls of the health
19 care setting to where patients live and work, helping them
20 with the behavior changes that they need in order to manage
21 a chronic condition they already have or prevent one that
22 they are at risk for, these are exactly the kind of skills

1 that we need. And we need to even go, you know, further
2 downstream from there to community health workers where the
3 evidence, you know, is quite good about the effectiveness
4 of their ability to help truly promote health in the
5 population.
6 So I absolutely agree with the point that we're
7 going to have to think about all of the unintended
8 consequences of what happens around where a payment gets
9 set and that 85 percent is arbitrary. But at the moment,
10 from where I sit, it looks like a really good idea, and at
11 least to begin to get the data clean, as several have made
12 that point, so that we can actually know with much more
13 certainty about what the outcomes are associated with these
14 types of clinicians versus their physician counterparts.
15 Thanks.
16 DR. CROSSON: Thank you. Jon.
17 DR. CHRISTIANSON: So just a question that I
18 think builds off of Amy's comments in the first and second
19 round. On Slide 14, we have Policy Option 1. Typically,
20 when we get a policy option from staff, they're very
21 meticulous about saying, well, here's the good things that
22 could happen, but here's the other things that might happen

1 that are not so good, pros and cons or pluses and minuses,
2 or however you want to term it. This seems like a list of
3 pros without any list of cons or cautions. Do you want to
4 give us any list of cautions or cons or things we should
5 worry about if we do this or negative impacts?
6 MR. O'DONNELL: So, right, we'll work in the
7 team-based care that we've heard into the chapter. When we
8 read through some of the things that folks objected to, if
9 direct billing were required, I think we -- you know, I'm
10 not sure we found them to be entirely credible. And so we
11 kind of walked through point/counterpoint in the paper, but
12 I think we drew somewhat of a blank on that.
13 DR. CHRISTIANSON: So there are no negative
14 impacts of doing this?
15 MS. BLONIARZ: I think one assertion, you know,
16 is that it's taking money away from, you know, team-based
17 care or primary care. I think just, you know, where we see
18 APRNs and PAs providing most of the services, most of that
19 money is not going to primary care. And so I think we kind
20 of don't necessarily agree with that one.
21 DR. CROSSON: Okay. So just for a change, let's
22 start down there with Jonathan.

1 DR. JAFFERY: Sure. Thank you, Jay.
2 So I also am in support of both of these. I
3 won't speak a lot to the incident-to because I think others
4 have articulated it well, other than, you know, as we think
5 about redeploying savings, there might be an opportunity to
6 actually address some of the team-based and primary care
7 issues by redeploying them preferentially to primary care,
8 even though they wouldn't all be coming from primary care.
9 In terms of the Slide 15 and Policy Option 2,
10 similar to what Jon said about Policy Option 1, I didn't
11 hear a lot of discussion about potential negative impacts,
12 so I would just suggest that there is a lot of positive
13 that could come out of this, and, you know, as a real-world
14 example, we have excluded all of our specialty PAs and
15 ARPNs, of which we have a lot, from our ACO. They're all
16 preferred providers instead of participants. So you can
17 comment -- I believe your point, ACO has done the same
18 thing because it perturbs our attribution model. And so we
19 don't want to do that, but we didn't feel like we had any
20 other choice. So I'll leave it at that.
21 MS. BLONIARZ: Yeah, and I just want to say one
22 thing about this option. I mean, this would have to be

1 basically self-identified specialty. The credentialing and
2 licensure for APRNs and PAs is a little different than
3 physicians, so it's not as if someone -- you know, someone
4 becomes a cardiologist and they may work in cardiology and
5 internal medicine and are boarded in both. On the
6 physician side it is a little bit more discretionary, on
7 the APRN and PA side, so that is a distinction. Maybe not
8 a downside but it is a distinction here.
9 DR. JAFFERY: But your report did lay out some of
10 the requirements you have to do, and there are some other
11 places where that has impact, like inpatient consultation
12 and follow-up and things like that.
13 DR. CROSSON: Warner.
14 MR. THOMAS: So one other question, and I know I
15 should have done this in round one but I just thought of
16 it. There's a comment about quality indicators, that
17 there's really no discernable difference in quality. Do
18 you know exactly what was looked at, in reference specific
19 articles, do you know exactly what they looked at?
20 MS. BLONIARZ: So -- and again, this was very --
21 this was just very general, right. And so we looked at a
22 number of different meta analyses or studies, you know,

1 that different organizations had put together, and then
2 Carolyn pulled a little over 100 articles herself. And a
3 lot of them are, you know, okay, for a set of discrete
4 outcomes, like diabetes outcomes in an outpatient setting
5 in the Veterans Health Administration, or HIV/AIDS care in
6 a certain setting. You know, there are a few kind of
7 quasi-randomized trials, quasi-randomized studies that
8 allocated among, you know, NPs and physicians, and then
9 it's, you know, did you -- just kind of patient experience
10 type measures. But it was a mix. It was kind of all over
11 the place.
12 MR. THOMAS: Okay. So I guess I definitely am in
13 favor of the policy recommendations. I think that the one
14 word of caution I would have is on the 15 percent, you
15 know, cost savings. I'm not quite sure if it would net out
16 that way, just given that there are utilization
17 differences, at least in our experience, of ancillaries,
18 and it's kind of referenced in the chapter, and I do think
19 that's an important distinction. It doesn't mean that we
20 shouldn't continue with what we're talking about doing, but
21 I'm not quite sure it would be a kind of a straight 15
22 percent savings, kind of service for service, once you kind

1 of look at the total cost of care.

2 But with that being said I still am supportive of
3 the recommendation. I do think in the subspecialty area
4 that's probably something that should be monitored a little
5 more closely than maybe some of the primary or kind of
6 wellness care. Just as far as we look at outcomes or as we
7 think about utilization going forward, that might be an
8 area to watch, as we look at a policy change like this.

9 DR. CROSSON: Karen.

10 DR. DeSALVO: I completely understand the second
11 recommendation and I think that helps with the murkiness of
12 the data, as well as understanding some of the implications
13 for access, which brings me to the first, where I feel on
14 the fence, largely because of what Jon described. I'm not
15 sure we've thought through all of the unintended
16 consequences or the downstream result of that, and I'm
17 hypothesizing here. For example, I was trying to get at it
18 with my question, that there's a salary cost that's less to
19 hire a nurse practitioner to take care of some primary care
20 work. You can still bill -- as an institution bill more,
21 so there's a nicer margin for you. And it may be true for
22 primary care offices but probably for institutions also,

1 and so I wonder if that changes in some way what that does
2 to ongoing employment for nurse practitioners, as an
3 example, in primary care, and to access.
4 I don't know if that's the fact or not, but I
5 would just want to think about that a little bit more than
6 I have. And secondly, that there are some implications for
7 the physicians in the states where they have collaborative
8 relationships, because it does take time to review cases
9 and charts, so it's not perfectly clean. Not that I'm
10 against it. I just think we should be thinking through if
11 the results are going to be what we're considering, whether
12 that's cost or access, et cetera.
13 And I want to just go back to this thing about
14 trying to understand the goal, in general, and we'll maybe
15 talk about this in the next chapter. But if the goal is
16 for the beneficiaries to have access to great quality care
17 and great health outcomes, how the teams work together to
18 make that happen. In a primary care, patient-centered,
19 medical home kind of model you'd want to give them maximal
20 flexibility as opposed to thinking about adjusting the fee
21 schedule. That's where I would really want to go for
22 global payments.

1 And so my initial reaction in reading this was a
2 food fight, almost, about who's going to be the primary
3 provider for the patient as opposed to thinking about the
4 patient and how we would best attend to them. It's not
5 necessarily a recommendation. It's just a general comment
6 about where this work could take us, which I think is
7 antithetical to where the field needs to go, around really
8 encouraging global payments to focus on outcomes and for
9 teams to meet patients where they are, with the skill set
10 that best works for that person, not only based on disease
11 acuity but on their overall situation.
12 DR. CROSSON: Okay. Further comments? Bruce and
13 Kathy.
14 DR. PYENSON: I support both recommendations.
15 Thinking about our commitment to site-neutral payments,
16 which might argue that in the absence of other information
17 we should not pay 85 percent but 100 percent, but I'm happy
18 with the recommendation as it is.
19 MS. BUTO: Bruce gets the award for the shortest
20 input.
21 So I support both recommendations. I think it's
22 an excellent direction that we're moving.

1 I would point out a couple of things. One is
2 that the issue of direct billing in the physician's office
3 it seems to me is very gameable. You pointed out that it's
4 hard to monitor now, or impossible, when something is
5 "incident to" or not. It seems to me equally hard to
6 figure out if a physician starts billing within an
7 assertion that the physician provided more than 51 percent
8 of the service. So I just point that out. I mean, we
9 think we might be getting a 15 percent savings but I
10 suspect we won't be getting that.
11 I'll also point out, as you have in the paper,
12 that this shouldn't be a big deal if we're already not
13 paying -- we're doing direct payment to the nurse
14 practitioner and physician assistant in the hospital
15 setting for new patients and for established patients with
16 new problems. So it seems to me that levels the playing
17 field between physician office and hospital settings and
18 for all patients.
19 Then I was struck by the fact that when you've
20 got an existing patient with a new problem, why wouldn't
21 the physician be involved? That seems like exactly the
22 case where you'd want the physician to take more of a role,

1 not necessarily the NP or the PA. So, anyway, I just raise
2 that question.
3 To other people's points about the 85 percent and
4 it's arbitrary, I wonder if we don't want to do it here but
5 we ought to think about a separate fee schedule for a non-
6 physician workforce.
7 Karen brought up the issue of global payments,
8 and I think that's a really good point. That would really
9 combine more of the physician payment and the NP payment
10 around something, a service, and I think that's one way to
11 go.
12 Another thing to think about, it seems to me, is
13 if we want to promote more organized systems of care, maybe
14 there's a different model for the NP or PA primary care
15 service that provides more of a per-month payment or
16 something else that's closer to per-beneficiary payments.
17 And I'm thinking back to our recommendations around the
18 per-beneficiary primary care payment to physicians.
19 So I'm just wondering if we can think differently
20 about how we pay them instead of 85 percent of what a
21 physician gets, and actually try to advance the idea of an
22 organized system of care, because I think many of us have

1 had the experience that the nurse practitioner is kind of
2 the core of organized care around any episode -- surgery or
3 a long chronic disease or whatever.
4 So I just ask us to think outside the box, in
5 terms of payment.
6 DR. CROSSON: Okay. Thank you, Kathy. So my
7 sense is here that we've got enough agreement on the
8 recommendations that we could consider asking you to come
9 back in December with draft recommendations for us to look
10 at, given the caveats that Karen and Jon and others have
11 brought up, try to see if we can't answer those, and
12 consideration for inclusion of this material in the March
13 report.
14 Okay. Thanks very much. Brian and Kate, you're
15 done early.
16 [Pause.]
17 DR. CROSSON: Okay. We're now going to continue
18 with our discussion about primary care workforce, and Ariel
19 here is going to take us through the next analysis of the
20 issue regarding primary care physicians.
21 MR. WINTER: Good afternoon.
22 As Jay said, I will be talking about Medicare's

1 role in the supply of primary care physicians, and before I
2 begin, I want to first thank Emma Achola for her help with
3 this presentation.
4 So here's the outline for the presentation today.
5 I'll start with some background information, including a
6 review of the Commission's prior work on primary care.
7 I'll describe beneficiaries' current access to primary care
8 physicians and discuss the factors that influence
9 physicians' choice of specialty. Then I'll talk about
10 HRSA's programs to increase the supply of primary care
11 clinicians and then conclude by discussing some options for
12 Medicare to increase the supply of primary care physicians.
13 High-quality primary care is essential for
14 creating a coordinated health care system. Physicians who
15 focus on primary care are generally trained in family
16 medicine, internal medicine, geriatric medicine, and
17 pediatrics. These physicians accounted for 19 percent of
18 all health professionals who billed Medicare in 2016. As
19 Kate and Brian talked about, other health professionals,
20 such as nurse practitioners and physician assistants, may
21 also provide primary care.
22 The Commission has been working on primary care

1 issues for several years. Although we have made several
2 recommendations to improve payment accuracy and better
3 support primary care, the Commission has recently expressed
4 interest in approaches that could have a larger impact on
5 the supply of primary care physicians.
6 This slide lists some of our key prior
7 recommendations in this area.
8 In 2008, we recommended that Congress create a
9 budget-neutral bonus for primary care services, which
10 eventually became the Primary Care Incentive Payment
11 program, or PCIP.
12 In 2011, we recommended that Congress repeal the
13 sustainable growth rate formula and provide higher updates
14 for primary care services relative to other services.
15 Also in 2011, we recommended that CMS identify
16 overpriced services in the fee schedule and reduce their
17 payment rates. To accomplish this, CMS should collect data
18 on clinician time and practice expenses from a cohort of
19 efficient practices.
20 And in 2015, we recommended that Congress
21 establish a per-beneficiary payment for primary care
22 clinicians to replace the expiring PCIP.

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 care
4 when needed.
5 Their access to care is comparable with or better
6 than access reported by privately insured individuals ages
7 50 to 64.
8 However, a small share of beneficiaries who are
9 looking for a new doctor reported trouble finding one.
10 They were more likely to report trouble finding a new
11 primary care doctor than a new specialist.
12 This is a cause for concern because it could
13 signal a problem with access to primary care for the small
14 share of beneficiaries who are seeking a new doctor. We
15 monitor the situation very closely every year when we redo
16 our survey.
17 Next, we will look at changes in the supply of
18 primary care physicians in Medicare.
19 I first want to point out that there are more
20 than twice as many specialists treating beneficiaries as
21 primary care physicians. This could be one reason why some
22 beneficiaries are having difficulty finding a new primary

1 care physician.

2 The second thing to point out is that the

3 absolute number of primary care physicians treating

4 beneficiaries increased between 2011 and 2016, although the

5 number per 1,000 beneficiaries declined modestly, from 3.8

6 in 2011 to 3.5 in 2016.

7 Likewise, the number of physicians in other

8 specialties also increased between 2011 and 2016, although

9 similar to primary care physicians, the number per 1,000

10 beneficiaries declined, from 8.4 in 2011 to 7.8 in 2016.

11 In recent years, there has been rapid growth in

12 the number of Medicare beneficiaries, as the baby boomers

13 begin to age into the program. This enrollment growth

14 shrinks the ratio of physicians to beneficiaries over time,

15 even though the overall number of physicians has been

16 increasing.

17 By way of comparison, the ratio of physicians per

18 1,000 U.S. residents has increased slightly between 2011

19 and 2016.

20 There is mixed evidence on the adequacy of the

21 pipeline of future primary care physicians. In recent

22 years, the number of active residents in family medicine

1 and internal medicine has increased faster than the total
2 number of active residents.
3 Between the 2013-2014 academic year and the 2017-
4 2018 academic year, the number of family medicine residents
5 grew by about 18 percent, and the number of internal
6 medicine residents grew by almost 16 percent. During the
7 same period, the total number of residents across all
8 specialties increased by almost 13 percent.
9 Although family medicine residents usually end up
10 practicing primary care, internal medicine residents may
11 decide to enter subspecialties, such as cardiology or
12 gastroenterology, instead of practicing primary care.
13 According to one estimate, 49 percent of internal
14 medicine residents who began their residencies in 2001 were
15 predicted to stay in primary care, compared with 43 percent
16 of internal medicine residents who began their residencies
17 in 2010.
18 Also, there are significant disparities in
19 compensation between primary care physicians and
20 specialists that could deter medical school graduates and
21 residents from choosing to practice primary care.
22 This chart shows differences in median annual

1 compensation from 2016. Median compensation for primary
2 care, which is the second bar from the left, was about
3 $236,000. By contrast, median compensation for radiology
4 was almost twice as high at $466,000, and for nonsurgical
5 procedural specialties, it was $435,000.
6 Based on a review of the literature, here are
7 some key factors that influence physicians' choice of
8 specialty, lifestyle preference, such as work hours and
9 family time. Characteristics of medical students; for
10 example, rural background, lower SES, and lower parental
11 income are correlated with the choice of family medicine.
12 Another factor is the characteristics of medical schools
13 and curricula; for example, medical schools that graduate a
14 higher share of primary care physicians are more likely to
15 use community hospitals as teaching sites instead of
16 academic medical centers.
17 Income expectations also play an important role.
18 One study found that students entering specialties such as
19 orthopedics and general surgery were more motivated by
20 income than lifestyle concerns.
21 Other studies found that students who chose
22 specialties other than family medicine were concerned about

1 the low-income potential of family medicine.

2 Evidence of the effect of student debt is mixed.
3 Some studies find it has a modest impact or no impact on
4 specialty choice, but other studies find that students with
5 no debt or high debt are less likely to choose primary
6 care.

7 The finding that medical students with high debt
8 levels are less likely to choose primary care is
9 particularly concerning because median medical education
10 debt has been rising.

11 According to data from AAMC, median debt among
12 medical school graduates grew from almost $165,000 in 2010
13 to $180,000 in 2016, and these numbers are adjusted for
14 inflation.

15 But the share of students graduating with no debt
16 increased from 16 percent in 2010 to 27 percent in 2016.
17 This indicates that debt is becoming more concentrated
18 among a smaller share of students. It also suggests growth
19 in the share of students from affluent backgrounds, which
20 is consistent with prior Commission research.

21 Now I am going to switch gears and talk about two
22 programs run by HRSA that are designed to increase the

1 supply of primary care clinicians. This information is
2 meant to give you some background, and it may also help
3 inform your thinking about the design choices for a program
4 to encourage medical school graduates to provide primary
5 care to Medicare beneficiaries.
6 The first HRSA program is the National Health
7 Service Corps, which provides scholarships and loan
8 repayment for primary care clinicians. It will receive
9 $300 million in mandatory funding in FY 2019.
10 Recipients must commit to practicing in an
11 underserved area for at least two years.
12 There are currently 10,200 NHSC clinicians, who
13 provide care to 10.7 million people. This is a substantial
14 increase from 2009, when there were only 3,000 NHSC
15 clinicians.
16 Participating clinicians include primary care
17 physicians, who are 20 percent of the total; nurse
18 practitioners, who are 21 percent; physician assistants who
19 account for 11 percent; nurse midwives; dentists; and
20 mental and behavioral health professionals.
21 Participants must serve in a health care site
22 approved by HRSA. Fifty-seven percent of clinicians serve

1 in federally qualified health centers. Other approved
2 sites include rural health clinics, community mental health
3 centers, private practices, and Indian Health Service
4 facilities.
5 The second HRSA program that I want to talk about
6 is the Primary Care Loan program, which provides low-
7 interest loans to medical students who commit to practicing
8 primary care.
9 Recipients must practice primary care for 10 years, which
10 includes their residency, or until the loan is paid off,
11 whichever comes first.
12 Unlike NHSC, there is no requirement to work in
13 underserved area. Medical schools that participate in the
14 program must match one-ninth of the loan amount received by
15 their students.
16 There is much less information available about
17 the Primary Care Loan program than about the NHSC.
18 According to most recent public information, this program
19 provided $30 million in loans to over 400 medical students
20 in 2009.
21 Due to concerns about the future supply of
22 primary care physicians, the Commission may wish to

1 consider options for Medicare to increase the supply of
2 primary care physicians or change how Medicare funds
3 graduate medical education.
4 Today, we will talk about an idea for a
5 scholarship or loan repayment program for medical students
6 or graduates who commit to providing primary care to
7 Medicare beneficiaries. Such a program could encourage
8 more students to choose primary care by alleviating their
9 concerns about repaying student loans.
10 At a future meeting, we'll discuss ways to
11 increase accountability for Medicare's GME payments.
12 As a reminder, in 2010, the Commission
13 recommended that the Secretary create a new performance-
14 based GME program to support workforce skills that will
15 improve the value of the delivery system. We said that
16 the funds should be distributed to institutions that meet
17 ambitious goals for practice-based learning and
18 improvement, interpersonal and communication skills,
19 professionalism, and systems-based practice.
20 In thinking about Medicare scholarship or loan
21 repayment program, there are some important design issues
22 to consider.

1 The first is the size of program in terms of
2 dollars and the number of physicians. As one reference
3 point, the NHSC will receive $300 million in funding in
4 2018, and there are 10,200 physicians and other health
5 professionals in the program.
6 The second issue is how to finance a Medicare
7 program.
8 Third, which types of medical students should be
9 eligible for the program? Should it be open to all
10 students or focus on underrepresented students, such as
11 those from minority, lower income, and rural backgrounds?
12 A scholarship or loan repayment program would
13 probably be more attractive to lower- or middle-income
14 students because they are less likely to have access to
15 family financial resources to pay for tuition.
16 The fourth issue is which types of specialties
17 should be considered primary care and therefore eligible
18 for this program. The Commission's recommendation in 2008
19 for a primary care bonus included the following specialties
20 as primary care: family medicine, geriatric medicine,
21 internal medicine, and pediatrics.
22 Assuming that Medicare is financing this program,

1 it could prioritize specialties that are in relatively
2 short supply, such as geriatrics.
3 The fifth issue is how to define the requirement
4 for physicians to treat Medicare beneficiaries. One option
5 is to require that they treat a minimum number of
6 beneficiaries, which is a measure that could be validated
7 with Medicare claims data.
8 And the sixth issue is the length of the service
9 commitment. This could be related to the amount of the
10 scholarship or loan repayment received by a physician, with
11 the length of the commitment increasing as the amount
12 increases.
13 For example, students who participate in the NHSC's
14 scholarship program serve for two to four years upon
15 graduation, depending on the length of the scholarship.
16 So for your discussion, is there additional
17 information that you'd like to see? Do you have an
18 interest in developing an idea for scholarship or loan
19 repayment program for medical students who commit to
20 providing primary care to Medicare beneficiaries? And do
21 you have any comments on the design questions that we've
22 raised?

1 This concludes my presentation, and I look
2 forward to your questions and discussion.
3 DR. CROSSON: Thank you, Ariel.
4 I have one I'd like to start with. Did you
5 happen to run across or do you know whether the uniform
6 services still provide scholarships? I know they did at
7 one time in exchange for some certain years of service. Is
8 that over with, or is that still good?
9 MR. WINTER: I will look into that. Last I
10 heard, that still exists, but we'll check into that and get
11 back to you.
12 DR. CROSSON: It might be interesting to know the
13 parameters for comparison as we get to that point.
14 MR. WINTER: Yeah.
15 DR. CROSSON: Okay. Other questions?
16 Start with Jon.
17 DR. CHRISTIANSON: On Slide 11, Ariel -- and you
18 noted the big increase in the number of clinicians that
19 participated in the NHSC since 2009. Does your data show
20 you whether that increase is concentrated among NPs and PAs
21 versus primary care physicians?
22

1 MR. WINTER: So since 2009, the share of
2 clinicians who are physicians has decreased sharply. In
3 2009, it was 35 percent of the total. Of course, there was
4 a smaller base, and currently, it's 20 percent, according
5 to HRSA data.
6 DR. CHRISTIANSON: So that suggests that --
7 MR. WINTER: That's gone down.
8 DR. CHRISTIANSON: -- the uptick is probably
9 among the NPs and PAs as opposed to primary care
10 physicians, then?
11 MR. WINTER: The biggest increase has occurred
12 among mental health and behavioral health professionals.
13 DR. CHRISTIANSON: Ah.
14 MR. WINTER: They've gone from, I think, about 10
15 percent to something along the lines of 27 percent.
16 DR. CHRISTIANSON: Okay.
17 MR. WINTER: NPs and PAs, I'll check and see what
18 the change has been.
19 DR. CHRISTIANSON: But the bottom line is it's
20 not been among primary care physicians? That's not what's
21 driving this increase?
22 MR. WINTER: That's correct.

1 DR. CROSSON: Over here. Dana, did you have your
2 hand up? No.
3 Go ahead, Jon.
4 DR. JAFFERY: Thanks.
5 DR. PERLIN: Great presentation.
6 I want to come back to in the realm of additional
7 information, implications for design issue, this question
8 of access. You noted in the presentation that access was
9 generally comparable, small share looking for a new doctor
10 or poor trouble finding one. Do you have any insight into
11 characteristics of patients who had trouble finding a
12 doctor? Does that vary by market or by the age of
13 beneficiary?
14 And I'm going to mention exactly why I'm asking
15 that second question in a moment.
16 MR. WINTER: So Kate is in charge of that survey,
17 so I'm going to look over to her and see if she wants to
18 join me up here and address your question. She's the most
19 qualified to do so.
20 Here she comes.
21 DR. PAUL GINSBURG: While Kate is getting there,
22 I can say I think a lot of it is beneficiaries who move,

1 they bear some of the brunt of these problems in access.

2 MS. BLONIARZ: And then generally, so access is

3 fairly comparable between urban and rural. There are some

4 geographic locations that have more trouble, but then by

5 demographic, the under-65 have much more trouble, and

6 people with behavioral health conditions have much more

7 trouble.

8 DR. PERLIN: Any difference in age?

9 I'll tell you what. I realize the anecdote is

10 not data, but it gives me pause to be sanguine without

11 looking at differences between the very old and the old.

12 I have found more difficulty placing patients

13 into primary care who are older and/or have more

14 simultaneous chronic conditions because the practices will

15 often try to sort of balance the impact with the load of

16 their practice by distributing as to not having too many

17 with multiple comorbidities or the older old. And I just

18 think as we think about the implications for program design

19 and the parsing toward which specialties like geriatrics

20 that behind the data, there may be another set of data

21 driving the metrics as to those who may have more trouble.

22 I'd just encourage us to see if we can't find any data that

1 would have that next-level nuance.

2 Thanks.

3 DR. CHRISTIANSON: Brian.

4 DR. DeBUSK: Really good chapter. I'm glad we're

5 exploring this.

6 I had a question about the grants and the loan

7 programs, and I suspect I know the answer. But is there

8 any way to measure the efficacy of these programs? Has GAO

9 or anyone gone in and looked at how -- I mean, what would

10 the counterfactual even be?

11 And maybe as a follow-up question, knowing that

12 it's virtually impossible to do, do we have a feel for how

13 subscribed or oversubscribed these programs are? I mean,

14 are they $300 million programs where there's $900 million

15 worth of requests, or is that -- where does that stand?

16 MR. WINTER: Both good questions.

17 When we did our 2010 chapter on graduate medical

18 education, we pointed out that there's not been a

19 comprehensive evaluation of NHSC, and that was years ago.

20 And I've looked online. I've not been able to find a

21 comprehensive evaluation by GAO, by OIG, or by HRSA.

22 HRSA does produce an annual report to Congress,

1 but it's sort of descriptive, like here's the number of
2 clinicians, here's some statistics about where they locate,
3 and that sort of thing.
4 DR. DeBUSK: Any information on retention, maybe,
5 or --
6 MR. WINTER: Yeah, there's information on
7 retention, and we cite that in the paper.
8 There's an evaluation by contractor, which found
9 that 55 or so percent of NHSC clinicians were still serving
10 in an underserved area 10 year after the program, 10 years
11 after they left the program, and underserved areas defined
12 by health professional shortage area.
13 Your second question was about -- just remind me.
14 I lost track.
15 DR. DeBUSK: How subscribed or oversubscribed was
16 the program?
17 MR. WINTER: Yeah. So HRSA notes in a recent
18 report, annual report, about the program that the demand
19 for NHSC clinicians by approved sites exceeds the number of
20 available clinicians. So it could be there's an issue of -
21 - it could be the limited funding is what's restricting the
22 total number of clinicians they can accept, or it could be

1 just interest. I'm not sure what that's a function of,
2 whether it's the money or interest by clinicians in joining
3 the program.
4 DR. CHRISTIANSON: Amy.
5 MS. BRICKER: Just a point of clarification. So
6 you note the question around what would be the length of
7 service, and I wasn't clear what was meant by that. So you
8 talk about a percent of Medicare beneficiaries as part of
9 your patient population. Is that what you mean? You must
10 maintain a certain caseload of Medicare beneficiaries for a
11 period of time?
12 MR. WINTER: Yeah. So I was trying to separate
13 the two, these two requirements. The one requirement is
14 presumably you would want to require physicians to treat a
15 certain number or percent of Medicare beneficiaries in
16 order to demonstrate that they're serving this population.
17 That's one issue. The second issue is: How long do they
18 need to be in this program? How long do they need to --
19 MS. BRICKER: Do that.
20 MR. WINTER: Yeah, serving that required number
21 of beneficiaries. And so I gave some examples in the paper
22 and in the presentation from other programs.

1 MS. BRICKER: Okay. Thanks.
2 DR. CHRISTIANSON: Back to Pat.
3 MS. WANG: Going back to Slide 6, given the
4 conversation that we just had, is it possible, does it make
5 sense to try and supplement the number of primary care
6 specialties per 1,000 beneficiaries by the number of NPs
7 and PAs practicing primary care? Because it's grown quite
8 a bit.
9 MR. WINTER: Yeah.
10 MS. WANG: So a decrease in the number of MDs in
11 this area may be more than offset compared to the starting
12 number given the growth in the other -- I think it's just -
13 - if we're talking about primary care supply, clinician
14 supply, that might be an important extra column to try to
15 add in.
16 Then the sort of related question is: Is there
17 an ideal number that we would choose to aim for with the
18 aging of the population and the anticipated growth in
19 Medicare from a workforce planning perspective, whether
20 it's MDs or MDs plus alternative practitioners, non-
21 physician clinicians? What should we be aiming for?
22 MR. WINTER: Yeah, good question. And with

1 regard to your first question or first observation about
2 this particular table, in the chapter we noted that over
3 the same period, the number of NPs and PAs per 1,000
4 beneficiaries increased from 2.8 in 2011 to 3.9 in 2016, so
5 really more than offsetting the decline in primary care
6 physicians per 1,000 beneficiaries. And it's something --
7 we include that in the table that we have in the physician
8 update chapter every year. We can certainly add another
9 column to this that includes -- another column with the NPs
10 and PAs.
11 Then the second issue is how do we know what the
12 right number and distribution is, which a really big and
13 important question. If you look back at our 2010 chapter
14 on graduate medical education, one of our recommendations
15 was for the Secretary to do a workforce analysis looking at
16 the number of residents in different specialties that would
17 be required for a high-value, low-cost health care system.
18 And as far as I know, that recommendation has not been --
19 that report has not been done.
20 One of the things we suggested as an example, an
21 illustration, they could look at a high-performing health
22 care system that currently exists and look at their

1 distribution of clinicians as an example or a benchmark.

2 So we can look into this more. I don't have, you

3 know, a number handy to give you, but it's something we can

4 look at more and see if there's more recent literature on

5 that.

6 DR. CHRISTIANSON: Let's finish up with this side

7 of the room with Paul, and then we'll come over here.

8 DR. PAUL GINSBURG: Ariel, you described -- I'm

9 really glad you're focusing us in this direction about

10 scholarships and loan forgiveness. It's really maybe more

11 effective.

12 You described the National Health Service Corps

13 as having mandatory funding?

14 MR. WINTER: Yes, which expires in 2019.

15 DR. PAUL GINSBURG: So does that mean it's not

16 appropriated, that it's kind of like entitlements?

17 MR. WINTER: So originally their funding was

18 discretionary, so it was appropriated every year. And then

19 they got -- under the ACA they got five years of mandatory

20 funding of $300 million per year for five years, and then

21 that was extended between 2016 -- 2017 through 2019, $300

22 million per year mandatory funding. After that it expires,

1 and there's no -- right now there's no provision for
2 additional funding after 2019?
3 DR. PAUL GINSBURG: So in a sense, maybe the
4 growth in the size of the program really reflects the
5 increase in funding.
6 MR. WINTER: Oh, yeah.
7 DR. PAUL GINSBURG: You use that as evidence that
8 it's a strong incentive to be in rural areas.
9 MR. WINTER: Right. I think definitely the
10 funding is a piece of it, but if there was no interest, if
11 clinicians did not have an interest in doing this program,
12 you wouldn't see an increase in clinicians. You could have
13 the money available, but if people are not interested in
14 making that tradeoff, then the enrollment will not grow.
15 DR. PAUL GINSBURG: Yeah. But isn't it possible
16 there are a lot of people that would have gone to rural
17 areas anyway, and now they have the opportunity to get a
18 scholarship or loan forgiveness to do it, so it's not
19 really changing anything? And I think we'd need a much
20 more elaborate study to have conclusions.
21 MR. WINTER: Okay, sure.
22 DR. CROSSON: Jonathan.

1 DR. JAFFERY: Thank you. So maybe building on
2 that and some of Brian's question, you may have answered
3 this or maybe I just didn't understand. So on Slide 12,
4 thinking about this other program, the primary care loan
5 program, you've said already that you've had trouble --
6 it's not easy to get a lot of data on it. But we should be
7 able to know what the budget is. It says it provided $30
8 million in loans. Isn't that, in fact, the budget for it?
9 Did it spend all of it? And I'm just thinking about design
10 questions. You know, this one has a ten-year practice time
11 frame, which is considerably longer than some of the other
12 ones. It requires matching that might make it more
13 difficult to get, and I'm not sure if medical schools --
14 how many medical schools are able and willing to do that.
15 Do you know off the top of your head if --
16 MR. WINTER: We have not been able --
17 DR. JAFFERY: -- greater than $30 million?
18 MR. WINTER: We have not been able to get any
19 information about their budget since 2009. We have sent
20 them a list of questions about that and other issues. We
21 have not heard back yet. We have been pursuing this, and -
22 -

1 DR. JAFFERY: So not even just what they spent,
2 but actually what they're allocated, we don't know that.
3 MR. WINTER: So one thing to point out is that
4 they actually do not get discretionary mandatory funding.
5 The way they finance their program is through loan
6 repayments and penalties when students default on their
7 loans. That's what they say on the website. They have
8 nothing on the website about how much -- the dollar value
9 of loans they've made in recent years or how many medical
10 students are currently receiving loans, nothing about that.
11 I can tell you that there are 35 medical schools
12 that participate in the program. The list is on their
13 website. They have to meet certain requirements to
14 participate, which I lay out in the draft paper, one of
15 which is matching the grants, one-ninth of the grants. And
16 they also have to graduate a minimum percent of their
17 students as primary care, I guess, residents or clinicians
18 -- physicians. I think it's 50 percent.
19 DR. JAFFERY: Thanks.
20 MR. WINTER: We'll keep looking into it [off
21 microphone].
22 DR. CROSSON: Okay. Karen, are you up?

1 DR. DeSALVO: I have what I hope is a simple
2 question that may have been in here, Ariel. Do you have a
3 sense of how many Medicare beneficiaries the National
4 Health Service Corps scholarship and loan repayment
5 programs serve currently? What's the impact on access for
6 beneficiaries in the current state?
7 MR. WINTER: That's a really good question. The
8 reports that I've read from HRSA and a CRS report do not
9 have that information. If we can get data from HRSA on
10 NHSC participants with some kind of NPI or identifier, we
11 can link it to Medicare claims and try to figure that out,
12 if that would be of interest.
13 DR. DeSALVO: Yeah.
14 DR. CROSSON: Okay. Bruce.
15 MR. PYENSON: Thank you very much, Ariel. I've
16 got actually a couple of complicated questions. I noted on
17 Slide 13 that today's discussion is about the scholarship
18 loan repayment, but some future meeting we're going to talk
19 about GME payments. So I am going to ask a question about
20 GME payments just in order to get a feel for which is more
21 important. So when we think about the student loan, on
22 Slide 10 you have a figure of $180,000 median for

1 presumably 2016 graduates. Do you have a figure or could
2 we come up with a figure of what's the total GME and IME
3 divided by the number of 2016 graduate students? And which
4 one's bigger?
5 MR. WINTER: I'll have to come back to you on
6 that unless one of my colleagues sitting over there has
7 that number off the top of their head. But no one is
8 signaling, so I'm guessing -- we'll have to calculate that
9 and get back to you. I assume you would want the
10 denominator to be the number of residents, right?
11 MR. PYENSON: I think so --
12 MR. WINTER: Because that's what they're supposed
13 to fund.
14 MR. PYENSON: You know, the 180 -- it's not quite
15 an apples-to-apples because debt is not -- but I'm trying
16 to get if GME and IME is just the over -- much, much more
17 important than student loans, then maybe our efforts are
18 better spent in the future discussion than on the loan --
19 you know, to prioritize which is more important.
20 DR. CROSSON: Well, I'm not sure I quite get it.
21 The last time, I remember the last time we looked at GME,
22 DME, and IME together, that was --

1 MR. WINTER: 2010

2 DR. CROSSON: -- a number of years ago -- yeah,

3 2010. It was $9 billion a year at that point. It's

4 probably inflated up from that, but it's in that range.

5 MR. PYENSON: So round numbers, $10 billion. How

6 many residents do we have a year?

7 MR. WINTER: We'll have to get back to you on

8 that

9 MR. PYENSON: -- graduates -- anyone? There's

10 roughly a million doctors in the country, so it's...

11 DR. DeBUSK: I thought it was 140,000 in the

12 program. That's what the report -- the published report,

13 the IOM report on graduate medical education from like

14 2014, 2015? So I'm sure it's inflated a little since then.

15 MR. WINTER: You're pretty close. According to

16 the most recent ACGME report, data resource book, there

17 were 135,000 active residents in the 2017-18 academic year

18 across all specialties.

19 DR. JAFFERY: They're not all GME-funded.

20 MR. PYENSON: So it could be half of that or --

21 MR. WINTER: Right, across all years, not

22 necessarily GME-funded.

1 MR. PYENSON: A quarter of that. So it sounds
2 like doing the division, the GME/IME could be a bigger
3 number. So that's my question. We don't have to figure it
4 out now.
5 The other question I have is there was a news
6 item recently that NYU is waiving its tuition, and if that
7 is a trend, and there's certainly other universities that
8 probably have more money than NYU -- a few, maybe. Okay.
9 If that's -- you know, is that something that we're going
10 to see? Is there any expectation of seeing tuition
11 actually decrease?
12 MR. WINTER: The long-term trend is increase,
13 that tuition has increased. I'm not aware of other medical
14 schools that have made the same commitment as NYU for all
15 their students. Some medical schools have done it -- I've
16 heard of one that's done it for students depending on their
17 income. I think Paul wants to get in here.
18 DR. PAUL GINSBURG: Yeah, I just want to say that
19 I think the NYU money came from a very wealthy donor who
20 wanted them to do this, and they're delighted because now
21 they can attract the very best students. But it seems to
22 me a very untargeted way of addressing the issue of cost to

1 medical school students.

2 MR. PYENSON: Well, a natural experiment, we'll

3 see if NYU changes and produces a lot more primary care.

4 DR. CROSSON: The other point I think is worth

5 making is that having a lot of money and being willing to

6 part with it are two separate things.

7 Kathy?

8 MS. BUTO: Okay, so this is a question you don't

9 have to answer right now, but I wondered whether we --

10 there are surveys where we know that physicians have said

11 that the issue is fees versus loan repayment versus status,

12 other things, lifestyle, that are driving them away from

13 primary care or driving them to specialty care.

14 MR. WINTER: Yeah.

15 MS. BUTO: So that's one question. I don't know

16 if you want me to stop. I have two others.

17 MR. WINTER: So, yeah, I can take that. So we

18 looked at several different studies, and in some studies

19 one factor is statistically significant, and another study

20 the same factor is not. So the ones that I included on

21 Slide 9 were the ones that -- with the exception of the

22 last one were pretty consistently related to choice of

1 specialty. Lifestyle preference, an example there would be
2 -- one study -- many studies that surveyed students or
3 residents when they asked them what factors they
4 considered, this one often rose to the top or near the top.
5 Student characteristics, that was pretty consistent across
6 studies. Type of medical school and curricula, and income
7 expectations. There was one study that found really no
8 relationship, but two other studies that found a
9 relationship, and student debt, as I said, the evidence was
10 mixed depending on the study, but there was a very large
11 retrospective study which found that students at either end
12 of the spectrum, those with no debt or those with high
13 amounts of debt, were less likely to choose primary care.
14 MS. BUTO: Okay. I did see that work, and I just
15 wondered whether we had a sense of dimension or priority
16 among those, and I guess the answer is it depends.
17 MR. WINTER: Yeah. So there are a couple of
18 studies that looked at, you know, many factors, and we can
19 get back to you with what they found in terms of the
20 ranking of the different factors. Other studies focused on
21 maybe just a couple.
22 MS. BUTO: Okay.

1 MR. WINTER: So it varies based on study design.
2 MS. BUTO: Okay, great. Thanks. What I'm trying
3 to get at here is: Would this loan repayment scholarship
4 program make a difference? And so I think we have to sort
5 of tie those together.
6 The other related question to that one has to do
7 with Slide 12, which is the issue of the primary care loan
8 program for which we have very little information. But I
9 think what would be really helpful, because this sounds a
10 lot like what we're trying to achieve, is whether there's
11 any staying power. In other words, do these students
12 really -- or these physicians stay in primary care for an
13 extended period of time? I don't know if we have a sense
14 of that.
15 MR. WINTER: That's another one of the questions
16 we've asked them that they have not yet gotten back to us
17 on.
18 MS. BUTO: That would be pretty important if we
19 could find out for deciding whether to advance this
20 proposal or not.
21 MR. WINTER: Yes. I agree.
22 MS. BUTO: The third question is race and

1 ethnicity, whether we have a sense of the extent to which
2 participants in these HRSA programs are disproportionately
3 minority, low-income, or other, you know, ethnic
4 categories. Really there's an undersupply of those
5 physicians. Do we know what the composition is of those
6 physicians?
7 MR. WINTER: I don't recall. I'll check and see
8 if that's included in one of the reports, and I'll get back
9 to you on that.
10 MS. BUTO: Okay. That would be helpful.
11 And, lastly, how would we operationalize
12 something like this? The Medicare program doesn't usually
13 run loan programs or scholarship programs. And I guess the
14 question that we would have to answer is: How would we
15 fund this? Would it be by taking an across-the-board hit
16 against the physician fee schedule and then reinvesting
17 that in students? I think we need to think about that
18 because that's going to make a difference as to how well
19 received our recommendations are.
20 Thank you.
21 DR. CROSSON: Okay. Kathy, I'm going to give you
22 five seconds, take a deep breath, and then we're going to

1 move on to the discussion period, and you're on again.

2 MS. BUTO: Okay, thank you. So I really think

3 this is an important topic. We keep coming back to it. We

4 have a couple of assumptions in coming back to it. One of

5 them there is going to be or there already is a primary

6 care shortage that we should try to address before it

7 becomes really acute.

8 I think the other assumption that we've had for a

9 long time is the physician fee schedule is part of the

10 problem. I have to say for me I've never been convinced

11 that it's the fee schedule. So I think this work is

12 important because I think there's a multifactorial picture

13 of why physicians are not choosing to stay in primary care

14 or even, you know, specialize in primary care in the first

15 place. I think this is one of them potentially, the issue

16 of debt. I also think the issue of debt may be deterring

17 some physicians who we want to be attracted into primary

18 care for beneficiaries, so racial and ethnic minorities,

19 language minorities, as the population changes

20 demographically. So I think this is really important work

21 for that reason, that that could make a difference

22 potentially.

1 I think the other factors might be things like
2 administrative burden, so things like faster payment, other
3 mechanisms that would advance or make more attractive
4 primary care from the standpoint of it's easier to practice
5 primary care in Medicare. There are others, I know, that
6 have to do with just burden of reporting, coding, et
7 cetera. Maybe there are other things that we may not have
8 time to do this go-round, but we ought to look at as part
9 of a bigger picture of what's making primary care less
10 attractive.
11 And then I'll go back to our last discussion,
12 which is I really think there's work that we've started to
13 look at advancing a more important role, a more key role
14 for primary care in Medicare so that more of the judgment,
15 decisionmaking, accountability, they are the hub and the
16 spokes are other specialties who provide care to the
17 beneficiary. Some change in status I think is going to be
18 important. How we get there, I don't know.
19 I just want to make two sort of more technical
20 comments, or more specific comments about the proposal.
21 You asked, among other things, about which specialties
22 should be considered. And I keep coming back to the fact

1 that diabetes is a root cause condition that has generated
2 tremendous cost in the Medicare program. If you look at, I
3 think CBO has done some work on this. If it's a root cause
4 condition then it seems to me that endocrinologists or
5 other specialists who become the primary care physician for
6 a patient with diabetes ought to be considered.
7 I would actually consider dropping internal
8 medicine because so many internists go into subspecialty,
9 but maybe it's internal medicine if subspecialty is
10 whatever.
11 So I actually think let's look at the areas where
12 we want to encourage physician primary care to treat
13 chronically ill Medicare beneficiaries and figure out if
14 there are some specialties in there who ought to be
15 considered for something like this, because we want to
16 encourage better supply of those individuals.
17 DR. CROSSON: Thank you, Kathy, and I would just
18 build on that last comment, and this has come up before, to
19 include mental health and substance abuse providers as
20 well. I think there's a problem there.
21 Okay. So let's continue the discussion. Let's
22 start over here again with Brian.

1 DR. DeBUSK: Again, great report. I'm really
2 glad we're digging into this. I know we've talked around
3 the primary care pipeline issue for a while. I'm glad
4 we're addressing it specifically.
5 Just dovetailing onto the last conversation that
6 we had, where we were talking about nurse practitioners and
7 PAs. There is one obvious solution that we could do, which
8 is encourage a degree completion program for some of these
9 people who have been successfully working in the field, as
10 PAs, particularly, because they have a pretty good basic
11 science background. To me it seems a little crazy that
12 someone can be working as a PA for years, successfully, but
13 if they want to go back and become a doctor or, say, go
14 into primary care, they basically start from scratch in
15 medical school.
16 So I think going to the accrediting bodies and
17 building a credible degree completion program does two
18 things. It addresses a lot of the quality and utilization
19 issues that we discussed in the previous session. We know
20 we have an adequate supply of these people because we've
21 been producing them at a good rate. And it would address
22 some of the primary care issues, because I think these

1 people could become primary care physicians.

2 Now the sticking point is going to be this issue

3 of we're calling them doctors, but that's why I made the

4 point in the last session, the title "doctor" is already

5 lost. I mean, I would make the analogy, if you look at

6 protecting the title, at least in the profession, I mean,

7 it's almost like a car that's skidding off the road. At

8 this point we can either steer into the skid or we can just

9 keep skidding off the road. But I would strongly encourage

10 us to explore a degree-completion program for midlevels.

11 The other thing that I want to focus on, I love

12 what you're talking about with the grants and the loan

13 forgiveness programs. I think those will be effective.

14 Kathy, I thought you were about to wander there when you

15 were talking about who's going to administer it.

16 If you look at the 145-ish or so medical schools

17 that we have in this country, we know the schools that are

18 really good at producing primary care physicians. And if

19 you look at those schools, both the DO schools and the

20 allopathic schools, a lot of what they do is very cultural.

21 I mean, they don't feel like traditional medical schools.

22 They're in rural locations, they recruit differently, they

1 market differently, their admissions process is different,
2 the composition of their faculty is different, their
3 clinical rotations spots are different. It is a
4 fundamentally different culture for these schools that are
5 producing 60, 70, 80 percent primary care physicians. And
6 there are schools that are producing 80 percent primary
7 care physicians. They're just very culturally different.
8 So I hope when we go into the final report that
9 we'll consider just a little variation on this. What if we
10 went to any school -- I don't think anyone shouldn't be
11 eligible -- what if we went to a school and said, "Look,
12 we're prepared to give you a block grant." Now let's do
13 matching money, but let's put them on the hook. Let say,
14 "You tell us what you're going to deliver for us, in
15 primary care physicians." We're not going to be as
16 prescriptive on the money. We're not going to say it has
17 to be a loan. As a matter of fact, the school might want
18 to spend some of its money, say, on recruiting.
19 A great example, you know, we know when we pick
20 rural students in medical schools they tend to not be as
21 academically prepared. I mean, they may want to spend some
22 of that money on remediation. Because when I'm trying to

1 find particularly a rural primary care physician, I don't
2 need to be recruiting out of Los Angeles and New York. I
3 mean, I need to be recruiting out of the locations that are
4 similar to or exactly where those people are going to
5 serve.
6 So I think culturally if we could go to these
7 schools -- and again, this isn't free money. They would
8 have to -- there would be limits on what they could spend
9 the money on. But if they could spend it on recruiting and
10 faculty and some of the other -- clinical rotation spots
11 are a great example. I mean, if you could spend a little
12 more and buy better, more prestigious clinical rotations
13 spots, yet another good use of that money that would draw
14 those students in and make them better prepared. And
15 again, too much detail here, but there are a lot of things
16 these schools could do.
17 What I like -- and, Kathy, this one would
18 dovetail on what you mentioned -- you've got accountability
19 there. I'd go to those schools that want those grants.
20 Number one, I'd make them match the grant, dollar for
21 dollar. If they don't deliver on the primary care
22 physicians that they promised I'd make them pay it back, so

1 you've got someone on the hook. And then, on top of that,
2 I would probably do some type of competitive bid process
3 where the schools would submit their bids, and basically I
4 would take the most attractive bids and go right down the
5 list to some cutoff point. But I hate to sound so
6 mercenary, but, I mean, if we want primary care physicians,
7 that's what I'd do.
8 DR. CROSSON: Okay. Let's go to Jon and Pat and
9 then Paul.
10 DR. JAFFERY: Just a brief point, because I think
11 it's so important in terms of tying together with Brian's
12 comment on which schools produce lots of primary care, and
13 to Kathy's point about encouraging diversity.
14 I serve on the board of Meharry Medical College,
15 one of four historically black graduate institutions.
16 Sixty-three to 64 percent per year of the graduates to into
17 primary care. Most come in with the intent of going into
18 primary care and serving vulnerable populations. And just
19 a comment on the survey and the granularity. Actually,
20 really, two comments. First that while some reports may
21 not indicate that compensation, loan debt, et cetera, is
22 the primary driver in lieu of lifestyle, et cetera, it may

1 actually be more acute amongst individuals who have fewer
2 resources or at certain schools. So I'd just note that, in
3 terms of driving diversity in workforce.
4 And two, you know, I've looked, in preparation for this
5 discussion, at the general questionnaires that's given out
6 from AAMC, and even though it identifies that lifestyle
7 and, you know, sort of intellectual interest in a
8 profession, et cetera, are the primary drivers, it's hard
9 to say that it doesn't co-vary with finance as a means to
10 support lifestyle.
11 So I'd just note those two pieces. You know, it
12 is worth mapping out, I think, you know, the
13 characteristics of those institutions that produce high
14 levels of primary care. Thanks.
15 DR. CROSSON: Thank you. Pat.
16 MS. WANG: I think this is such an important
17 discussion, so, Ariel, it's great that you've stimulated us
18 here, and I think all the comments that people have made
19 are really good and great ideas.
20 You know, just my struggle with this is that, you
21 know, the Medicare program is changing. It's not static.
22 And I struggle because there are so many ideas about doing

1 more and more and more and more, in all these different
2 areas, and I wonder whether -- I, at least, would benefit
3 from just having some context of, like, what are we
4 striving for? In 12 years, you know, the number of
5 Medicare beneficiaries in the country is going to increase
6 by 50 percent. Like how are we getting our care at that
7 point? It's probably not going to be the old-fashioned
8 Marcus Welby way. We're already beyond that.
9 But maybe there are folks who have already
10 imagined what that caregiving system looks like. You know,
11 it's NPs and PAs when you're relatively healthy, and then
12 when you have events, then you get a geriatrician. I mean,
13 there's a distribution, maybe, that starts happening with
14 the clinician workforce which then sort of suggests that
15 there should be -- all these things are linked -- that
16 suggests that there should be more of a unified strategy in
17 thinking about the last conversation, what should we be
18 thinking about paying NPs and PAs? How many do we want to
19 encourage. The growth in the loan forgiveness programs
20 have been, in those non-physician clinical specialties.
21 Maybe we'd want to encourage that more.
22 I do think that the factors that others have

1 raised, about what are the financial and non-financial
2 factors that affect people's decision to go into primary
3 care are really important to identify. I would add to
4 those that have been mentioned status. I know a very, very
5 leading geriatrician in New York City who explained to me
6 the pressure he felt in residency at a big academic medical
7 center, to subspecialize, because geriatric is not viewed
8 as a really sexy -- you know, you're dealing with old
9 people and then you're dealing with old, old people in
10 nursing homes. It's just not -- and they said, "You're so
11 bright. You know, you could have a future as whatever."
12 And he really wanted to be a geriatrician. So it's things
13 like status and money, before status, but maybe there are
14 other things.
15 I think the expectations of primary care doctors
16 today are huge, and there is a reason why they employ NPs
17 in their offices, because they are responsible for
18 everything now. They're responsible for care coordination.
19 They're responsible for readmission rates. They're
20 responsible for coordinating with specialists who never
21 return their phone calls. And, you know, it's just a lot
22 of pressure. So, you know, being mindful of how to make a

1 PCP office environment or work environment as friendly as
2 possible should factor into it.
3 I just say these things because I think that they
4 are connected and that we should be mindful of all of these
5 individual actions, whether it's loan forgiveness or fee
6 schedule or what have you, but try to have a touch point of
7 this fits with a philosophy that the ratio of NPs to
8 physicians in the future in primary care is going to be 2-
9 to-1, and I'm making this up. That's the ratio that we're
10 kind of striving for. How are we doing against that? That
11 would be my request, I guess, that we keep in mind as we
12 continue the conversation.
13 DR. CROSSON: Pat, I'd just add to your story
14 that when I was graduating from medical school, my two
15 roommates, one who became a cataract surgeon and the other
16 become an invasive cardiologist, seriously thought of
17 having me committed when I said I was going to become a
18 pediatrician. I'm sorry. Paul.
19 DR. PAUL GINSBURG: I mentioned before that I was
20 really glad that our discussion is being steered into loan
21 repayment scholarships. And I came to it, I was doing a
22 project with some colleagues on graduate medical education,

1 and, you know, concluded that there really was very little
2 scope, that Medicare could make changes in GME funding that
3 would really do much for primary care, because it would be
4 so overwhelmed by the payment discrepancies that are just
5 so much more powerful.

6 And then, very belatedly in the project, we were
7 going to finish it just say, a whole bunch of policies,
8 don't bother doing these. It came to focusing on the
9 residents and the students, and thinking that, well,
10 there's potential here. And I think if we can make the
11 case that these incentives could be designed in a way to
12 make it powerful, to actually lead to different choices,
13 more focus on primary care, I think it would be a very
14 valuable contribution. So I'm very enthusiastic.

15 DR. CROSSON: Jonathan.

16 DR. JAFFERY: Thank you. Well, so first I just
17 wanted to comment for a second on Brian's comment on degree
18 completion. And if we started to explore that one other
19 thing we'd have to think about would be residency training,
20 subsequent, because that would potentially require addition
21 --

22 DR. DeBUSK: It would have to be equivalent.

1 DR. JAFFERY: Well, I mean, potentially require
2 incremental GME funding as opposed to what we could do
3 through incentives or mandates around a redistribution of
4 current slots.
5 But I also wanted to comment on, I think this is
6 a wonderful discussion and I think it's really important to
7 be talking about things like loan repayment and other
8 financial incentives. But I really want to come back to a
9 little bit of what Kathy and what Pat brought up, about
10 really encourage us to think through some of these non-
11 financial incentives. So the burden of documentation is a
12 huge thing and it impacts all physicians, really, but
13 particularly those who are E&M focused and spending 9 or 10
14 half-days seeing many patients in a half-day session. And
15 we know there's lots of surveys now and information about
16 how much time people spend documenting after hours and how
17 much less time they spend with their families.
18 And, you know, we really do see a lot, more and
19 more people coming into the field interested in some of
20 these lifestyle issues. And at the same time, again, and
21 Pat, you started to talk about this a lot, I mean, we've
22 been talking a lot about creating this team-based model of

1 care, and the primary care physician being really at the
2 center of, I think, care coordination is maybe a unifying
3 concept around this, and asking them to take the lead of
4 that and at least implicitly start thinking about non-
5 medical determinants and how to coordinate with mental
6 health and things like that.
7 So perhaps there's an opportunity for us to think
8 through how do we define, really, the optimal team? I
9 don't think it would be an impossible task to get some
10 consensus about what the optimal team is in a primary care
11 practice. And then how can we financially support a
12 practice to actually have those services -- behavioral
13 health, social work, and so forth, navigators, or whatnot.
14 So really trying to bring that joy of practice back to why
15 people are thinking about going to primary care in the
16 first place.
17 DR. CROSSON: Thank you. Warner.
18 MR. THOMAS: So just a couple of comments. I do
19 like the idea of degree completion. I do think that, you
20 know, coupled with this, as we think about, you know,
21 repayment for medical students, I do think we ought to
22 think about the GME programs and perhaps, you know,

1 additional funding specifically around these disciplines,
2 not just in general but specifically around these
3 disciplines.
4 And I agree with you, Jay. I think including
5 behavioral health in that area is critically important as
6 well.
7 The other subspecialty is really around
8 palliative care, that we may want to think about. You
9 know, folks getting additional training there, how do we
10 consider that s well.
11 The last idea, it's a little bit different, but,
12 you know, more and more organizations want to do loan
13 repayment. You know, right now certainly doing it in
14 certain regions of the country is possible. But one of the
15 things we could think about -- it's just kind of a
16 different idea -- is could loan repayment, if it's specific
17 to people in these disciplines, you know, by -- if they
18 become employed or it's by an entity that's employing them
19 -- could it be with tax-free income? So, essentially, if
20 you had, you know, an employer that gave a $100,000 loan
21 repayment, it becomes tax-free income. So it's another way
22 to encourage a loan repayment, specifically around these

1 disciplines, and maybe get more people to go into these
2 types of positions.
3 So just another idea that doesn't necessarily --
4 well, it does cost money because obviously it would cost
5 tax revenue, but it's not like you're having to pay the
6 full amount in a program like this. So it's just another
7 idea to consider.
8 DR. CROSSON: Karen.
9 DR. DeSALVO: When I was deciding what specialty
10 that I wanted to go into, and decided to do internal
11 medicine, we formed a club at my med school because we were
12 considered outcasts, and maybe it was really a support
13 group. So I empathize with you people who didn't
14 understand what was wrong with us, that we wouldn't want to
15 go into ortho or ENT.
16 And one of the reasons that I was driven that way
17 or pulled that way was because I was in the National Health
18 Service Corps in the Scholar Program. So I sit here today
19 because of the National Service Corps program. And I did
20 my time at Charity Hospital, in a clinic there, and then
21 stayed for years subsequently, caring for patients after
22 the period ended of my scholarship, which, as you've heard,

1 isn't completely unusual for people who go into the
2 program. And I, in fact, stayed in that community for
3 years after that.
4 So I can't tell you from a data standpoint but I
5 can tell you from a personal standpoint, very rewarding.
6 And part of this thing about going into primary care, and I
7 hadn't thought about it until today, was one of the things
8 the National Health Service Corps does is it creates this
9 national family for you, as a primary care provider working
10 in an underserved community. So they do a good job of
11 making you feel like you're not alone but you have
12 resources and a team and that you're a part of a thing.
13 And so there is something about the culture and the
14 encouragement that goes beyond just the financial incentive
15 of the payback.
16 In terms of -- so I'm obviously supportive of
17 both the idea of scholarship and loan repayment for people
18 who are not of means and want to go to school, or people
19 who are interested in going into fields or areas of the
20 country where we may not pay back as much. The National
21 Health Service Corps could be a way to operationalize a
22 program like this, so to double their budget, to find some

1 way, if statutorily allowable, for CMS to contract with
2 HRSA, to do the program, instead of creating something new.
3 Even if you did that, though, I think one of the
4 limitations of the National Health Service Corps that
5 wasn't explicitly brought out today is that as site applies
6 it's a matching program. So if there's a community where
7 there's not a federally qualified health center or an
8 Indian health service center, or some other entity that can
9 apply, then they may not be able to grab a provider or a
10 set of providers. So maybe some more flexibility, and I'm
11 going to go hang up a shingle in rural North Dakota, even
12 if there's not a site that's on a list, might be a way to
13 add some of the flexibility. But I think it's worthy for
14 us to explore other ways that this might happen, going
15 forward.
16 I, originally thinking that maybe rural was where
17 we had more need, was leaning towards specialties in
18 medicine that had broader skills, like med peds or family
19 medicine. On the other hand, if it's really like peanut
20 butter we've got to spread, then we ought to be thinking
21 that we need to support all teams. And I just -- all types
22 of specialties but also teams, and I want to end on that,

1 which is, again from personal experience, in New Orleans,
2 after Katrina, we had a special loan repayment program that
3 the taxpayers gave us, to return health professionals after
4 we had the largest exodus in U.S. history. And we realized
5 very quickly, as we were working with the feds to design
6 that program, it wasn't just doctors that we would need.
7 We'd need mental health professionals and social workers,
8 and everybody who was part of our team, because they also
9 had loans and they also were coming to work in a hardship
10 area.
11 And to the point about, then, who is on the
12 optimal team, I can tell you, even from the few clinics
13 that I built, that were patient-centered medical homes, in
14 one neighborhood we had more need for legal aid services or
15 social work, and that was where we were building out our
16 team to meet that community where they were, and in another
17 it was that we needed to have more psychiatry, as opposed
18 to just a licensed clinical counselor, maybe even some
19 specialists in that area.
20 So it's a longer conversation worthy of digging
21 into, but there is no template for the best team, and I
22 think most people in primary care who do team-based care

1 will tell you that it's really got to reflect the
2 epidemiology and the cultural characteristics of the
3 community, and that's why programs like this, Ariel, need
4 to be probably as flexible as possible in who is eligible
5 for loan repayment and let, in the way that the National
6 Health Service Corps has done, the local community decide
7 where they have the greatest need and put forward an
8 application for that kind of a provider.
9 DR. CROSSON: Thank you, Karen. Jaewon.
10 DR. RYU: I kind of struggle for the same reasons
11 that Pat articulated earlier. It feels like there are
12 still questions around how aggressive. I think it's a
13 multifactorial issue, sort of like what we were just
14 talking about. It's not all financial. And I think all of
15 these things make sense to do, but I don't know to what
16 degree. And if there was some way to properly size the
17 need, we know that there's a tremendous shortage in primary
18 care, but how much? And maybe shy of doing a full-fledged
19 workforce planning assessment, I'm not sure it's easy to
20 get at that. But I think that would be helpful, just even
21 to kind of put a size and scope on this thing.
22 We talked a lot about pipeline and ways to

1 encourage more folks coming into the pipeline. I think
2 there's a lot that we should be assessing on the exit line,
3 because a lot of the information I've seen suggests a lot
4 of the primary care workforce that we do have is within
5 five, seven years of retirement. So the shortage may be
6 even bigger than what we think, but to me it just feels
7 like it's tough to know how deep, how aggressive should we
8 going unless we do some sizing up front of what's the gap
9 and what do we anticipate the gap to be, and what forces
10 are coming and what's the optimal model that we want to get
11 to that impacts what that gap would be.
12 DR. CROSSON: Okay. Further comments? No.
13 Thank you, everybody. Good discussion.
14 Oh, sorry. Did I miss somebody? Paul.
15 DR. PAUL GINSBURG: Yes. Just a couple more
16 thoughts. One is that from this discussion it sounds like
17 maybe a way to think of this topic is not just scholarships
18 and loans but policies that impact directly primary care
19 practitioners, whether they're at the younger or even older
20 level.
21 And the other comment I thought is that
22 throughout today, or this afternoon, we've had a few

1 comments from Commissioners who are thinking about, well,
2 this costs money; here's where we're going to pay for it,
3 or the opposite. This is going to save money; this is
4 where we can spend it. And I just want to caution my
5 colleagues that I just don't think this is an effective way
6 for MedPAC to function, kind of getting into the pay-for
7 business, because it inevitably picks up enemies. It kind
8 of detracts from what we really are focusing on. And there
9 may be situations where we haven't done the work on the
10 accompanying policy that we have on what we really got
11 started on.
12 DR. CROSSON: Okay. There's some wisdom there.
13 Ariel, I hope you've had a significant amount of
14 input here.
15 MR. WINTER: Plenty, yes. Thanks.
16 DR. CROSSON: We will send you off with our good
17 graces, to come back at a later time and help us through
18 this again. Thank you.
19 [Pause.]
20 DR. CROSSON: Now, you look a lot like Dana
21 Kelley.
22 So we now have a person who apparently has two

1 jobs, and Dana is going to take us through something we
2 have not discussed in a while, as I remember, and that has
3 to do with inpatient psychiatric facilities.
4 You're on.
5 MS. KELLEY: Okay. Thank you.
6 So, as Jay said, this presentation is on the
7 inpatient psychiatric facility prospective payment system
8 and the care provided to beneficiaries who use those
9 services, and it's a status report of sorts, bringing you
10 up to date on some ongoing work that staff has been doing
11 on this topic.
12 And before I go any further, I want to recognize
13 Olivia Berci's contribution to this work.
14 So, today, I will provide some background on IPFs
15 and describe the characteristics of beneficiaries who use
16 them, and then I'll review the basics of the IPF PPS and
17 raise some questions and concerns we have about the
18 accuracy of Medicare's payments to some IPFs. And then,
19 finally, I'll provide some information about quality
20 measurement in these facilities.
21 As I said, this presentation is a status report
22 intended to inform. There is no immediate action item

1 here.

2 Medicare beneficiaries with serious mental
3 illnesses or substance abuse disorders who are experiencing
4 acute crisis may be treated in dedicated inpatient
5 psychiatric facilities. These are hospitals or specialized
6 psychiatric units in acute care hospitals. Medicare pays
7 for these services under the IPF PPS.

8 In 2016, about 1,600 IPFs provided roughly
9 409,000 inpatient stays to Medicare beneficiaries at a cost
10 of $4.3 billion dollars.

11 The number of IPF cases has fallen over the last
12 15 years. On a per fee-for-service beneficiary basis, IPF
13 cases fell 1.4 percent per year, on average, between 2004
14 and 2014, and fell more quickly from 2014 to 2016,
15 declining about 4 percent per year, on average. This more
16 rapid recent decline in IPF cases echoes the decline we've
17 seen in acute care hospital admissions.

18 To be admitted to an IPF, beneficiaries generally
19 must be considered a risk to others or to themselves,
20 either intentional or as the result of impaired self-care.

21 The goal of inpatient psychiatric care is mood
22 stabilization and restoration of the ability to live

1 independently.

2 In addition, IPFs provide supervision and

3 behavioral management to reduce the risk of harm to self or

4 others.

5 Patients receive a variety of services such as

6 individual and group therapy, psychosocial rehabilitation,

7 illness management training, and electroconvulsive therapy.

8 A majority of IPF patients also receive drug therapy in the

9 form of antipsychotics, mood stabilizers, antidepressants,

10 and anticonvulsants. Patients also may receive care for

11 medical comorbidities such as diabetes or cardiac

12 conditions.

13 More than half of the beneficiaries who have an

14 inpatient stay at an IPF are under 65 and entitled to

15 Medicare based on disability. Thirty percent are under age

16 49. About 55 percent are partially or fully dually

17 eligible for Medicaid.

18 IPF users as a group consume more health care

19 services than other beneficiaries. In 2015, beneficiaries

20 who had an IPF stay on average had 3.1 visits to the

21 emergency department, making them six times more likely to

22 use the ED than all beneficiaries. They also had more than

1 40 E&M visits during the year, again six times the average
2 for all beneficiaries. They filled almost twice the number
3 of Part D prescriptions.
4 And consistent with this higher use, the total
5 per-beneficiary spending for IPF users was very high, over
6 $40,000 in 2015, compared with just under $12,000 for all
7 fee-for-service beneficiaries.
8 This slide outlines the basic mechanics of the
9 IPF PPS, and one thing I want to underline here is that
10 payments are made on a per-diem basis. Payments are
11 adjusted for the diagnosis and other patient
12 characteristics such as age, certain medical comorbidities,
13 and length of stay. Payments are also adjusted for
14 facility characteristics such as area wages, teaching
15 status, rural location, and the presence of an emergency
16 department.
17 There is an add-on payment for each
18 electroconvulsive therapy treatment and an outlier pool
19 equal to 2 percent of total payments.
20 So under the IPF PPS, Medicare cases generally
21 are assigned to one of 17 psychiatric MS-DRGs. In 2015,
22 the most frequent IPF diagnosis, accounting for 73 percent

1 of IPF discharges, was psychosis, which generally comprises
2 schizophrenia, bipolar disorder, and major depression.
3 Organic disturbances and mental retardation,
4 substance abuse or dependency, and degenerative nervous
5 system disorders each accounted for a little more than 6
6 percent of cases.
7 As you can see in the last column, the number of
8 discharges with a principal diagnosis of substance abuse or
9 dependency has increased disproportionately in recent
10 years, climbing almost 9 percent from 2011 to 2015, even as
11 the total number of IPF cases declined by 7 percent.
12 The aggregate Medicare margin for 2016 in IPFs
13 was negative 2.4 percent, but financial performance under
14 the IPF PPS has varied quite widely.
15 Freestanding IPFs that were for-profit had an
16 aggregate Medicare margin of 29.2 percent, compared with
17 negative 6.6 percent for nonprofit freestanding facilities.
18 The high margins in freestanding for-profit IPFs are driven
19 by low costs per case.
20 The very low costs and high margins in some IPFs
21 raises some questions. As with any payment system,
22 Medicare's payments for IPF services need to be well

1 calibrated to patient costliness, so as not to create
2 incentives for providers to admit certain types of patients
3 and avoid others.
4 But the wide variation in IPF margins could
5 indicate here that Medicare's payments don't track closely
6 to patient costs, and if that's true, the PPS could be
7 paying too little for patients with high-care needs and too
8 much for patients requiring fewer resources.
9 As I noted a minute ago, almost three-quarters of
10 IPF cases are in one MS-DRG, so even with the patient- and
11 facility-specific adjusters that are applied to payment,
12 the payments do vary relatively little across patients.
13 But concerns about the accuracy of Medicare's
14 payments to IPFs are mitigated to some extent because the
15 PPS pays on a per-diem basis, and generally, the smaller
16 the unit of payment, the less costs will vary across
17 patients and providers.
18 In fact, research on the costs of inpatient
19 psychiatric care in the U.S. and in other countries
20 suggests that the per-diem costs of psychiatric inpatients
21 may be relatively homogenous. But complexity of disease
22 may not be well accounted for in these studies.

1 CMS's administrative data cannot be used to
2 describe differences across patients in routine nursing and
3 staff time, which is the majority of the resources used in
4 these settings. So that undermines our ability to fully
5 account for how costs vary with patient complexity.
6 Although we can't use administrative data to
7 fully account for differences in costs across patients, we
8 wondered if it would be possible to identify patients with
9 more complex conditions using administrative data, since
10 Medicare does not collect patient assessment information
11 for IPF users.
12 MedPAC staff worked with 3M Health Information
13 Systems to develop 22 clinically homogenous groups of
14 mental health conditions based on DRG assignment, such as
15 schizophrenia and alcohol disorder, and then further
16 subdivided the conditions based on the complexity of the
17 mental health condition, as measured by the ICD-9 codes.
18 So, for example, paranoid-type schizophrenia
19 chronic was considered less complex than paranoid-type
20 schizophrenia acute exacerbation. 3M's methodology yielded
21 41 mental health groups, more than twice as many payment
22 groups than are currently used in the IPF PPS.

1 But under this clinical classification scheme, we
2 still would have just a handful of mental health groups
3 accounting for the vast majority of patients. Eighty
4 percent of all cases in 2011 fell into one of four out of
5 22 base mental health conditions, shown here.
6 The most frequent mental health condition was
7 schizophrenia, accounting for about 26 percent of cases.
8 The red portion of each bar shows the share of cases in
9 each base mental health condition that was of higher
10 complexity, as indicated by ICD-9 codes.
11 For IPF patients, several other variables may be
12 more important predictors of complexity or costs than
13 diagnosis is, such as degree of social support, need for
14 assistance with activities of daily living, justice system
15 involvement, and dangerous behavior such as suicidal
16 tendencies. This information is not available in
17 Medicare's administrative data.
18 Another issue that complicates our assessment of
19 the IPF PPS is a relative lack of information on the
20 ancillary services beneficiaries receive in IPFs.
21 Like all hospitals, IPFs are required to
22 apportion allowable Medicare costs to each ancillary

1 department unless they have an all-inclusive rate; that is,
2 unless they have one charge covering all services.
3 All-inclusive rate status must be designated by a
4 Medicare administrative contractor, and that status is
5 indicated on the cost report.
6 Medicare cost reporting rules specify that
7 hospitals cannot elect to move to less detailed methods of
8 cost apportionment. So if a hospital apportions its costs,
9 it should not later decide to pursue all-inclusive rate
10 status.
11 Relatively few IPFs have an official all-
12 inclusive rate designation, about 188 in 2016. These
13 facilities accounted for about 10 percent of Medicare IPF
14 days. About 45 IPFs with an all-inclusive rate designation
15 nevertheless reported separate charges for drugs in 2016.
16 But there's a growing number of IPFs who report
17 no drug costs even though they are not all-inclusive rate
18 providers. And I'll call these facilities "non-reporters."
19 There were 190 non-reporters in 2016, up from 50 in 2007.
20 Almost all of these providers are freestanding, and about
21 80 percent are for-profit.
22 These non-reporters accounted for 21 percent of

1 Medicare IPF days in 2016. Most of the providers that
2 reported no drug charges in 2016 also reported no charges
3 for laboratory services. Together, these two groups, the
4 all-inclusive rate providers and the non-reporters, account
5 for about 31 percent of all Medicare IPF days. So that
6 means we have no data on ancillary costs for about a third
7 of the IPF days.
8 We expect not to have data on ancillary costs for
9 designated all-inclusive rate providers, but the growing
10 number of IPFs that are non-reporters who submit no costs
11 for drugs or lab services and submit no claims with drug or
12 lab charges on them seems very surprising.
13 CMS has stated that it expects most IPF patients
14 will need ancillary services and supplies such as drugs and
15 lab, and our analysis of claims data has found that 97
16 percent of the claims submitted by hospital-based IPFs do
17 include charges for drugs, which would seem to confirm that
18 CMS's expectation is reasonable.
19 So what explains the lack of reported drug costs?
20 One hypothesis is that some facilities might
21 inappropriately be billing outside of the IPF payment
22 bundle, and we have not yet tested this hypothesis. But

1 CMS has looked at a sample of claims and doesn't believe
2 that this is going on.
3 When we asked a provider association about the
4 lack of reported drug costs, we were told that it's common
5 for IPFs to have one flat rate, and so some providers might
6 simply be rolling up their ancillary costs into their
7 routine costs. As I mentioned, this is not allowed under
8 Medicare cost reporting rules, but if this is what is
9 happening, then we might expect that the total costs of the
10 non-reporters would be similar to those of other IPFs that
11 are properly apportioning their costs.
12 Yet when we looked at the average unadjusted per-
13 day costs of non-reporters, we found that, at $546 per day,
14 they were considerably lower than those of other
15 freestanding IPFs, $745. So it's not clear whether the low
16 costs are indicative of efficient care delivery or a
17 patient mix with lower care needs or stinting on care.
18 Recently, CMS implemented a cost report edit that
19 rejects cost reports from psychiatric hospitals if they
20 exclude certain ancillary costs. So, hopefully, in the
21 future, we'll have better data on this, but it will be a
22 few years before we see that.

1 The appropriateness of costs cannot be evaluated
2 without consideration of outcomes, and so this brings us to
3 the issue of quality measurement in IPFs.
4 In general, there are few meaningful, frequent,
5 and easily collected clinical outcome measures that have
6 been assessed for validity and reliability in the IPF
7 setting.
8 Developing outcomes measures for IPFs is
9 complicated by the length of treatment required during the
10 acute phase of behavioral health disorders. For example,
11 successful treatment of an acute episode of major
12 depression typically requires six to eight weeks, but
13 patients usually require inpatient care for only a fraction
14 of that period.
15 To date, most attempts to measure quality in IPFs
16 have focused on clinical process measures. CMS's IPF
17 Quality Reporting program, implemented in fiscal year 2014,
18 requires submission of data on process measures such as
19 hours of physical restraint use, substance abuse treatment
20 provided, and timely transmission of records to subsequent
21 care providers. In fiscal year 2019, CMS will also use
22 administrative data to calculate two outcomes measures --

1 follow-up after discharge from the IPF and 30-day all-cause
2 unplanned readmission rates.
3 CMS has not begun reporting these outcome
4 measures yet, but our work with 3M looked at similar
5 measures. As shown here, not all beneficiaries who used
6 IPFs in 2011 had follow-up care after discharge.
7 Almost a quarter of IPF episodes admitted for
8 alcohol use disorder had no Part A or B bills for services
9 provided in the 30 days after discharge.
10 Seventeen percent of episodes admitted with a
11 diagnosis of less complicated schizophrenia appeared to
12 receive no follow-up care. This could represent a missed
13 opportunity to establish or strengthen a beneficiary's
14 connection to community-based care and support, and some
15 studies have found that lack of follow-up care increases
16 the risk of readmission.
17 3M also looked at potentially preventable
18 readmission rates following discharge from the IPF. This
19 analysis looked at any hospital admission in the 30 and 90
20 days after discharge from the IPF, including admissions to
21 the acute care hospital, and then determined which of these
22 were related to the initial hospitalization and potentially

1 preventable.

2 We found that the highest rates of readmission
3 for episodes with complex schizophrenia. Twenty-one
4 percent of these episodes were readmitted to a hospital of
5 any type for a potentially preventable condition within 30
6 days of discharge from the IPF. Thirty-six percent were
7 readmitted within 90 days of discharge.

8 Most commonly, beneficiaries were readmitted for
9 the same psychiatric diagnosis, but beneficiaries often
10 also had additional hospitalizations for cardiovascular
11 conditions.

12 These readmission rates must be interpreted with
13 caution. Readmissions may potentially be preventable, but
14 some percentage of patients in this vulnerable population
15 are always going to need additional inpatient care.

16 Still, to minimize the need for subsequent
17 hospitalization, it's important to ensure that IPFs have
18 incentives to provide appropriate patient-centered care and
19 to coordinate hand-offs to community-based providers.

20 So, in conclusion, our work to date confirms that
21 IPF users are a high-need, high-service-use population, yet
22 we see a surprising lack of ancillary costs reported by

1 some IPFs.

2 Although it's possible that this is simply a cost
3 reporting issue, it does raise concerns about appropriate
4 provision of care. Rates of follow-up care after discharge
5 and rates of readmission also suggest room for improvements
6 in care for this vulnerable population.

7 That concludes my presentation. As I said at the
8 outset, there are no specific action items for you to
9 address, but I'm happy to take questions about this
10 information or to hear your thoughts about future work here
11 you'd be interested in.

12 Thank you.

13 DR. CROSSON: Thank you, Dana.

14 I have one question I'd like to start with, and
15 it has to do with this peculiar situation where there's a
16 substantial amount of non-reporting of the use of
17 psychoactive drugs. I'm not a psychiatrist, but I would
18 imagine that a large majority of people who are sick enough
19 to be hospitalized are going to be benefitted by the use of
20 one or more psychoactive drugs. So it's either that
21 they're not getting the drugs, or they're not being
22 reported. I'm not sure which.

1 One thing that would be interesting to know --
2 and I don't know if this is possible, but as we've seen
3 with some other institutional settings, sometimes the
4 actual cost at the facility is a consequence of how long
5 the patient is there. In other words, depending on the
6 nature of the diagnosis, one could imagine that the cost
7 would be potentially very high in the beginning, the actual
8 cost.
9 Reimbursement is the same, irrespective of what
10 day; is that right?
11 MS. KELLEY: So the IPF PPS actually has a
12 declining reimbursement as length of stay increases.
13 DR. CROSSON: It does. Okay. All right. No,
14 that's helpful. That's what I want to know. Thank you.
15 Other questions? Jon.
16 DR. CHRISTIANSON: Yeah, same -- I couldn't tell
17 from your presentation or the report whether there are
18 circumstances under with the non-reporters are actually
19 breaking the law?
20 MS. KELLEY: I don't think we know the answer to
21 that question.
22 DR. CROSSON: Okay. Let's start with Brian.

1 DR. DeBUSK: On page 7 of the presentation, I
2 noticed the psychosis diagnosis or the DRG and then the
3 substance abuse or dependency. Two questions. How do you
4 tell the difference between someone who is experiencing
5 psychosis and self-medicating with substances or alcohol or
6 who is substance- and alcohol-dependent and experiencing
7 psychosis? And is there a financial benefit in how they
8 classify like a per diem rate to the DRG and how they do
9 that classification?
10 MS. KELLEY: So I'm not a psychiatrist. These
11 are principal diagnoses, so the principal diagnosis on the
12 claim will dictate what MS-DRG is assigned. Under the IPF
13 PPS, the psychosis DRG has an adjuster of 1, and substance
14 abuse or dependency do have an adjuster of less than 1. So
15 there is a higher payment from a psychosis DRG than for
16 substance abuse.
17 DR. DeBUSK: So there's a distinct financial
18 advantage in the current system to seeing it as a psychotic
19 patient that happens to be using drugs or alcohol?
20 MS. KELLEY: Potentially, yes.
21 DR. DeBUSK: Okay.
22 DR. CROSSON: Other questions? Kathy?

1 MS. BUTO: Dana, thank you for this. I had
2 questions about the role of the IPF in treating patients as
3 relates to community care. Do we have any sense of whether
4 these are patients who have failed outpatient mental health
5 services or happen to have a readily available IPF versus
6 other options?
7 MS. KELLEY: I don't think we know the answer to
8 that question. I think we do know that even patients who
9 receive appropriate and adequate community-based care will
10 sometimes need to be hospitalized. So for some patients, I
11 think an inpatient hospitalization does mark a failure of
12 community-based care, but for other patients, you know,
13 given the course of their disease, the inpatient stay is
14 unavoidable and necessary.
15 MS. BUTO: Just to follow up, to our knowledge,
16 there hasn't been any assessment that says some percentage
17 of IPF patients really shouldn't be there, that --
18 MS. KELLEY: Not to my knowledge.
19 MS. BUTO: Okay.
20 MS. KELLEY: But that's certainly something we
21 should look into.
22 DR. CROSSON: I saw Karen.

1 DR. DeSALVO: Thank you. Dana, this is really
2 well done and I think a really important topic, so I hope
3 we get to revisit it, which is my question about the
4 timeliness of the data. The 3M analysis used 2011, and
5 there's probably been a lot of changes in the mental health
6 and substance use infrastructure since then. So I wondered
7 if you could share when we might have more current data
8 available.
9 MS. KELLEY: So the 3M work is something we did a
10 few years back, and it's taken awhile to process. We are
11 working with the Urban Institute right now to do more of a
12 deep dive into the payment side where the 3M work was a
13 little more clinical in nature. So that will give us some
14 updated information.
15 DR. CROSSON: Warner.
16 MR. THOMAS: Dana, thanks for the information. I
17 think it's great.
18 A quick question I had. You showed a chart
19 really where there's a lack of follow-up care kind of post-
20 inpatient discharge. Do you have a sense or do we have an
21 idea of how many Medicare participating providers we have
22 in the psychiatry or mental health area and whether access

1 to mental health providers for Medicare recipients is an
2 issue and maybe leading to some of this? Do we have any
3 information or insight into that?
4 MS. KELLEY: Kate?
5 MS. BLONIARZ: I think we do. I think there's a
6 relative undersupply of behavioral health providers in
7 Medicare. The share of psychiatrists taking Medicare is
8 about 50 percent, which is actually pretty similar to
9 private and Medicaid as well. So it's less a feature of
10 kind of Medicare's rules and more just, you know, what --
11 how psychiatrists have traditionally served and billed for
12 their services.
13 We did look at LCSWs, you know, finding a fairly
14 high participation rate for social workers, but I think we
15 do think there's a general undersupply in this area.
16 DR. CROSSON: Seeing no further -- oh, Dana --
17 MR. THOMAS: Maybe just a quick follow-up. So
18 that's 2011. Do we have any sense whether that may be
19 better or worse now?
20 MS. KELLEY: We don't. But my analyses of the
21 IPF data itself between 2011 and 2016, I'd be surprised if
22 things had changed that much.

1 DR. CROSSON: Okay. I think -- I'm sorry. Dana,
2 and then Pat.
3 DR. SAFRAN: Thank you. This is interesting.
4 It's a disturbing set of findings. Lots to think about. I
5 guess one question is just whether -- what kind of
6 oversight exists for IPFs? Do they fall under JCAHO, for
7 example?
8 MS. KELLEY: Sure. They are certified as
9 hospitals.
10 DR. SAFRAN: Okay. And so is there any way
11 through JCAHO to get insight about the ancillary non-
12 reporting issue?
13 MS. KELLEY: That's a good idea and something we
14 can look into.
15 DR. SAFRAN: Okay. That would be great. And I
16 assume, but I don't want to assume just because I don't
17 think in my year on the Commission we've talked about IPFs
18 before. We don't have any -- Medicare does not have any
19 kind of quality-based payment for IPFs? In fact --
20 MS. KELLEY: No. It's pay for reporting only.
21 DR. SAFRAN: Okay. Thank you.
22 DR. CROSSON: Pat.

1 MS. WANG: Dana, I apologize. This may have been
2 in the paper, but IPFs are not the only source of inpatient
3 care for people who need to be hospitalized for a
4 behavioral health issue. Approximately what proportion of
5 Medicare beneficiaries are using IPFs for behavioral health
6 versus spread throughout the acute-care system?
7 MS. KELLEY: Yeah, so beneficiaries who need to
8 be hospitalized for a principal diagnosis of a psychiatric
9 condition can also be cared for in a general acute-care bed
10 in an acute-care hospital. And there were about 290,000 in
11 2016. Did you ask me something else about --
12 MS. WANG: Two hundred ninety thousand in --
13 MS. KELLEY: In scatter bed admissions. So there
14 were about 407,000 IPF admissions -- or discharges, and
15 290,000 scatter bed discharges.
16 MS. WANG: So more than a third.
17 MS. KELLEY: Yeah.
18 MS. WANG: That's interesting. So for
19 information such as you've presented on Slide 15 that
20 Warner was asking you about, is there -- would it make
21 sense to look at follow-up within 30 days for those who had
22 been admitted into scatter beds?

1 MS. KELLEY: So that is something we could do.
2 This is only for IPFs, this data here. We did not -- I do
3 not -- well, actually I do have this information for
4 scatter beds. I don't know it off the top of my head, but
5 I do have this information for scatter beds as well, and I
6 can provide that for you.
7 MS. WANG: I can tell you at least, you know, for
8 state Medicaid programs, for example, the quality programs
9 expect follow-up within seven days after discharge. So
10 that's what a Medicaid managed care plan will work towards,
11 and it is possible. So --
12 MS. KELLEY: So one thing I --
13 MS. WANG: -- it's still pretty extreme.
14 MS. KELLEY: Yeah, and one thing I might
15 hypothesize -- you asked about how things may have changed
16 since 2011. I think in an acute-care hospital setting
17 where there has been, you know, increased focus on outcomes
18 measurement and follow-up care, I do wonder whether things
19 have changed more for discharges from scatter beds than
20 they have in the IPF setting, where there has been, I
21 think, less attention.
22 MS. WANG: It might be an interesting -- thank

1 you.

2 DR. CROSSON: Okay. Thank you for the questions.

3 We'll now have a discussion or commentary period

4 for further input to Dana on this report. Jon.

5 DR. PERLIN: First, let me add thanks for really

6 an insightful report. This is an area that has

7 extraordinary opportunity. As someone who has been a

8 health services researcher and focused on measures, I am

9 not satisfied with the state of quality measurement in this

10 area. That someone wasn't restrained may prevent a safety

11 issue, but it's not therapeutic. And I really encourage

12 our consideration of how to drive measures that imply

13 therapy.

14 For all the reasons that you so eloquently

15 outlined in the paper, I think it's very difficult to look

16 at some of the outcome measures, but this may be one of the

17 areas where we need to look at a better set of process

18 measures and structural measures that have some degree of

19 reasonable evidentiary base.

20 In this regard, one of the things that concerns

21 me the most is if the hypothesis that some of the cost

22 differentials has to do with services rendered, then let's

1 look right at the services rendered. And I would want to
2 know what the state of the therapeutic programming is for
3 those individuals. So I think a measure set may also have
4 a hierarchy of those things that are regulatory compliance,
5 those things that are safety, but those things ultimately
6 that are therapeutic. So that's the first point there.
7
8 I think other areas of focus in measures beyond
9 the programs might be the user of extenders. We know
10 there's a shortage of psychiatrists. We know that there is
11 a lot of extension, and I do worry about some of the
12 linkages.
13 The second is I think we need to expand our data
14 set in terms of looking at follow-up. I did have the
15 privilege of spending my residency divided between mental
16 health and internal medicine, and for alcohol, in
17 particular, you know, there actually at least evidence for
18 12-step and other sort of social support programs, and I'm
19 wondering if we get the data in that 24 percent that those
20 individuals who are discharged not to a Medicare provider
21 but to a social service agency where we're not getting that
22 back.

1 That said, that doesn't hold true for the other
2 diagnoses that are up there, and just for the record, a
3 junction with the discussion of opioids, there is
4 absolutely no extrapolation of the evidence to those social
5 service programs versus, you know, medication as therapy.
6 So I think additional measures and extension of the data
7 sources.
8 Then, finally, one of the things that's noted in
9 the pre-read paper is some contemplation of bundling in
10 this area. This is one of the areas where I think it's
11 good in theory, but in practice I worry about it
12 exacerbating the difficulty in this position. In my
13 organization, the fastest-growing part of our inpatient
14 services in our acute hospitals is psychiatric because
15 these patients had nowhere to go, and so rather than having
16 them languish, we built that out. I could see these
17 bundles potentially operating as a disincentive to the beds
18 in the acute part if all of a sudden there's an obligation
19 to discharge patients to a resource that just doesn't
20 exist. And so I think we need to think about how to
21 cultivate the resources, then think about how to link it.
22 So those are my three comments and, again, just

1 brilliant work.

2 MS. KELLEY: One thing I did want to respond to,
3 talking about the services that are being offered, I was
4 really interested in the reports that have come out lately
5 about nursing home staffing that have come from the new
6 payroll-based reporting. And it did make me wonder what
7 staffing in IPFs looks like and whether or not there could
8 be more information that would be useful along those lines.

9 DR. PERLIN: I think that's absolutely right on
10 target, but back to Dana's point, you know, those who
11 survey facilities might have the ability to actually
12 abstract to some degree what the types of therapeutic
13 programming are. You may nominally have criteria about
14 staff, but you still may be bereft of, you know, really
15 optimal therapeutic programming.

16 DR. CROSSON: Okay. Thank you, Jon.

17 Other comments? Kathy and Warner.

18 MS. BUTO: Just very briefly, Dana. I keep
19 hoping that we'll be able to expand this analysis or an
20 analysis about inpatient to outpatient and sort of the
21 whole issue of the lack of continuity of care for mental
22 health and behavioral health patients in Medicare. I think

1 that lack of have an organized -- again, some kind of
2 organized way of managing or being available to those
3 patients is really important. And I know that's not the
4 task here, but something that I'd like us to think about.
5 DR. CROSSON: Warner.
6 MR. THOMAS: So one of the things that comes to
7 mind for me is just especially when you -- number one, this
8 to me is a very disturbing slide, just having the lack of
9 follow-up. I'm not surprised by it given, you know, where
10 things are. And we talk a lot about additional
11 reimbursement and dollars for primary care. I think we've
12 got to put mental health, outpatient mental health there as
13 well, and probably -- it's probably even more important,
14 frankly, than primary care.
15 But the question I have is just especially when
16 you look at the spend that's like, you know, 4X kind of a
17 traditional beneficiary, I think it was like $40,000-plus
18 versus 11. Do we have a sense of the population of people
19 we're talking about, so how large an issue this is just in
20 aggregate?
21 MS. KELLEY: So the numbers that I presented
22 today and that are presented in your paper are only for

1 users of IPF services in 2015.

2 MR. THOMAS: Right.

3 MS. KELLEY: So there were two hundred and --

4 gosh, off the top of my head, I can't remember now. I want

5 to say there were 290-some-odd thousand beneficiaries who

6 had 407,000 IPF stays. I think that's right.

7 UNKNOWN STAFF: 409 [off microphone].

8 MS. KELLEY: 409? Thank you. So those numbers

9 are for that population. You know, there are other ways --

10 there are plenty of Medicare beneficiaries with behavioral

11 health conditions who did not have an IPF stay, and, you

12 know, that's obviously a much larger population.

13 MR. THOMAS: It might be interesting, as we

14 revise this or complete this work, to try to size this a

15 little larger just as a total impact, maybe looking at it

16 over a couple of years or trying to extrapolate over a

17 couple years, because I think it probably is a larger

18 economic issue than we realize.

19 MS. KELLEY: Yeah.

20 MR. THOMAS: And that may kind of lead us to take

21 a more bold approach in kind of how we want to try to

22 address it.

1 MS. KELLEY: In some work we had done a couple of
2 years ago, Kate did sort of a wider-lens look, and we can
3 try and bring back some of those numbers in the future.
4 DR. CROSSON: Kathy.
5 MS. BUTO: It just occurred to me I remember from
6 the paper and your presentation that a large percentage are
7 Medicaid and/or dual eligibles, and Medicaid dual eligibles
8 or under 65 dual eligibles, a very specific kind of
9 population. And I wonder if -- so I didn't see Alzheimer's
10 on the list or dementia. Is that not one of the major --
11 oh, okay, it is. Dementia. That actually is a small
12 percentage compared to the other disorders. But is that
13 where the over-65 population resides for the most part?
14 MS. KELLEY: So these are the data from 2011, but
15 the shares haven't changed that much. Many of the -- the
16 dementia category is almost entirely beneficiaries over 65.
17 But there are beneficiaries over 65 who fall into other
18 conditions as well.
19 MS. BUTO: Okay. I just wonder if there are
20 special issues that we ought to be considering. I know you
21 brought the IMD issue in the paper in Medicaid, the
22 exclusion, that we ought to think beyond just what's going

1 on in the inpatient psych facility to whether -- it's,
2 again, that issue of linkage to other resources in the
3 community that isn't happening.
4 DR. DeSALVO: Can I just add? I just want to
5 agree with Kathy, and it gets back to my question before,
6 and that may be that changes not only in the care system
7 but some driven by changes in the way we are approaching
8 care management for dual-eligible individuals and the
9 better coordination. So it probably is not better, but it
10 would be nice to see if in states where they're doing a
11 better job of bridging between care and bridges between the
12 inpatient and outpatient sector.
13 Thank you.
14 DR. CROSSON: Pat.
15 MS. WANG: We have a little bit of -- we have
16 talked a lot about coordinated care models and ACOs and the
17 importance of MAPD plans. I think it's important to stress
18 that for this particular group of beneficiaries, it's, you
19 know, it's times 100. So looking at, you know, what's
20 going on in an inpatient facility is very important because
21 of the payment structure. But I think that where folks
22 have moved is we want to get people out of the hospitals as

1 soon as possible. And it's not just the availability of
2 resources. It's active management of the person probably
3 to a community resource. We are working very hard on this
4 right now, and it's obviously very difficult. But there's
5 a whole infrastructure that is required, I would say, a
6 different kind of network -- health homes, peer bridgers,
7 folks who can help people get back to the community. And
8 the availability of psychiatrists is important, but it's
9 really not the most important thing, I would say. It is
10 just -- it's keeping medical appointments, it's keeping
11 medications filled, it's having somebody who perhaps has
12 experienced something similar when it comes to alcohol
13 disorders, and substance abuse in particular, to really,
14 you know, sort of wrap a person w lots of support.
15 So I just want to -- I think that the field has
16 moved substantially from what goes on inside of an
17 inpatient facility, and it's very important to get this
18 payment right. But the notion of earlier discharge to
19 community resources is a really big endeavor and requires,
20 in my opinion, extremely active management. You know,
21 plans do that if they are in this business to do it, but
22 it's very, very active. It's care management inside the

1 plan. It's care managers in the community. It's other
2 kinds of community resources as well as clinical.
3 So I think people have alluded to that, but I
4 think, you know, to kind of hang the bill on the cat, it's
5 really -- it's much bigger than just sort of the usual
6 approach.
7 DR. CROSSON: Okay. Thank you. Good discussion.
8 Dana, thank you for the presentation. That concludes the
9 discussion portion of our meeting.
10 We now have an opportunity for public comment.
11 If there is anyone in our audience who would like to make a
12 public comment, you can do it at this time by stepping to
13 the microphone so we can see who you are.
14 [Pause.]
15 DR. CROSSON: We have one individual. I will
16 just give you a little preamble, if that's okay.
17 So what we would ask you to do is identify
18 yourself and any organization that you are associated with,
19 and we'd ask you to limit your comments to two minutes.
20 When this light goes back on then the two minutes will have
21 expired.
22 MS. FISHER: I will talk very fast. I'm not used

1 to that but I will try to talk fast.

2 I'm Karen Fisher with the Association of American

3 Medical Colleges. I appreciate the fact that MedPAC today

4 talked about primary care shortages, and always appreciate

5 the discussion by the Commission.

6 We agree with the discussion and the issue about

7 there being a primary care shortage. Many of you may know

8 that the AAMC has an independent consultant every year do a

9 study looking at projections of workforce shortages, and we

10 continue to see workforce shortages going into the future,

11 up to 120,000 potentially in 2030.

12 I think what is important to remember is that in

13 our own modeling we predict and include current primary

14 care shortages but there are also going to be other

15 shortages, of other specialists, and that's going to be

16 important as we look at the Medicare population, as it was

17 mentioned previously. In some cases Medicare beneficiaries

18 need a specialist as much more as they need a primary care

19 physician. So we need to make sure that we look at these

20 all globally.

21 Jim and the staff have reached out to us. We

22 very closely follow the loan repayment programs and the

1 medical school debt issues and are going to be coming in
2 and talking to the staff about that because I think we have
3 a lot of information we can help provide on some of the
4 questions that were raised today.
5 But I would say that every year we do a study,
6 since 1978, a survey of the graduating seniors from medical
7 school. This year, the survey results were 80 percent.
8 They tend to be very high. And since we've been tracking
9 information on debt, debt has always ranked lowest in terms
10 of factors influencing specialty choice, as was mentioned
11 here today. As was mentioned, specialty content,
12 personality fit tend to be higher. Work-life balance tends
13 to be higher, role modeling, et cetera. Even those who
14 ranked it high tend to rank personality fit and specialty
15 content higher than debt itself, and I think that's
16 important to factor in.
17 Income, which was mentioned a little bit, does
18 rank higher than debt, but still ranks lower than the
19 factors I just mentioned. But if you're going to look at
20 income, I think someone mentioned today looking at the
21 payment is very important.
22 Finally, as was noted, the number of primary care

1 residency positions has increased, and the fill rate for
2 those positions has increased. The issue we're facing is
3 that Medicare has capped the support it's providing for
4 residency training through the Medicare caps. That issue
5 should be looked at by this Commission, and I don't think
6 it has been since 1997, explicitly, and we'd love to have
7 that discussion as we talk about the importance of GME.
8 I'm happy to talk and engage more with the
9 Commission as this goes on. Thank you very much.
10 DR. CROSSON: Thank you, Karen. Seeing no one
11 else at the microphone, we are adjourned until tomorrow
12 morning at 8:30.
13 [Whereupon, at 4:05 p.m., the meeting was
14 adjourned, to resume at 8:30 a.m. on Friday, October 5,
15 2018.]
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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, October 5, 2018
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
PAUL GINSBURG, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
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SUSAN THOMPSON, MS, RN
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AGENDA PAGE

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1 P R O C E E D I N G S

2 [8:30 a.m.]

3 DR. CROSSON: Good morning, everyone. This is
4 the Friday session of our October meeting. We have two
5 topics before us today. In the first one, we're going to
6 have Carol and Ledia take us through some excellent
7 refinements to the ongoing project on the PAC PPS. Carol,
8 are you starting?

9 DR. CARTER: I am. Good morning, everybody.

10 Today Ledia and I will present information on
11 work we have planned for this coming year on the PAC PPS
12 and quality measures that we are developing for PAC
13 providers. For the new Commissioners and those in the
14 audience who are new to the topic, I'll quickly review the
15 work the Commission has done on a PAC PPS to date and the
16 work we have planned on an episode-based design. Then
17 Ledia will review the Commission's past work on uniform
18 readmission and resource use measures and outline
19 additional outcome measures that we have planned for the
20 year. Together, the measures could form the basis of a
21 value-based purchasing program for PAC providers.

22 In our work, post-acute care refers to care

1 furnished in home health agencies, skilled nursing
2 facilities, inpatient rehab facilities, and long-term-care
3 hospitals, including care furnished to beneficiaries
4 admitted from the community. Spending across the four
5 settings totaled $60 billion in 2016.
6 We and others have documented that similar
7 patients are treated in the four settings, yet payments can
8 differ substantially, in part because each setting uses its
9 own payment system. There is limited evidence to guide
10 placement decisions and so, not surprisingly, there is more
11 variation in per capita PAC spending than any other
12 Medicare service. Further complicating the picture are
13 setting-specific patient assessments and outcome measures
14 so that the patients treated and the outcomes of that care
15 cannot be easily compared. Finally, each year the
16 Commission reports that fee-for-service payments for PAC
17 are high relative to the cost of care, which can distort
18 benchmarks for MA and ACOs.
19 As a reminder, in 2016 we completed a mandated
20 report on the recommended design features of a uniform
21 payment system for PAC. Our assessment of the feasibility
22 of a unified payment system was based on analysis of 8.9

1 million stays in 2016, not a sample of providers, stays, or
2 beneficiaries. The unit of service was a stay, or in the
3 case of home health, an episode, and each stay was
4 considered an independent event. Payments would be based
5 on the average cost of stays and would be adjusted using
6 patient and stay characteristics such as a patient's age
7 and their comorbidities. There would need to be a large
8 adjustment for home health stays to reflect the much lower
9 costs of non-institutional care. The design should also
10 include short-stay and high-cost outlier policies. The
11 Commission concluded that a unified PAC PPS design using
12 administrative data was feasible and could accurately
13 predict the cost of stays for most of the 40 or more
14 patient groups that we focused on.
15 Payments under a PAC PPS would be redistributed
16 considerably, becoming more equitable across different
17 patient conditions compared with current policy. Payments
18 would increase for medically complex patients and decrease
19 for patients who receive rehabilitation care that appears
20 to be unrelated to their clinical conditions. As a result,
21 providers would have much less financial incentive to
22 prefer to treat certain types of patients and avoid others.

1 Since 2016, the Commission worked on several
2 implementation issues, including the alignment of
3 regulatory requirements that you discussed at last month's
4 meeting. In 2017, the Commission assessed the level of
5 spending and recommended that the aggregate should be
6 lowered by 5 percent when the PPS is implemented.
7 Regarding timing, the Commission recommended that a PAC PPS
8 be implemented sooner than contemplated by the IMPACT Act
9 with a three-year phase in. To maintain the system's
10 accuracy, the PPS should be revised and rebased over time
11 as needed. To begin to increase the equity of payments
12 within each setting before a PAC PPS is implemented,
13 earlier this year the Commission recommended blending PAC
14 PPS payments with setting-specific payments.
15 Our initial work on the unified PPS considered
16 each stay as independent, yet about one-third of PAC stays
17 are part of a sequence of care, where patients transition
18 from one setting to another or extend their care. A stay-
19 based payment system encourages stays and discourages
20 providers from offering a continuum of care.
21 In this diagram, a stay-based PPS is illustrated
22 in the first row, with the two stays in blue and green

1 boxes. Two separate payments would be made. In an
2 episode-based PPS, illustrated in the second row, a single
3 payment would be made for both stays in the episode of PAC
4 care. Note that the episode would only include post-acute
5 care, and other services, like hospital or physician
6 services, would not be included in the bundle.
7 There are three advantages to an episode-based
8 PPS. First, it would encourage a more efficient mix of PAC
9 and encourage institutional PAC providers to offer a
10 continuum of care. This would benefit beneficiaries by
11 reducing the number of transitions a patient may experience
12 over the course of care. Such transitions are often
13 disruptive for beneficiaries and, in addition, put them at
14 risk for poor handoffs. Finally, a more efficient mix of
15 PAC is likely to lower program spending and could lower
16 beneficiary cost sharing.
17 To conduct the work on an episode-based PPS,
18 we'll start by updating our stay-based design using 2017
19 stays. This will give us a more recent starting point for
20 our analysis. Consistent with our work on sequential PAC
21 stays, we plan to construct episodes from individual PAC
22 stays that are within seven days of each other. We will

1 evaluate the overall accuracy of the design and its
2 accuracy by type of episode -- using the same 40 or so
3 patient groups that we've been using throughout the PAC
4 work. That way, we can compare payments under a stay-based
5 design and an episode-based design.
6 To make those comparisons, we will add up the
7 stay-based payments for individual stays encompassed by the
8 episode and compare them to the episode-based payments for
9 the same stays. Our initial analysis will focus on solo
10 and pairs of stays since they make up 85 percent of PAC
11 sequences, with the idea that if those results look
12 promising, we can expand our analysis to longer sequences.
13 Now Ledia will talk about the quality measures
14 work.
15 MS. TABOR: Thanks, Carol.
16 We'll now turn to our work developing uniform PAC
17 quality measures. The Commission contends that Medicare
18 payments should not be made without consideration of
19 quality of care delivered to beneficiaries. Medicare
20 should score a small set of population-based outcome,
21 patient experience, and value measures to compare
22 performance across populations and PAC providers.

1 Under a unified PAC PPS, distinctions between
2 settings are less important so Medicare needs unified
3 quality measures to assess provider performance.
4 The IMPACT Act of 2014 required the Secretary to
5 develop quality and cost measures that span the PAC
6 settings in several domains, for example, functional status
7 and discharge to the community.
8 Although the IMPACT Act calls for uniform
9 comparisons of quality and cost measures across PAC
10 settings, CMS has tailored many of the measures to each
11 setting, using different definitions and risk adjusters.
12 For example, to gauge readmissions that occur during PAC
13 stays, the home health and SNF measures include
14 readmissions that occur only in the first 30 days, even
15 though many home health and SNF stays last longer than 30
16 days. The IRF measure captures readmissions that occur
17 anytime during the IRF stay.
18 Over the past year and throughout this next year,
19 we continue to develop uniform measures that can be used to
20 measure quality of care across providers.
21 Consistent with our principles and our discussion
22 of the design features of a PAC PPS, the Commission

1 recommended in June 2016 that CMS should implement a
2 unified VBP program concurrently with a PAC PPS. By tying
3 a portion of payments to measures of quality and value, or
4 cost, a VBP would discourage overuse of care, stinting on
5 services, and shifting of care to other providers.
6 In order to assess quality of care in the new PAC
7 PPS and implement a VBP, we need uniform cost and quality
8 measures.
9 A PAC VBP could consider some of these uniform,
10 claims-based measures: hospital readmissions, Medicare
11 spending per beneficiary, combined admissions and
12 readmissions, and discharge to the community. Based on the
13 Commission's principles, we could score a unified patient
14 experience survey and infection rates; however, these
15 measure concepts are currently only collected by providers
16 in some PAC settings. For example, only home health
17 agencies are required to administer a CAHPS patient
18 experience survey.
19 Last April, Carol presented analysis results of
20 two uniform, risk-adjusted outcome measures: MSPB and
21 readmissions. I'm going to briefly review that work.
22 MSPB is a claims-based value measure that rewards

1 efficient, effective PAC care, which may reduce delivery
2 system fragmentation. MSPB results could also detect both
3 stinting and unwarranted use of services by identifying
4 providers with unusually low or unusually high spending.
5 The measure includes the total spending for Parts
6 A and B services during an episode of care that begins with
7 an initial PAC stay and ends 30 days after discharge.
8 We found that risk-adjusted MSPB varied
9 considerably across providers. We also found that accurate
10 risk-adjusted MSPB measures were problematic for small
11 providers, leading us to conclude that pooling of data over
12 multiple years would be one solution to help ensure
13 accurate measures.
14 Measuring a PAC provider's rates of readmission
15 to the hospital gives providers strong incentives for
16 ensuring beneficiaries receive the care they need and
17 encourages providers to coordinate with other providers.
18 Working with a contractor, we developed risk-
19 adjusted measures of both all-cause and potentially
20 preventable readmissions during the stay and in the 30 days
21 after discharge. Rates of readmissions during the PAC stay
22 gauge the quality of care furnished during the

1 beneficiary's entire stay, while the rates of readmissions
2 during the 30 days after discharge detect premature
3 discharges and gauge how well the provider managed the
4 transition to the next setting or home.
5 While uniformly defined, these measures have two
6 shortcomings. First, the readmission measure does not
7 consider hospital admissions for beneficiaries admitted to
8 PAC from the community. This constraint effectively
9 excludes about two-thirds of home health stays from the
10 measure calculation. Second, we do not consider
11 readmissions from LTCHs because there is no claim to detect
12 short hospital stays.
13 Overall, we found that the risk-adjusted rates of
14 readmission varied widely across all PAC providers.
15 This year we plan to develop a combined measure
16 of admissions and readmissions. Unlike the readmissions
17 measure, this measure will include admissions to hospitals
18 for both community and inpatient admitted beneficiaries.
19 We are also addressing the second shortcoming of
20 the readmissions measure by including LTCHs in the measure
21 calculation. However, because we will not be able to
22 detect admissions and readmissions to acute hospitals for

1 short stays, which are three days or less, the during-stay
2 rates will be understated.
3 Because observation stays have become more
4 prevalent and longer in duration, we also plan to include
5 them in our definition of admissions and readmissions
6 because from the patient's perspective the observation stay
7 may appear identical to an inpatient stay.
8 Building off our previous readmissions measure,
9 we will work with our contractors to identify planned and
10 potentially avoidable hospitalizations, then develop a
11 uniform risk adjustment methodology using readily available
12 information from claims. The risk adjustment model will
13 consider factors included in the Commission's previous PAC
14 readmissions measure work and CMS' readmission measures.
15 In the spring, we plan to present multiple years
16 of rates of both all-cause and potentially preventable
17 measures within stay and 30 days after in the four PAC
18 settings.
19 Discharge to home, when appropriate, is the
20 primary goal for the majority of patients in post-acute
21 care settings, making it a priority for quality measure
22 development.

1 The discharge-to-community measure gauges how
2 successfully PAC providers discharge beneficiaries home
3 with no unplanned readmissions or death within 31 days
4 following discharge.
5 As part of the IMPACT Act, CMS did develop
6 discharge-to-community measures, but the setting-specific
7 variables included in the risk adjustment models make it
8 difficult to compare the measures across providers in
9 different settings and undermine their inclusion in a
10 unified PAC PPS.
11 Therefore, we plan to create a uniform measure
12 definition and risk adjustment model and calculate results
13 using multiple years of fee-for-service data.
14 In the spring, we plan to report results of the
15 episode-based PAC PPS design and development of two uniform
16 outcome measures. In the future, if the Commission would
17 like, we could select from these measures to model the
18 potential PAC VBP.
19 After answering any clarifying questions, we
20 would like your feedback on our work plan.
21 Thank you, and we look forward to the discussion.
22 DR. CROSSON: Thank you, Ledia, Carol. We'll now

1 be open for clarifying questions.

2 [Pause.]

3 DR. CROSSON: Every once in a while, we see a

4 presentation that is so direct and clear that no one has

5 any questions. Bruce has one.

6 MR. PYENSON: There was mention in the material

7 of the potential for high expense or low expense within a

8 PAC setting so that -- because PAC providers can choose who

9 they decide to treat or not, whether there is a risk of PAC

10 providers avoiding the more expensive cases or

11 inappropriately admitting less expensive cases. And you

12 mentioned in the writeup that there are ways to detect that

13 based on looking at the cost versus the risk. I wonder if

14 you could elaborate on that.

15 DR. CARTER: Sure. So in any prospective payment

16 system, because you're paid an average -- the average is

17 set for a group of patients, a provider would have an

18 incentive to avoid what will look like expensive patients.

19 And particularly in PAC settings, since they're not subject

20 to EMTALA rules, you can select who you admit.

21 So one of the things we've tried to do in the PAC

22 PPS design work is to include indicators in the risk

1 adjustment that signal the things that would make a patient
2 expensive, so things like ventilator care, tracheostomy
3 care, severe wound care, patients who have five or more
4 conditions, things that indicate this patient is going to
5 be above average in costs. So that's sort of on the design
6 side, and even if you didn't go with a regression model,
7 you could establish case mix groups that make groups for
8 those -- groups of patients that are expected to be high
9 cost. And I think it's important to say that you wouldn't
10 want to rely on a high-cost outlier policy to compensate
11 providers for groups of patients who are systematically
12 going to be high cost. Outliers are supposed to be for the
13 random events, not the predictable ones. And so we need to
14 not rely on an outlier policy for unusually high cost.
15 And then in the monitoring phase, we've been
16 clear about sort of the kinds of things that CMS needs to
17 monitor, and I think some high-level analysis of high-cost
18 patients would be relatively straightforward to do and
19 important to do. It's important for CMS to identify
20 providers that are under- and overserving and also
21 systematically selecting. And I think that in the
22 monitoring and doing kind of large-scale data analysis,

1 some of that would be pretty straightforward.
2 MR. PYENSON: I have another question. In your
3 material on quality, there is a brief mention of mortality
4 as a potential quality measure. Of course, as an actuary,
5 I think mortality is well defined usually. But you suggest
6 that mortality is very variable, and I'm wondering if
7 there's the potential to either use risk adjustment or
8 multiple years of data or some form of collective
9 assessment of groups of small providers to achieve a
10 quality metric tied to mortality.
11 MS. TABOR: Yes, I would open that up for the
12 Commission's discussion, if that's a measure that should be
13 included in the PAC VBP. And I do agree that we could pool
14 multiple years of data to increase the potential accuracy
15 of a mortality measure.
16 I will also say one thing I like about the
17 discharge-to-community measure is that it is both a measure
18 of mortality and readmissions, so it does take away some of
19 the potential small numbers issues as well as also capture
20 the ability to keep people alive.
21 MR. PYENSON: How does it capture the mortality
22 measure?

1 MS. TABOR: So the discharge-to-community measure
2 is a measure of how many patients go home after a PAC stay
3 and stay alive and are not readmitted to the hospital for
4 30 to 31 days afterwards.
5 DR. CROSSON: Yes. Kathy, John, and Pat.
6 MS. BUTO: So I love the continuation of this
7 work.
8 I am wondering whether you're thinking about, as
9 you create an episode payment, keeping that budget-neutral
10 to the two states; in other words, really not assuming any
11 cost related or cost savings related to the combination.
12 And then my second thought was episodes get to be
13 large enough that the reason for the second stay might be
14 very different from one patient to the other, and I
15 wondered whether the episode is, in a sense, too broad or
16 needs to be adjusted in some other way or whether you're
17 going to look at that.
18 DR. CARTER: So we had thought that we would use
19 the PAC stays within seven days, so that kind of constrains
20 how far -- well, that's not really true. For some of the
21 home health stays, they're going to be 60 days plus another
22 60 days. But we are trying to limit the gap, so that helps

1 a little bit.

2 In terms of -- what was the other part of your

3 question?

4 MS. BUTO: Budget neutral.

5 DR. CARTER: Oh, yeah. We'll certainly do that

6 budget neutral. I guess the question would be would we

7 take into account the standing recommendation of the

8 Commission to lower payments by 5 percent.

9 Jim is nodding his head yes; we will do that.

10 And we also probably will think about modeling.

11 In the work that we issued in July, we looked at the

12 alignment of costs and payments for subsequent home health

13 stays and noticed that the later home health stays were

14 considerably overpaid compared to their cost. And so we

15 would probably discount those, just like in the home health

16 PPS that's now in place.

17 So we will probably have a discount factor that

18 reflects current policy, and we'll look at the data. I was

19 looking at it yesterday to sort of see the size that we

20 might think about. But we will think about trying to

21 incorporate work that we've already presented in terms of

22 budget neutrality and the discount on that, and we'll put

1 in place both the outlier policies.

2 DR. CROSSON: Jon.

3 DR. CHRISTIANSON: So on the discharge to
4 community measure, which you sometimes call "discharge to
5 home," would that require some kind of data collection from
6 a discharge planner to determine whether there is a home-
7 to-discharge too or what the situation is in the community
8 that would impede discharge to the community and penalize
9 unfairly the PAC providers who are not doing that?

10 MS. TABOR: It is a claims-based measure, so it's
11 using discharge codes that are set up to be discharge to
12 home or discharge to other PAC providers or discharge to
13 intermediate care facilities.

14 DR. CHRISTIANSON: So there is no attempt to
15 account for a variation in terms of people's individual
16 circumstances, whether they have a home or a community-
17 based place to be discharged to?

18 MS. TABOR: There is not. There's risk
19 adjustment built into the measure, but it's the typical
20 risk adjustment of age and severity of illness.

21 DR. CROSSON: Pat.

22 MS. WANG: My question is actually a little bit

1 related I think to what Jon was asking.

2 For the readmissions measure, the discharge to

3 home -- and I have another question about that. What are

4 your thoughts about adjusting for what we have come to call

5 "SES factors"?

6 In the hospital setting, you did such good work

7 to develop this sort of peer-grouping approach because you

8 could kind of come up with an apples-to-apples comparison

9 of differences in hospital payer mix and proportion of low-

10 income patients, and frankly, what goes on inside of an

11 acute care hospital is more similar to what goes on in

12 another acute care hospital.

13 Here, you have different types of providers.

14 Some are institutional care; some are sporadic home-based

15 visit care. I suspect that the payer mix among these

16 provider type is going to differ from each other. What are

17 your thoughts about that? Because when it comes to -- you

18 know, readmissions are potentially preventable. It seems

19 like there needs to be some recognition of difference in

20 provider type or provider service, home health versus IRF

21 and some kind of SES recognition.

22 MS. TABOR: Right. So I'll answer the social

1 risk factor question first.

2 Consistent with the measures that we calculated

3 for the hospital value incentive program, we did not adjust

4 for social risk factors. But we do plan on a potential PAC

5 VBP to use some kind of peer grouping so that providers

6 would be compared to providers that serve similar

7 populations, so it's just consistent with kind of the work

8 Commission has been doing in our principles.

9 And the second question about looking at

10 differences between settings, I think that's part of the

11 analysis that we're going to do this year is really see how

12 are the readmissions -- well, not so much readmissions, but

13 the discharge to community and the admissions and plus

14 readmissions measures or difference across settings and

15 even looking at not-for-profit versus for-provide. So I'd

16 say we'll come back to you on that question.

17 MS. WANG: I have a second question on that.

18 I am glad you are going to look at this. I

19 suspect it will be good to see how you even determine type

20 of patient because there's no DSH fact. There's no -- I

21 don't know what metric you use that would be consistent

22 across all of these provider types.

1 I do have concerns about the home health type of
2 visit too. It starts to feel a little bit more attenuated
3 when you move from IRF to home health in terms of the
4 provider's responsibility to prevent admissions. So we'll
5 look forward to more on that.
6 On the discharge to home or discharge to
7 community measure, are you planning to account for the fact
8 that sometimes discharge to community is not purely like
9 the value in and of itself because sometimes a safe
10 discharge might mean a discharge to permanent placement in
11 a nursing home, for example? How are you going to --
12 MS. TABOR: So the way that the -- since we are
13 using a claims-based measure, the way that the discharge
14 codes are set up now is that we'll include beneficiaries
15 who are discharged home or to a non-state-accredited -- or
16 state-assisted living facility. But if you go to an
17 assisted living facility that is also kind of an
18 intermediate care facility, that does not count as going
19 home.
20 Does that answer your question?
21 MS. WANG: If someone determines that the patient
22 cannot live safely at home, even with 24/7 anything, and

1 the discharge is to permanent placement in a nursing
2 facility, that's considered home?
3 MS. TABOR: It is not considered home, so they
4 are not counted in the measure.
5 So we're really only looking at beneficiaries who
6 are seen fit to go home, who are discharged to home and
7 looking at, for those beneficiaries that did go home, how
8 many did not pass away or did not go back to the hospital
9 for 30 days.
10 MS. WANG: Thank you.
11 DR. CROSSON: Dana.
12 DR. SAFRAN: Thanks, Jay. Sorry for my lateness.
13 So I like where you're going here so much. I
14 think this is really exciting and really will complement
15 the episode payment work.
16 The measurement question I have is on page 10,
17 you talk about functional status measures -- Slide 10, I
18 should say, talked about functional status, which I think
19 is a really important piece of what we'd want to see
20 included here. And I didn't see any specifics on how you
21 might do that.
22 I wondered whether you've considered the measure

1 that has been in Medicare Advantage, the Health Outcomes
2 Survey, which scores the SF-36 or 12 -- I forget which --
3 into its physical component summary and mental component
4 summary.
5 It's something worth considering. I know that it
6 hasn't been a huge success in the plan world because it
7 doesn't really differentiate, but I think in this
8 population, you could see it differentiate.
9 So I was just curious what your thoughts are
10 specifically about functional status and whether that's one
11 that you've thought about.
12 MS. TABOR: Thanks for teeing up Carol's and my
13 November presentation because we're coming back in November
14 to talk about some analysis that we plan to do on the
15 functional data that's been coming out of the PAC setting,
16 and we do also talk a bit about the patient-reported
17 outcomes and that potential, so stay tuned.
18 DR. CROSSON: Yes, Jon.
19 DR. PERLIN: Actually a very similar question. I
20 was thinking about both the SF-12 and 36. I might comment
21 to you the work of Lewis Kazis with respect to VA because
22 one of the problems with such a potentially debilitated

1 population is floor and ceiling effects on the sort of
2 broad population, SF-12 and 36 and other indicators of
3 functional status. There's some permutations that are
4 adjusted for populations that have very impaired function.
5 DR. CARTER: Thanks.
6 DR. PERLIN: Thanks.
7 DR. CROSSON: Warner.
8 MR. THOMAS: Did you guys see any utilization
9 where there is essentially all of these services used by
10 similar patients or many of them? I'm sure you did.
11 I think the comment I bring up is -- where do you
12 see as you go to more of a unified system? Which services
13 do you think would be most likely impacted?
14 I think about avoidance of service when I kind of
15 think about this, that there's probably duplication between
16 the types of services. So I think about some will be
17 avoided.
18 I guess just as a comment, it seems like probably
19 this will put more pressure on home health over time
20 because my guess is we'll be discharging a more acute
21 patient home -- would be my guess because there's going to
22 be more pressure to shorten the stay. So any thoughts on

1 that?

2 DR. CARTER: So I think just the results that

3 we've seen from alternative payment models shows that home

4 health is being used more often. When patients can go

5 home, I think you were seeing that that setting is used

6 more, and SNF stays are definitely shorter.

7 So I think that that's sort of the broad backdrop

8 of sort of what's going on in the hospital space that is

9 shaping the use of PAC providers.

10 In a PAC PPS design, the most common episodes are

11 ones and twos, and the twos are mostly home health and SNF

12 going to home health. So if a design to pay for an entire

13 episode may shorten home health stays, if you're being paid

14 for an entire episode, is probably the most likely

15 pressure, just looking at what are the most frequent types

16 of episodes.

17 Does that help?

18 MR. THOMAS: Yeah. It just strikes me that the

19 typical LTCH stay, unless someone is on a vent, is going to

20 basically transition into one of the other historical

21 disciplines, if you will.

22 DR. CARTER: Right.

1 MR. THOMAS: So that you'd see -- once again,
2 you'd have folks that are on a vent that are going to be
3 one type of comprehensive patient, and others are probably
4 going to kind of slide into rehab or SNF, which will be a
5 more comprehensive patient.
6 Given that this is a case rate, you then are
7 going to probably see people move to a home care situation
8 that on the front end is going to be much more intensive.
9 I agree with you that the back end of home health stays
10 will probably be less intensive.
11 I mean, number one, I'm a huge fan of this model.
12 I think it makes a lot of sense. I was just trying to
13 think. What we've seen is just more elimination of certain
14 types of post-acute care and then higher usage of others.
15 It may just be something that you're looking at that as you
16 go through the model, but I was just trying to understand
17 what your view is of how that shift is taking place.
18 DR. CARTER: I mean, we are hoping that
19 institutional PAC providers -- if you set the rates so that
20 they're adequate, there may be more institutional providers
21 than the current LTCH folks that are treating the very high
22 end.

1 We're already seeing some SNFs are in that space
2 -- not most. But if you're paying fairly for taking trach
3 cases, you might have more providers offering that service
4 and then continuing to care for them through the weaning
5 and less intensive care.
6 I would hope that there would be fewer
7 transitions for patients because they really are disruptive
8 for patients and their families. So if one of the outcomes
9 of this could be just fewer handoffs between institutional
10 providers, I would think that's great.
11 MR. THOMAS: Yeah. Okay.
12 DR. CROSSON: Okay. Thank you.
13 We are going to proceed now with the discussion
14 period.
15 We have a request on the last slide there to
16 provide feedback. There's already been some to Carol and
17 Ledia about the work plan.
18 So I think, Brian, we are going to begin with
19 you.
20 DR. DeBUSK: Well, first of all, thank you for a
21 very exciting chapter. Obviously, this is great work, and
22 it's really great to see it keep appearing in front of us.

1 So I'm glad to know you are going to be back in November.
2 There's some obvious reasons that this work is
3 important and that we should continue to pursue it. We are
4 dealing with a $60 billion spend area that clearly has
5 payment equity issues, misaligned incentives, and obviously
6 inconsistent quality measures.
7 But I want to point out -- and to make a larger
8 point, I want to point out the importance to me of the
9 nontraditional approach that we've taken here by trying to
10 cross all four venues with a unified payment model as
11 opposed to more of a traditional site-neutral mentality.
12 You guys are doing something that is inherently site-
13 neutral as opposed to transactional.
14 It's also exciting to see how this -- and I think
15 Warner touched on this -- how it's going to really realign
16 the industry.
17 Carol, I loved your point about the fact that if
18 nothing comes out of this, but there's just less shifting
19 of patients and more treatment in place, I think that's
20 going to be a wonderful benefit to this.
21 Then my final point, sort of the larger
22 perspective, it's also nice to see us work, try to solve

1 these kinds of problems in a $60 billion payment area,
2 knowing that it's really a microcosm to the $600 billion
3 issue, because I think a lot of the issues that we're
4 addressing here, like being able to cross venues, payments
5 that are inherently site-neutral instead of being forced to
6 be site-neutral, and then this episodic thinking.
7 I like in the chapter how you started to
8 speculate a little bit on who is going to manage that
9 bundle. Is it a convener? Is it a hospital? Is it a
10 group of physicians? I think those are all issues that
11 don't just appear at the $60 billion level, but again
12 appear at the $600 billion level.
13 Now, the specifics of this chapter, I'm really,
14 really excited to see us working on episodes. I'm also
15 really excited to see that you went with the 85 percent of
16 the episodes that were one or two stays. Instead of trying
17 to boil the ocean and fit all of these complex post-op care
18 patterns, I think it's great that you went after that 85
19 percent.
20 I also think that -- even if when you do this
21 initial analysis, even if it's not quite not as accurate or
22 even if maybe we could cobble some stays together and get a

1 better fit, I hope we won't blink, and I hope we'll stay in
2 the episode world because I think the learning and the
3 experience that we're going to get from this, not only over
4 time will it get better, I think, but it will also again
5 help us address the larger Medicare issue.
6 The other reason I really like the episode
7 approach is the moment that we start, if we did retreat
8 back the stays, we're going to be right back to, well, how
9 do you deal with serial stays, how do you deal with -- I
10 mean, we'd be trading one problem for another, and I'd much
11 rather be working on a problem that's part of our future
12 instead of a problem that's part of our past.
13 The other thing that was great to see, you talked
14 about the unified value, value-based purchasing program. I
15 mean, this idea of having -- I loved that in the chapter,
16 this idea of having domains that when possible will cross
17 venues, but when they're not possible -- for example, I
18 really like the MSPB PAC measure. I hope it pans out
19 because that's a good example where even in the hospital
20 value-based program, the one we proposed last month, it has
21 MSPB in it, and even if MSPB and MSPB PAC are two different
22 values, at least they're methodologically consistent.

1 So it's almost like I'd rather have the same
2 domain transcend the venue and then something that's at
3 least methodologically consistent and then again accept the
4 fact that there are just some domains that are only going
5 to work within specific payment models. I don't think we
6 should be held hostage to the idea that we have to reuse
7 all those domains.
8 I really, really like the peer-grouping approach
9 and again the fact that we're going to be consistent with
10 the proposed hospital program.
11 I know I've mentioned this before to some of the
12 staff. I hope we will explore peer grouping first, that
13 we'll peer group first and then regress within each peer
14 group to do the risk adjustment.
15 And long story short there, I mean, it is
16 reasonable to assume that the underlying sensitivities --
17 let's say, of age or gender or race -- it's reasonable to
18 assume that those underlying sensitivities are a function
19 of SES. So the thought of maybe doing the peer grouping
20 first, doing the regression, I just wanted to plant that
21 bug.
22 Now, as far as the specific measures, again, I've

1 already mentioned MSPB PAC. I hope it pans out. This
2 combined admission and readmission measure, I think there's
3 some real novelty there. I like the way you're trying to
4 work around some of the limitations of the data that we
5 have. So, again, I look forward to seeing if that one
6 works out. Then, obviously, I think discharge to community
7 is a great measure too.
8 I think we're on the right track of finding the
9 right domains, putting them in the right place, and again,
10 it's just very exciting work. And I look forward to seeing
11 you in November.
12 DR. CROSSON: Thank you, Brian.
13 Additional discussants? I see Bruce, Kathy,
14 Warner, Jon, and Pat. Bruce.
15 MR. PYENSON: Well, thank you very much for a
16 terrific chapter. Last year the Commission endorsed a plan
17 to replace MIPS with a system that evaluated groups of
18 physicians based on their quality and outcomes. And part
19 of the thinking of that was that it was important to have
20 groups of physicians rather than individual physicians to
21 have the credibility for measurement but also that the
22 system measures and quality measures are more meaningful

1 and also promote efficiency on a collective basis rather
2 than an individual physician basis. So that happened last
3 year. I think we're heading in a similar direction with --
4 or similar issues with post-acute providers because many of
5 them are relatively small, and there's a lot of them.
6 So as a follow-up to Brian's comments, I think
7 we're inviting ourselves through the quality metrics to
8 look at some form of group measure by clustering individual
9 providers perhaps on a voluntary or perhaps on a regional
10 basis when they're small. And if we think about that by
11 analogy to our proposal to replace MIPS, I think we can
12 come up with useful measures that will be credible because
13 of the larger scale. I had mentioned mortality, but I
14 think it would also bolster some of the measures that you
15 had performed. So I'm not suggesting that as part of the
16 agenda for November, but I think it's something I'd like to
17 see us keep in mind as we move ahead on this.
18 DR. CROSSON: Thank you, Bruce. Kathy.
19 MS. BUTO: Yeah, I want to support the direction
20 we're going both on episode-based payment and quality in
21 this area. You know, I especially like the fact that I
22 think the episode-based payment has a lot of potential for

1 bringing home health closer into the overall PAC system.
2 Although we keep talking about a unified PAC, really it
3 feels like it is always a little bit outside, it's
4 different than institutional post-acute care. And this
5 really brings it together where there are two sequential
6 episodes.

7 When I first read the paper, I thought you were
8 only talking about rationalizing single institutional
9 sequential PAC stays, but you're not, as I understand it.
10 So I think that's really good.

11 The one thing I wanted to mention -- and this is
12 down the road -- is as we develop this approach, I think
13 there's a good chance it's going to lead to a lot greater
14 consolidation of providers. And that may be a good thing.
15 We may think that will enhance care coordination. It could
16 be a bad thing depending on how much consolidation happens
17 and whether it eliminates more community-based options for
18 beneficiaries. So just something for us to keep in mind.
19 I don't know where we'd come out on it, but I think we
20 ought to just be aware of it.

21 DR. CROSSON: Thank you, Kathy. Warner.

22 MR. THOMAS: So I agree, I think this is great

1 work. As I've said, I think going to a unified model in
2 post-acute makes a lot of sense.
3 Just as I was reading the chapter and thinking
4 more about -- and we build the model facility that kind of
5 is configured this way with all of the post-acute areas in
6 one location. Some things to maybe think about.
7 One, I think you have to make sure you have the
8 right incentives for organizations in the SNF world to try
9 to upscale to want to take a more complex patient. So as
10 you think about the reimbursement, you want to make sure
11 it's attractive there. Likewise, you want to make sure
12 LTCHs will downscale, right? That they'll take, you know,
13 patients that are of less acuity. So as you think about
14 the methodology, I would think about how those
15 organizations may look at it, because they're going to have
16 to evolve and change and think about what that economic
17 model might look like for them.
18 The other thing to perhaps think about is, to
19 build this off of -- you know, I know we use the efficient
20 provider model and inpatient hospital. I don't know how
21 that could be applicable here, because I know there's a
22 wide variety of -- especially in home health, there's a

1 wide variety of performance. And so thinking about what
2 the efficient provider might look like, it just may be
3 something to think about as you try to model this, you
4 know, which ones do you use the model in, maybe not
5 building it off the outliers, building off the ones that
6 are higher performing.
7 The one area I get concerned about is really in
8 home health because I really do think that they're going to
9 see much more acute patients, especially on the front end.
10 And they're going to need to have a different capability to
11 deal with that. So I would just continue to challenge you
12 to think about how you engage those folks to understand
13 what that would look like. And I understand there's a tail
14 on those stays, and there's a lot of stays at the --
15 there's organizations that have long home health stays that
16 we know at the end there's not a lot of costs associated
17 with that. But I think this is going to be a very
18 different patient that they're going to see on the front
19 end, so it's just something to think about.
20 And then the last comment -- I don't know if this
21 goes in this chapter, Jay, or not, but it would just be
22 what could we do in the interim? You know, because this is

1 still going to take a while. And I just think if we could
2 reduce some of the regulatory issues around which component
3 of post-acute you use, there's just so many challenging
4 regulations around that. There's been some relaxation of
5 that under the ACO model. But I also think it may give us
6 a time period to learn more as we go to this unified post-
7 acute, and it would be nice to see more flexibility in what
8 post-acute model you use on an interim basis.
9 And, finally, for skilled nursing, the reason we
10 don't see a lot of skilled nursing is because the
11 reimbursement is challenging for skilled nursing. And I
12 think on those lower-acuity stays you're going to have to
13 look at making sure that you've got the right economic
14 model there, because that's why we don't have as many
15 skilled nursing beds. The economic model doesn't work.
16 And I just think you need to think about those lower-acuity
17 stays, making sure that you've got the right reimbursement
18 mechanism there to make sure that you don't have all the
19 post-acute providers just trying to go for the higher-
20 acuity patient and then a lower-acuity patient is a
21 challenge or gets pushed into home care. So that would
22 just be something for you to think about as you continue to

1 look at this.

2 DR. CROSSON: Thank you, Warner. Jon.

3 DR. CHRISTIANSON: I also like the direction that
4 you're going with all of this, and I look forward to the
5 next presentation.

6 I want to come back to a comment I made earlier
7 with respect to the discharge to home. That sounds like a
8 nice, warm, fuzzy concept, and I agree, for most
9 beneficiaries that would be a desirable goal, but not for
10 all. I think there are beneficiaries who would actually be
11 hurt by being discharged to the community when the
12 community doesn't provide them with a home, with a place to
13 live, with a place to get better. And it's probably the
14 case more likely for lower-income beneficiaries.

15 So I would like you to keep thinking about that
16 measure and to be thinking about whether there's a way of
17 differentiating situations where discharging to the home is
18 a feasible and desirable thing versus discharging to the
19 home or community is bad for the beneficiary, because the
20 incentives will be for providers to get them out of the
21 system and into something but not -- unless we worry about
22 what something is, that's a pretty strong -- that's a

1 pretty strong incentive with a potentially undesirable
2 outcome for at least some of our beneficiaries. So I'd
3 just like you to keep thinking about that issue.
4 DR. CROSSON: Okay. I've got Pat, Jonathan, and
5 Dana.
6 MS. WANG: I very much support the direction of
7 the work, especially on the development of payment
8 episodes. I think I understand that a little bit better.
9 On the quality metrics, I have -- you know, I
10 raised the questions before in my comments, or along those
11 lines. I share the same concern that Jon just articulated
12 and that I alluded to before. Sometimes it's a little bit
13 too black and white to say discharge to community is like
14 the best thing. I think about it is as safe discharge.
15 Safe discharge might mean there's no supports at home. You
16 know, when you get to that stage, it's -- different states
17 vary. For example, if it's a dual, there might be personal
18 care available through the Medicaid program. There might
19 be family support for some people and not others. But you
20 can't count on that, and I think it's important to somehow
21 recognize in this measure whether it's through -- I don't
22 think it's an SES adjustment per se. I think, again, to me

1 it's a little bit more of a safe discharge with a bias
2 towards community, but not sort of like if it doesn't
3 happen that that's a bad thing. Sometimes people really
4 should not stay home or go home because there's nobody to
5 take care of them, and at that point I think the PAC
6 provider, really there's not much that they can do. So I
7 look forward to hearing more details about that in November
8 because you explained it, Ledia, but I'm not sure I got
9 what's in and out of that measure. But I would ask you to
10 kind of think about these other factors as well.
11 And then just in general --
12 MS. TABOR: Can I just clarify one thing? In
13 November, we're coming back on the functional status topic
14 only. In the spring, we'll come back to you on this
15 measure.
16 MS. WANG: Okay, thank you. But the more you can
17 explain about what's in the measure and, if you can, think
18 about the comments that have been raised particularly the
19 situation of the individual beneficiary and what's
20 available to them in the community, that would be great.
21 And then the other comment is just to reiterate
22 the questions that I had before about the importance of

1 some kind of recognition or adjustment for socioeconomic
2 status in the evaluation of readmissions, you know,
3 avoidable readmissions and all-cause readmissions.
4 Thanks.
5 DR. CROSSON: Jonathan.
6 DR. JAFFERY: Thank you. I'm also generally
7 supportive of the direction, both from the unified payment
8 system and the quality metrics. I just wanted to comment
9 on one thing that I didn't hear much about in the
10 presentation today but I saw in the report around how the
11 payment would get distributed. Brian touched on this, but
12 it seems to me from some experiences we've had with some of
13 the other -- trying to work with bundled payments and
14 episodic payments with commercial payers, the notion of
15 taking in a lump sum up front and then distributing it,
16 creating the infrastructure for that is a pretty heavy lift
17 for organizations that don't have those capabilities. And
18 so I just want you to consider that as you think about --
19 you came up with a couple other different ideas at a very
20 high level of the report around how do you apportion it or,
21 you know, there may be some opportunity to look at some
22 other -- CMS' other episodic payments in terms of

1 retrospective reconciliation, creating the infrastructure -
2 - I would hate to see added administrative complexity and
3 costs go into this because organizations need to create
4 that infrastructure.
5 DR. CROSSON: Dana.
6 DR. SAFRAN: Thanks. I have just a couple things
7 to add, just very supportive of this direction. One
8 comment that I don't think has been mentioned but is an
9 important feature of this that I really like is that I've
10 seen in our -- I think it will give lift to the work on
11 ACOs. And I say that based on my experience in our market,
12 commercial, and knowing how it's even more important for
13 Medicare ACOs to address post-acute care and how much I've
14 seen our ACO providers grappling for a way to have metrics
15 on which they can evaluate who their best post-acute care
16 partners are. And there's very little right now.
17 So I think that by creating accountability on a
18 post-acute care side that mirrors what we're asking in an
19 even broader way for ACOs to take care of is really going
20 to give lift to those efforts. And, you know, as you note
21 in the chapter and as we've talked about a little bit this
22 morning, quality measurement in post-acute care is really,

1 really lagging. So I think that's another value of this
2 work, is pushing it forward. I think, you know, some of
3 the challenges of defining a readmission measure, Pat has
4 pointed to, but overcoming those challenges will be, again,
5 really helpful where we're holding the hospital accountable
6 for that, and for them to know that their post-acute care
7 partners are also accountable for that is just, you know,
8 getting everyone rowing in the same direction.
9 The final thing on that, I already expressed in
10 Round 1 my enthusiasm for the functional status measures,
11 and I think that could be particularly important. Jon's
12 comments made me think about how the time frame we put
13 around accountability for functional outcomes is going to
14 be important, whether it extends beyond the post-acute
15 stay, for example. But it did make me wonder whether we
16 need to consider having a parallel measure on the hospital
17 side, because we don't have that parallelism right now. So
18 it's just something to think about.
19 DR. CROSSON: Jon.
20 DR. PERLIN: Thanks. Let me add my general
21 support for this work and the terrific presentation of it.
22 You know, one of the issues with the functional status

1 measure or, frankly, the concerns expressed in this chapter
2 as well is that there are incentives to particularly
3 represent the patient, the particular level of complexity.
4 Actually, if the functional status were required in the
5 acute environment, not the post-acute environment, then it
6 would be deconflicted from the potential incentives.
7 Putting that aside, though, you know, I want to
8 identify with Warner's point that however long it takes to
9 implement this, we have the here and now, and there are
10 some things we can do in the here and now. And, you know,
11 it stuns me that discharges in the post-acute environments
12 are so biased toward a higher level of care than necessary,
13 the data would show that. And that is not motivated -- or
14 let me rephrase that. It may be motivated by a desire to
15 protect the patient's interests, some of the constraints to
16 the most rational discharge possible.
17 I would just note two of the limitations. First,
18 you know, some of the Stark anticompetitive, anti-kickback
19 issues make it difficult to discharge to a facility that
20 you know actually has lower rates of infection per se, some
21 of the discussions around, you know, what would be the best
22 facility for a patient to go to are constrained by some of

1 this regulatory -- regulation and statute. I know it
2 exists. I know in the ACO context, you know, you have
3 relief and bundles. You have relief around that. But just
4 look at the difference between the ACO bundles and the more
5 traditional mechanisms, and you'll see how much of an
6 influence that has even with the ability to look at star
7 ratings as an example, which don't necessarily recover
8 specific rates of readmission or infection rates at a
9 particular facility, things that are known.
10 So the concrete suggestion would be actually
11 regulatory relief that allows providers to discuss the
12 known complications of an institution, whether from public
13 data or their own data, on readmission and infection rates.
14 I suspect you could actually channel patients to more
15 appropriate levels of care as well as reduce rates of
16 readmission.
17 Maybe just as an asterisk to that, the other is
18 that, you know, I agree that home health will be seeing
19 increased levels of acuity. That said, because of the
20 history of home health, it's ironically the most difficult
21 of the post-acute settings oftentimes to get a patient into
22 when it may, in fact, be the most appropriate.

1 Thanks.

2 DR. CROSSON: Yes, Kathy, on that.

3 MS. BUTO: I just wanted to ask Jon about the
4 Stark rule. Is it the ownership and affiliation rules of
5 Stark that you are talking about? What is it that is
6 confounding this more efficient use?

7 DR. PERLIN: Yeah, sometimes there may be,
8 particularly with large consolidated physician groups,
9 there may be their individual physicians who are also
10 medical directors at a particular skilled nursing facility
11 or elsewhere, or they may be members of the same group. If
12 that group is virtually all the physicians, you know, in
13 primary care or geriatrics or whatever in town, then it
14 just precludes what is necessary, outside of an ACO bundled
15 type arrangement.

16 MS. BUTO: I was just going to add that is a
17 regulatory requirement that should be looked at, because it
18 also confounds the issue of continuity of care and some
19 other things. So, really, I think that's a good point.

20 DR. CROSSON: Okay, so remind me. I think we've
21 recently discussed this issue, right? And, in addition,
22 isn't there a proscription on discharge planners directing

1 patients? Am I missing something?

2 MS. BUTO: I don't remember talking about it in

3 the context of post-acute care, except for discharge

4 planners. Did we do that?

5 DR. MATHEWS: We did it last spring, I believe it

6 was. We had a session on --

7 MS. BUTO: [Comment off microphone.]

8 DR. MATHEWS: Correct, allowing hospitals to use

9 quality information to be more directive about where a

10 patient might go for their post-acute care. And we did not

11 come to a clear consensus on whether or not that was an

12 advisable thing to do. So the discussion is out there, but

13 no Commission position.

14 MS. BUTO: I think Jon is going a step further,

15 which is actually where that patient actually can go given

16 issues of ownership and financial investment.

17 DR. CROSSON: Yeah, these are separate but

18 related issues, both constraining that freedom of

19 direction.

20 Brian?

21 DR. DeBUSK: Well, on this, I do think one of the

22 issues that will come up is how do we qualify -- for

1 example, anti-kickback relief, Stark relief, you know, as
2 part of modernizing that, how do we qualify who can and who
3 can't do that? And I think that's something we're going to
4 have to take up almost like in MACRA where you look at,
5 well, if a certain percentage of your revenues come from
6 these A-APMs, we're going to need some type of threshold
7 like that so that we can sort of qualify who's in and who's
8 out of being able to participate in the relaxed regulatory
9 environment.

10 DR. CROSSON: Okay, Pat and Warner, and then I
11 think we're going to have to proceed on.

12 MS. WANG: I just want to pick up on something
13 that he was saying. I'm channeling my inner IG here.
14 There's a reason that those anti-self-referral laws are in
15 place, and there are a lot of bad actors out there. I just
16 want us to be careful that in trying to do something good,
17 you know, that we do it carefully, because I think Jon's
18 point is extremely well taken, and if I were part of his
19 organization, I'd want him to be referring me directly to
20 other components of his organization or what have you. But
21 there are a lot of bad actors out there, so there's a
22 reason that these things exist.

1 DR. CROSSON: Jon, you can respond, and then
2 Warner.
3 DR. PERLIN: Quick. For the record, we don't
4 have those other parts, and so it's relationships with
5 other providers exclusively, and their observation, you
6 know, at significant scale is just how oftentimes we're
7 forced into observing because of the constraints that are
8 there, patients going to less than ideal settings with the
9 predictable readmissions or acquisition of infection, when,
10 in fact, there exists data but preclusions to actually
11 share those data.
12 I think Brian may offer a way of really thinking
13 about that where actually you can have discharge planners
14 who are, frankly, disinterested but can share those data
15 where it may actually not be a physician who's a member of
16 the same group that also covers the skilled nursing
17 facility or what have you, so that they're disinterested,
18 but simply have the data on, well, you know, we see 47
19 percent readmission from Facility A and 32 percent
20 readmission from Facility B, and, you know, I know that B
21 actually has a higher star rating -- I'm sorry, that A has
22 a higher star rating than B, which would be the discussion

1 you can have. But why would you in the face of the data of
2 the actual readmissions or the higher rates of infection
3 send a patient to that facility or be precluded from
4 discussing, you know, the actual data on the readmission?
5 So I think, Brian, you offer wise advice on a
6 means that both appreciates Pat's concerns about making
7 sure we don't fall into where we don't want to go but, in
8 fact, do allow patients the benefit of following the data.
9 DR. CROSSON: Okay. Warner, last comment.
10 MR. THOMAS: I'd just make a quick comment. I
11 would agree with Jonathan on this, and I think that,
12 although I agree with Pat as well that you can kind of go
13 overboard, I do think hospitals who have this information
14 and not being able to share it in a direct way is a real
15 challenge, and it would be nice, even though maybe we
16 weren't definitive on this when we talked about it before,
17 if we could have references in this chapter that these are
18 interim steps that could be taken, because I think it would
19 really help us get people in the right place.
20 DR. CROSSON: Okay. Good discussion. Carol and
21 Ledia, we look forward to seeing you back in November and
22 later on as well. Thanks for this continuing terrific

1 work.

2 [Pause.]

3 DR. CROSSON: We're going to proceed with our

4 final presentation for the October meeting, and that's on

5 Medicare policy issues related to urgent care and emergency

6 room use.

7 Zach and Dan are here, and it looks like, Zach,

8 you're going to begin.

9 MR. GAUMER: Yes, sir.

10 Okay. Good morning.

11 Today we dive back into the topic of emergency

12 department services.

13 Before we do, I want to thank Carolyn San Soucie

14 for all of her work on this project.

15 Last spring, you made two emergency department

16 recommendations, and in doing so, you asked for more

17 information on urgent care centers and their role in

18 providing low-acuity care, some of which is also provided

19 in hospital emergency departments.

20 You also asked us to give more thought to trends

21 in ED coding practices.

22 As a bit of context, for the first topic,

1 Commissioners expressed concern about the rapid growth in
2 Medicare ED use and wanted to ensure Medicare payment
3 policy was not encouraging this growth.
4 In response, we found that this growth
5 encompassed both emergency and non-urgent care and in part
6 may be driven by higher payment rates, relative to urgent
7 care centers.
8 For the second topic, you expressed concern about
9 the rapid growth in ED spending relative to service use and
10 the increase in the volume of claims with higher ED code
11 levels.
12 I will walk through the first topic, and Dan will
13 walk through the second.
14 Okay. So this is the first time the Commission
15 has examined urgent care centers, so I want to take a slide
16 to review some details about these facilities.
17 There are over 8,000 urgent care centers
18 operating today, and the industry is expanding. In fact,
19 the number of UCCs increased 33 percent in the last five
20 years.
21 The majority of these facilities are independent
22 of hospitals and are owned by private equity firms,

1 physician groups, or payers. The remainder of the
2 facilities are affiliated with hospitals.
3 UCCs offer patients basic medical services and
4 basic procedures. X-ray and lab services are a part of
5 their standard business model. However, they do not offer
6 higher complexity imaging and lab services.
7 UCCs, on average, serve a large share of
8 commercially insured patients and a low share of Medicare
9 patients.
10 Use of UCCs by Medicare beneficiaries is low, but
11 the growth has been rapid in this service. In 2017,
12 beneficiaries had roughly 3 million visits to UCCs, and
13 this is about 1 percent of all physician E&M claims.
14 However, from 2013 to 2017, use of these facilities for E&M
15 services increased 73 percent per beneficiary. This is
16 faster than any other type of provider for this service.
17 The most common conditions beneficiaries were
18 treated for at UCCs in 2017 included upper respiratory
19 infection, bronchitis, and other relatively low-complexity
20 conditions.
21 Medicare pays UCCs differently, depending on the
22 hospital affiliation. In general, independent UCCs receive

1 only physician payments, and hospital-affiliated UCCs
2 receive both a physician payment and a facility payment.
3 To illustrate the difference between Medicare's
4 basic payments rates to EDs and UCCs, we will compare the
5 2018 payment rates for a level 4 ED visit at a hospital ED
6 to the payment for an equivalent case at the two types of
7 UCCs.
8 On the left, you can see that a level 4 ED visit
9 generates a combined physician payment and facility payment
10 of $476.
11 By contrast, the same beneficiary treated at a
12 hospital-affiliated UCC would generate a total payment of
13 $246.
14 Then on the far right is the payment rate for the
15 same beneficiary treated at an independent UCC, which
16 generates only a physician payment of $167.
17 There are two dynamics to consider with this.
18 First, in all three settings, the beneficiaries are
19 responsible for 20 percent cost sharing, so their liability
20 is higher in the ED than in the urgent care center. And,
21 second, the dollar values on the slide reflect the
22 physician and the facility payment rates the providers

1 would receive, but it does not include the ancillary
2 services that typically occur with visits to the EDs and
3 UCCs, such as MRIs and x-rays and lab services.
4 In our mailing materials, we explained that when
5 you factor in spending on ancillary services, ED spending
6 per encounter is on average 5 to 35 times higher than at
7 UCCs. So the ancillary services tend to enhance the
8 payment differences in these two settings.
9 So I've just told you about UCCs and how Medicare
10 pays them relative to EDs. So I will now turn to our
11 comparison of hospital ED and the UCC.
12 In general, we see overlap in the types of
13 conditions treated at these two types of providers. Among
14 the 20 most common conditions provided to Medicare
15 beneficiaries at both EDs and UCCs, they had 8 conditions
16 in common and 12 that were not in common.
17 With this in mind, it was necessary to create a
18 common sample of conditions to compare these provider
19 types. To do so, we used a method developed by researchers
20 at Dartmouth to identify what they call non-urgent care.
21 As a part of this method, non-urgent care is defined as any
22 claim containing one of seven conditions as the principal

1 diagnosis. Using this method, within the 2017 physician
2 claims, we identified 15 million claims involving non-
3 urgent care. Most of these claims occurred at physician
4 offices, but a significant number occurred at EDs and UCCs.
5 Also, from 2013 to 2017, the number of claims for
6 non-urgent care per beneficiaries at UCCs increased 72
7 percent, significantly faster than at EDs.
8 In 2017, as I said, there were approximately 1.5
9 million claims at EDs involving non-urgent care, and this
10 represent 7 percent of all physician ED claims.
11 The beneficiaries receiving non-urgent care at
12 EDs in 2017 appeared more complex than beneficiaries
13 receiving non-urgent care at UCCs.
14 As you can see in the table above, for the
15 beneficiaries receiving non-urgent care, the average
16 beneficiary risk score was higher at the ED. Beneficiaries
17 treated at EDs also had a higher average number of chronic
18 conditions, and a larger share of these beneficiaries were
19 75 years or older.
20 So given the apparent higher complexity of the
21 claims for non-urgent care at EDs, it seemed reasonable
22 that only a subset of the 1.5 million claims occurring at

1 EDs might be appropriate for treatment at a UCC.

2 To specifically identify how many of these 1.5

3 million ED claims might be appropriately treated in a UCC,

4 we identified those claims for non-urgent care at EDs where

5 the beneficiary had a relatively low risk score and few

6 chronic conditions. Therefore, these were beneficiaries

7 treated at EDs that looked a lot like beneficiaries treated

8 in UCCs.

9 As a result, we identified roughly 500,000 claims

10 at EDs which may be appropriated treated at a UCC, which

11 represents 33 percent of claims for non-urgent care at EDs

12 and 2 percent of all physician ED claims.

13 Using this estimate and our estimate of the

14 average spending per non-urgent care encounter, we estimate

15 that Medicare paid between 1- and $2 billion more per year

16 because these beneficiaries were treated at a hospital ED,

17 rather than an urgent care center.

18 Commercial insurers have responded to the high

19 costs of ED services with retrospective claims audits and

20 patient education efforts. The public and the media have

21 reacted negatively to the auditing approach.

22 It is also worth mentioning that a recent study

1 using data for Aetna members found a decrease in the use of
2 EDs for non-urgent care and an increase in the use of UCCs.
3 Because Aetna was not one of the insurers to use
4 the auditing approach and because we do not think it is
5 reasonable to penalize beneficiaries when they are trying
6 to get care immediately, we suggest the Commission consider
7 a softer policy approach, softer than retrospective audits.
8 For example, the Commission might consider initiating a
9 Medicare beneficiary education campaign, expanding quality
10 measurement to include variables like avoidable or
11 preventable ED visits, or encouraging EDs to better
12 coordinate with primary care physicians.
13 So, with that, I'm going to hand this off to Dan
14 to discuss the second topic.
15 DR. ZABINSKI: Okay. When a Medicare beneficiary
16 receives care in a hospital emergency department, the
17 hospital codes the visit into one of five levels, and each
18 level reflects a different level of expected resource use
19 to treat the patient. Therefore, the payments for ED
20 visits increase with the level that's coded.
21 An odd feature of the codes for ED visits is that
22 national guidelines aren't used. Instead, CMS has directed

1 hospitals use their own internal guidelines, which gives
2 hospitals much discretion over how they code ED patients.
3 We found that the coding of ED visits has
4 steadily shifted from more levels to higher levels. In
5 this diagram, the yellow columns show that in 2005, ED
6 visits approximated a normal distribution across the five
7 levels, and CMS at that time said that this is a desirable
8 outcome because it indicates that hospitals were billing
9 the full range of codes in an appropriate manner.
10 But the red columns indicate that by 2016, ED
11 visits had become much more skewed towards the high levels
12 and the longer approximated normal distribution. For
13 example, the share of ED visits coded at level 5 increased
14 from 11 percent in 2005 to 28.3 percent in 2016.
15 This shift has important implications for the
16 Medicare program. For example, if the distribution of ED
17 visits in 2016 was approximately the same as a normal
18 distribution that they had in 2005, combined program
19 spending and beneficiary cost sharing would have been
20 nearly $1 billion lower.
21 The shift of coding ED visits from lower levels
22 to the higher levels could occur for two reasons. One is

1 that the clinical attributes of ED patients may have
2 changed. In particular, ED patients, on average, might
3 have more conditions requiring substantial hospital
4 resources, or the conditions might not have changed much,
5 but the severity of the conditions might have. The other
6 possibility is that hospitals are upcoding by coding
7 patients with similar clinical attributes to higher levels.
8 We've examined the change in conditions treated
9 in EDs and the severity of ED patients, and the results do
10 suggest that some upcoding has occurred. In particular, we
11 found that there's been little change in the conditions
12 treated in EDs, and it's unlikely that patient severity has
13 changed enough to explain the change in ED coding.
14 To examine the change in conditions treated in
15 EDs, we examined ED claims from 2011 and identified the 210
16 most frequently coded principal diagnoses. These principal
17 diagnoses were on about 75 percent of the ED claims in
18 2011. Moreover, these principal diagnoses were also on
19 about 75 percent of ED claims in 2016.
20 We found that for each of these 210 principal
21 diagnoses, the share of all ED visits that had a particular
22 diagnosis code was usually very similar in 2011 and 2016.

1 For example, the most common principal diagnosis in both
2 years was unspecified chest pain. This condition was the
3 principal diagnosis on 3.3 percent of all ED claims in both
4 2011 and 2016, and this similarity across the years in
5 terms of the share for each code was consistent for both
6 2011 and 2016.
7 This result indicates little change in the
8 conditions treated in EDs from 2011 to 2016, even though
9 the share of ED visits coded as level 5 increased from 21
10 percent in 2011 to 28 percent in 2016.
11 Moreover, for 97 percent of these principal
12 diagnoses that we evaluated, the share of ED claims that
13 was coded at level 5 increased from 2011 to 2016.
14 To determine whether patient severity could
15 explain the shift of ED codes to higher levels, we started
16 with the idea that the most likely way for patient severity
17 to increase among ED patients is that low severity cases
18 migrated to other settings.
19 And by far, the largest growth in alternative
20 settings to emergency departments is the urgent care
21 centers that Zach discussed, with an increase of 1 million
22 UCC visits from 2013 to 2016.

1 But we found that even if all of that growth in
2 UCC visits was from migration of low-severity ED patients,
3 the growth in the UCCs has not been large enough to explain
4 the increase in coding of ED visits to level 5.
5 To the extent that upcoding has occurred, one way
6 to address it is to create new ED codes. One alternative
7 to the current codes is a single code for all ED visits.
8 So there would be no levels.
9 Another alternative is to continue to use
10 multiple levels but create national guidelines for coding,
11 with attention to reducing incentives for upcoding.
12 National guidelines for ED coding currently don't exist.
13 As I said earlier, hospitals use their own internal
14 guidelines. But having national guidelines would provide a
15 consistent basis for assessing coding patterns, in contrast
16 to internal codes where hospitals have discretion over
17 their own guidelines.
18 Both of these alternatives have advantages and
19 disadvantages. For a single code, the advantages are that
20 there would be no opportunities for upcoding. Also, it
21 would be simple to implement and use because some burden on
22 hospitals would be lifted, as they would no longer have to

1 expend resources for coding decisions. The disadvantage of
2 a single code is that hospitals that have a high share of
3 high-acuity patients may be disadvantaged.
4 For the alternative of establishing national
5 guidelines to be used with multiple code levels, advantages
6 include that it would be more equitable for hospitals that
7 have high-acuity patients. Also, relative to the current
8 codes, there would be a consistent basis for assessing and
9 auditing coding practices.
10 The disadvantages of this approach relative to
11 using a single code are that no matter how hard we try,
12 having multiple levels will provide incentives for
13 upcoding, so resources would be needed to monitor for
14 upcoding. Also, hospitals would have to expend resources
15 to determine the level for each ED visit.
16 CMS has considered implementing both of these
17 alternatives into the Outpatient Prospective Payment
18 System. For 2014, CMS proposed a single code for all ED
19 visits. CMS listed many benefits of this approach,
20 including that it would prevent upcoding. But this
21 proposal met with strong opposition based on equity
22 concerns, including from the Commission, and CMS did not

1 implement it.

2 CMS made a considerable effort from 2002 through
3 2007 for ED codes that have multiple levels and are based
4 on national guidelines. This involved many entities,
5 including the AHA, the American Health Information
6 Management Association, and the American College of
7 Emergency Physicians. There was a lot of support for this
8 approach, but CMS chose not to implement it, citing
9 complexity concerns.

10 So for your discussion today, we are looking for
11 feedback and guidance for the non-urgent care provided in
12 hospitals that Zach discussed. Further, we would like to
13 pursue work that more strongly confirms whether upcoding
14 has occurred for ED visits, and this may involve a claim-
15 by-claim assessment.

16 And, finally, we seek Commission guidance on how
17 to proceed in regard to creating new codes for ED visits in
18 response to any upcoding concerns.

19 I turn things back to the Commission.

20 DR. CHRISTIANSON: So clarifying questions. Jon?

21 DR. PERLIN: Well, thanks, Jon. And, Dan and
22 Zach, thanks for a terrific and thoughtful presentation.

1 I have two clarifying questions, one on the first
2 topic, the distribution of care between emergency
3 departments and urgent care centers, and the second on the
4 coding.
5 It's fascinating that there is incredible overlap
6 of the types of conditions seen in both the urgent care and
7 the emergency department, and you pointed out some
8 stratification, patients with higher risk and greater
9 complexity, and that makes sense. But might there also be
10 some other systematic factors -- there are probably too
11 many mics on -- that drive the distribution ultimately of
12 the patient's decision to go to one of the two places?
13 I would just note that you pointed out some of
14 the ownership of the urgent care centers, but many of the
15 urgent care centers are not 24/7. That might change. And
16 so given their locations also, which would be in areas of
17 higher socioeconomic status, that may systematically
18 preclude who's able to go to a different facility.
19 So if you corrected for that and the fact that
20 they're not simply available in all markets as ubiquitously
21 as emergency departments, do we have any sense of how those
22 numbers would change of those who might be construed as

1 discretionary?

2 MR. GAUMER: It's hard to say. There have been a

3 couple of studies out there on this. You know, within our

4 own data, we haven't done any kind of stratification on,

5 you know, market. We've looked at some of the states, and

6 there are some states that have more urgent care centers

7 than others. And we see, you know, in some of the states

8 the use of urgent care for non-urgent care conditions, if

9 they go up in urgent care, they go down in the ED. We see

10 a little bit of that. But we haven't done a detailed

11 analysis of the different markets.

12 The other research that's out there has done some

13 more sophisticated statistical work to control for risk

14 adjustment and that kind of thing, and they're finding

15 similar things.

16 DR. PERLIN: I'd just commend to consider, you

17 know, looking at the differences in hours of operation, the

18 differences in geographic access, and the difference in

19 some of their models, some of those urgent care centers do

20 not actually, you know, accept government payers. They

21 accept commercial insurance only. So there may be some

22 systematic variables that drive differences, and I'd

1 absolutely -- I think we need further discussion about the
2 patient's sort of choice with respect to those risk
3 factors.
4 Just to give you a sort of concrete example, take
5 two 80-year-olds who have some respiratory symptoms. One
6 is your individual 3.1, other comorbidities, the other a
7 2.0 comorbidities. Let's for the sake of argument say that
8 the 80-year-old with the two comorbidities has some
9 arthritis and something else, and the other actually has
10 diabetes and heart failure. You know, that individual is
11 wondering: Is this heart failure or is this a cold? That
12 may drive choice.
13 Let me flip over to the second question, which is
14 the effect on coding and distribution. I'd be interested
15 in how your research has -- or any comments on the
16 systematic effect of ACEP. I know CMS chose not to
17 incorporate the guidelines, but, you know, when this
18 discussion was going on with CMS, I think people were
19 looking for a reference point, and the American College of
20 Emergency Physicians offered some guidance on that and did
21 that exert a systematic influence on the coding?
22 The second is I wonder if your research

1 contemplates the effect of the EHR capturing work that
2 would not have been systematically captured over that
3 period of time, because obviously in this past decade,
4 there has been an exceptional increase in the use of
5 electronic health records systematically capturing things
6 that may not have been scribbled, in fact, probably
7 prompting for capture of elements of procedures and
8 physical examination.
9 And then the third is even though you note that
10 the constellation of diagnoses is the same, I wonder if it
11 contemplates how the therapy has changed. So if I had a
12 stroke and showed up in an emergency room a decade ago, I'd
13 be given an aspirin and observed. Today, you know, you're
14 seeking a door-to-needle time for either a thrombolytic or
15 mechanical thrombectomy in less than an hour, and so the
16 intensity of the response to the nominally same diagnosis
17 with the same degree of comorbidity or risk is very
18 different. So I'd just appreciate any comments on those
19 other aspects of comparison.
20 DR. ZABINSKI: All right. I'll tackle the first
21 one. Then you're going to have to remind me of the other
22 two because I can never remember.

1 DR. PERLIN: Okay.
2 DR. ZABINSKI: After answering one question, I
3 can never remember the follow-ups.
4 The first one was on the ACEP guideline.
5 DR. PERLIN: Yeah, did it impose a systematic
6 influence despite not being a CMS-sponsored guideline?
7 DR. ZABINSKI: I'm not sure. It might have. I
8 think that's something to think about. I do know, you
9 know, CMS did not spend a lot of time talking about the
10 various internal guidelines that hospitals might use, but
11 they did make it clear that there's some variation in the
12 approaches that different hospitals take. But they didn't
13 really say -- you know, there's just a couple sentences in
14 one of their regulations, and I also know that there was
15 some discussion that, you know, the ACEP approach was sort
16 of the gold standard and the way to go, but also when the
17 AMA and the -- sorry, yeah, the AHA came up with their
18 approach that that was also considered quite a good one,
19 and then some hospitals I know developed their own.
20 So it's probably the case that the ACEP approach
21 had some influence. I'm not sure the extent to which it
22 did, though.

1 DR. PERLIN: Yeah, but I think your point is well
2 taken there. The gold standard, it probably influenced --
3 even though they're independent nominally, you know,
4 guidelines that institutions implemented, they didn't sort
5 of pull it out of the air. They kind of out of safety,
6 frankly, likely went to a reference -- it may be worth
7 surveying.
8 Let me go back to the second, and that was the
9 systematic effect of the electronic health record in terms
10 of capturing workload.
11 DR. ZABINSKI: Yeah, probably -- you know, the
12 electronic health record, I think what you're getting at is
13 there's more complete information about patients or --
14 DR. PERLIN: The more complete capture, I mean,
15 so any of us using the electronic health record, you know,
16 it will take you through and it prompted you, Did you do
17 this? What were the elements of your physical? And, you
18 know, we know from our other E&M coding activities in other
19 parts of an institution, three elements of this, four
20 elements of this, so, you know, you can actually -- they
21 prompt with templates for this, that, or the other to get a
22 complete history, physical, and capture of procedures. So

1 things that may not have been captured as workload are more
2 systematically captured as workload.
3 I just think it's worth an assessment. I'd be
4 happy offline to discuss with you ways to capture that.
5 DR. ZABINSKI: My thought on that is, you know,
6 it's a definition possibility, but this shift to the higher
7 levels of coding has been going on for quite a long time,
8 probably back to a period that preceded the use of EHRs.
9 We'll go back all the way to 2005, and there's been --
10 there was a movement toward the higher levels. So I'm not
11 sure.
12 DR. MATHEWS: Hey, Dan, let me try and get in
13 here for a second. So, Jonathan, if I understand what you
14 are saying, one of the policy options that we're proposing
15 here is a more definitive refinement of the five levels of
16 coding that are used to classify patients in the ED. And
17 what you are suggesting is that data on level of effort and
18 work that is now captured in the electronic health record
19 could be a source of information to help with that
20 refinement. Is that what --
21 DR. PERLIN: I think that's a great comment, and
22 I think that change may also reflect the increased capture

1 over the period of time. And I conceded that, you know, if
2 you draw the beginning to 2005, that may have been adoption
3 before the thrust of the meaningful use high tech which
4 really came, you know, full bore in 2009. But there seems
5 to be an increase in capture of that sort of workload.
6 The last is the intensity of treatment for the
7 same diagnosis, which would co-vary with the other --
8 because the biggest clusters, as you said, are chest pain -
9 - chest pain, stroke, those things that are the common ED
10 big-ticket items -- have changed significantly.
11 DR. ZABINSKI: That's definitely an angle I've
12 considered and thought about, and I would say -- there are
13 approaches to national guidelines that I think would help
14 capture that sort of issue. You know, one of them is the -
15 - there's sort of a point system where you assign a certain
16 number of points to each intervention, and you add up the
17 points and whatever the number of points you get, that's
18 what level you fall into. And I think changes like, you
19 know, in methods of treating something would be captured in
20 that.
21 DR. PERLIN: Well, I'll look forward to
22 discussion of some of the approaches in Round 2, but thanks

1 for those clarifying answers.

2 DR. CROSSON: Okay. All right. Let's start with

3 Pat and go down that way.

4 MS. WANG: Zach, you said something that I want

5 to make sure that I caught correctly, because of the sort

6 of geographic lumpiness of the distribution of UCCs in

7 certain markets and not others, the study that you

8 performed to test whether or not the increase in UCC visits

9 could explain part of the increase in the prevalence of

10 Level 4 and 5 ED coding because the lower-intensity visits

11 were being decanted to UCCs, and you didn't really find a

12 correlation. It's just a question. Does it make sense --

13 because that's on a national scale. Does it make sense to

14 further test that correlation or lack thereof in a

15 geography that has, you know, a density of urgent care

16 centers that Medicare beneficiaries use compared to the ED

17 utilization and the Level 4 and 5 coding in the hospital

18 emergency department? Because I think -- I guess I just

19 wondered. It feels like it's very peanut butter to cross

20 the whole country, and there are not UCCs everywhere, so

21 maybe the correlation is too small.

22 MR. GAUMER: So I think there are two things

1 going on here. The second part about the coding is
2 something Dan looked into, so he should address that. But
3 in terms of looking on the market level, I think that's
4 something that we can do the next time you see this, and we
5 can talk about the characteristics of the patients going
6 into UCCs and their risk scores and that kind of thing to
7 see if there are big differences. But I think the
8 correlation between the coding is Dan's department.
9 DR. ZABINSKI: Handoff, okay. The question
10 again, what was it exactly?
11 MS. WANG: Just not to make extra work for you,
12 but whether you think it would be worth validating the sort
13 of conclusion or observation that the increase in UCC
14 visits is not explaining the increase in Level 4 an 5
15 coding.
16 DR. ZABINSKI: Uh-huh.
17 MS. WANG: Whether you think it would be worth it
18 to take a look at a geographic area that has a prevalence
19 of UCCs and hospital EDs and just look within that smaller
20 area whether that phenomenon is borne out.
21 DR. ZABINSKI: That's a reasonable -- yeah,
22 actually I like that idea.

1 MS. WANG: Okay. The second question that I had
2 has to do with the coding phenomenon. On Slide 4 you
3 mentioned that when you showed the difference in payment
4 across these different settings, it doesn't include sort of
5 all of the ancillary and other services that are provided.
6 Have you looked at in the hospital ED setting in particular
7 for Level 4 and 5 whether there is -- what the total cost
8 is for the 4 and 5 levels and whether there's consistency
9 there? I guess, you know, it's not just the 500 bucks for
10 the facility and the physician fee. It's everything else
11 that goes along with it. And as you mentioned, Zach, it's
12 a multiple. And I just wondered whether there was anything
13 of merit to observe about the bundle of cost or services
14 that are delivered around 4 and 5 visits. That's a
15 question. And where that leads me is just to wonder
16 whether, as you're looking at 4 and 5, because Slide 11 was
17 kind of fascinating to me. Regardless of the reason for
18 the change in coding -- and it might be better information
19 capture; it might be actual patient acuity, maybe not --
20 you know, you see the shift in the bell-shaped curve from
21 the original -- I have black and white here -- from 2005 to
22 2016. Is it crazy to think that one would simply just

1 rebase and shift the curve over to achieve some budget
2 neutrality in the amount that is being spent? That's what
3 that slide kind of cries out to me.
4 And the second sort of separate thing and the
5 reason I was asking about the bundle of cost is whether you
6 think it might be appropriate to look at a different type
7 of payment for emergency department visits that accounts
8 for the additional spending to the extent that it's
9 predictably related to that level of coding.
10 DR. ZABINSKI: Let's see. On the first part, as
11 far as, you know, the shift -- shifting the whole thing
12 over, that's an issue that I think is important to think
13 about. Even if there is not upcoding, the fact that you
14 have such a high share at the high level tells you that the
15 codes probably need some sort of massaging or changing in
16 some way to get it to look more normal. As I said, in 2005
17 CMS' response to that distribution was that this is
18 comforting because it shows that hospitals are coding
19 completely and, you know, in a way that we're looking for.
20 And it doesn't exist anymore. So, yeah, just changing the
21 codes for the sake of getting them to be more normally
22 distributed I think is a reasonable idea to pursue.

1 And, once again, you're going to have to remind
2 me of the second question.
3 MS. WANG: This probably doesn't make sense, but
4 I just was curious about if there is a bundle of cost that
5 is predictably related to a Level 4 --
6 DR. ZABINSKI: Oh, yeah --
7 MS. WANG: -- coding, whether there's any utility
8 in your mind of exploring a different type of payment for
9 an ED visit.
10 DR. ZABINSKI: I'm not sure, but I would say
11 this: CMS over the last five years has really been pushing
12 towards greater bundles in the outpatient payment system,
13 so that, you know, fits in well with where they're heading.
14 Maybe they'll get there without even any prompting. Maybe
15 it's in their plan, I don't know, but I think that's a
16 reasonable approach. You know, they have these
17 comprehensive APCs where for the more advanced type
18 procedures like implanting a defibrillator, everything on a
19 claim gets packaged together. It doesn't matter what it
20 is. That's fairly new, and perhaps they'll head that
21 direction for ED visits. They're already doing it for
22 observation care. So it's an idea.

1 DR. CROSSON: Okay. Brian.
2 DR. DeBUSK: Two questions. First of all, when I
3 was doing the reading, I was wondering: Is there any
4 evidence that UCCs induce utilization? I know there's some
5 work in ASCs where it looks like you could look at, say,
6 use per 1,000 beneficiaries, you add an ASC, and you watch
7 it spike up.
8 MR. GAUMER: So our own research and the current
9 research out there doesn't speak to the inducement issue,
10 but, you know, this might be something to explore. When
11 you look at growth rates on a per beneficiary basis, use of
12 all these settings that do E&M services are going up. So
13 there could be some inducement there if a new facility
14 popped into a neighborhood that had never been there
15 before. There could be. But we haven't really looked at
16 it yet, and there's no clear evidence that it's happening.
17 DR. SAFRAN: One way or the other, okay. So
18 there's nothing in the literature.
19 Then a question for both of you. Has any site-
20 neutral work been done here looking at UCCs and EDs?
21 MR. GAUMER: I think with UCCs specifically in
22 mind, no, but the site-neutral policy, Section 603 that Dan

1 has worked -- I won't go into that description, but it does
2 affect these facilities. And so as you saw in the reading
3 material, there's great complexity with how these
4 facilities get paid, whether they began after November 2,
5 2015, or before that date. So the Section 603 site-neutral
6 policy does affect UCCs.
7 DR. DeBUSK: But between EDs and UCCs, they're
8 explicitly exempted through 603, right?
9 MR. GAUMER: EDs are exempted from this, yeah.
10 DR. DeBUSK: Okay. But back to just because it's
11 exempted, Dan, is there any site-neutral work that you've
12 done in this area?
13 DR. ZABINSKI: No, there's not. But I think it's
14 something to strongly consider. How about that?
15 DR. CROSSON: Brian, I just want to be clear.
16 When you talk about inducement, do you mean just the simple
17 existence, new existence, or purposeful inducement or both?
18 DR. DeBUSK: Just simply the existence. I've
19 read a paper that looked at ASCs. They looked at regions
20 where they added an ASC, and it looked like claims per
21 1,000 beneficiaries actually spiked up. I wondered if
22 anyone had looked at something similar for UCCs, because I

1 wondered if they were additive to the overall volume of
2 claims or if they were somehow, you know -- all this
3 squeezing a balloon.
4 DR. CROSSON: Are these both on this point? Dana
5 first, and then Pat.
6 DR. SAFRAN: Yeah, on this point. So we have
7 looked at this in our commercial and both from our data and
8 from what our members say when we talk to them, and we do
9 see that there is new utilization happening where UCCs come
10 into place. And when we talk to members to understand if
11 you hadn't sought care at this UCC, what would you have
12 done? A very small percent seem to be substituting UCC for
13 emergency room. Most seem to be going to a UCC rather
14 than, you know, the wait-and-see attitude just because it's
15 convenient, it's there, it's a low co-pay.
16 And just while I have the mic, it seems to me
17 that similar to Pat's point, you could leverage geography
18 here to look at that question in the data. It would be
19 very instructive.
20 DR. CROSSON: Pat.
21 MS. WANG: Just on this point, is it possible
22 from the data that you have to see where a UCC visit was

1 followed by an ED visit? Because this definitely happens,
2 and this happens in my -- and it's a great caution. We
3 really like to have UCCs in the network because it provides
4 additional access, but the thing that we try to really pay
5 attention to is is it really addictive or is it
6 substitutive.

7 So if you are going to look in a small area, if
8 there's a way to ascertain that, I think it might be useful
9 because some of the presentation of the information here
10 suggests that UCC is a lower-cost alternative. It might
11 not be. It might be additive.

12 MR. GAUMER: Yeah. You can connect kind of the
13 whole episode over a period of time. It can be done, yeah,
14 and we've done it in other cases too.

15 DR. CROSSON: Okay. Amy and Paul.

16 MS. BRICKER: I have three questions.

17 2014, you said the Commission opposed the single
18 payment for ED. Can you give some background on that and
19 why now it's for maybe putting it back on the table?

20 DR. ZABINSKI: Well, it was very brief. It's in
21 the comment letter to the 2014 ASC OPPS proposed rule, and
22 we didn't say a lot. Just our opposition at that time was

1 that it could be unfair to hospitals that have a lot of
2 high-acuity patients. You're paying the same rate for
3 everybody, but if a hospital happens to get a very sick
4 population in, they're going to, on average, get underpaid.
5 As far as reintroducing it, it's the case of just
6 trying to be complete with possibilities in terms of how to
7 approach this issue. This is just one way to approach it.
8 I guess that's about it.
9 MS. BRICKER: Okay, fair enough.
10 So the costs that you showed in one of the graphs
11 around the independent versus hospital-owned, UCC versus
12 ED, is there also ability to look at the quality associated
13 with each of those venues?
14 Instinctively, you had suggested education, and
15 maybe that's what we need to do is educate beneficiaries,
16 that there are lower-cost alternatives. I agree with that,
17 so long as the outcomes are the same. So have you looked
18 at that?
19 MR. GAUMER: We thought a little bit about this,
20 but there are a couple of pieces of literature that are out
21 there that talk about it. And we can include that the next
22 time we come back to you.

1 MS. BRICKER: Okay.
2 MR. GAUMER: But, generally, what they say is
3 that the quality of care at urgent care centers is similar
4 to the quality of care for these non-urgent care cases, but
5 we need to dive in a little bit deeper to see more about
6 who conducted the studies and who's paying for them and
7 that kind of thing.
8 MS. BRICKER: Perfect.
9 Lastly, we've done work previously on standalone
10 EDs, and if we might consider putting that work -- tying
11 that back into future work here. We talked about whether
12 folks end up going to a standalone ED over a lower-cost
13 UCC. The cost impact, when you put ED up, is it connected
14 to a hospital versus standalone? All of that is rolled up
15 together?
16 MR. GAUMER: Yeah. When we did our estimate of
17 the 1- to $2 billion in extra payments, is that what you're
18 referring to?
19 MS. BRICKER: So you represent EDs. Is that
20 traditional ED as well as standalone ED?
21 MR. GAUMER: Yeah. We're thinking of them
22 together, and when we did our calculations, we considered

1 all EDs kind of as type A EDs, the higher-paid EDs, and it
2 would include your standalone EDs as well.
3 MS. BRICKER: So if I recall, those standalone
4 EDs saw low-acuity patients. I don't know if it was you or
5 Dan that did that study. We talked about how ambulances
6 pass the standalone EDs and go to the traditional EDs.
7 They act more like urgent cares and not EDs. So I think
8 just to refresh, maybe the Commission on that work might be
9 helpful here.
10 MR. GAUMER: Okay, okay. Sure.
11 MS. BRICKER: Thanks.
12 DR. CROSSON: Paul.
13 DR. PAUL GINSBURG: This is for Dan.
14 Dan, the coding process, what role does the ED
15 physician play in that?
16 DR. ZABINSKI: My understanding is not much. The
17 physician codes for themselves, and then the hospital codes
18 for the hospital.
19 DR. PAUL GINSBURG: Okay. So the code doesn't
20 have to be the same?
21 DR. ZABINSKI: Oh, no. It is often different.
22 The other thing I'd notice is that if you count

1 the number of ED visits that show up on physician claims
2 versus the number of facility claims, there's more
3 physician.
4 My guess is that because you have a patient comes
5 in and more than one physician sees them.
6 DR. PAUL GINSBURG: More than one physician,
7 yeah.
8 DR. ZABINSKI: Yeah. There's a definite
9 difference between the physician coding and the hospital
10 coding.
11 DR. PAUL GINSBURG: Yeah. I think it might be
12 instructive to compare the trends in the mix of levels for
13 the physician claims versus the ED facility claim to see if
14 they're lining up.
15 In the ED physician worlds, there's been a very
16 rapid transition to corporate staffing models, which it
17 would be an obvious opportunity for coaching physicians to
18 code more aggressively. This may be a part of the picture.
19 It may be a distinct picture that perhaps we
20 should bring into the analysis and not restrict ourselves
21 to what's happening on the facility coding.
22 DR. CROSSON: On this point, Jon?

1 DR. PERLIN: Thanks.
2 I think that is a really good point, Paul,
3 because the other thing that occurred over this period of
4 time, just the implementation of observation status, that
5 may also have some bearing on the trend.
6 By the way, just back to that point in 2005
7 versus 2009, we're looking at 2005. It may be useful to
8 actually look at 2009 versus 2015 or whatever the out date
9 was on those charts.
10 Thanks.
11 DR. CROSSON: Jaewon, on this point as well?
12 DR. RYU: Yeah. I think Paul raises a good
13 point. It would be good to match up the physician coding
14 aspect.
15 The other question is, On the facility component,
16 does length of stay in the ED play a role at all into how
17 that gets coded? Because I believe it does, and ED
18 boarding has also increased during the same time period.
19 So it may be a function of just longer length of stay in
20 the ED.
21 DR. ZABINSKI: My own thought on that is -- let
22 me start again. The rationale that hospitals use in their

1 coding, because it's hospital-specific to some degree, it's
2 a bit of a black box for us in terms of what factors come
3 into play from one hospital to the next because there's not
4 one uniform guideline there.
5 DR. RYU: Yeah. It may be helpful just to -- I
6 don't know if it's a focus group or what, but I know that
7 extended care as a unit of time is a big component and
8 driver of facility charging in the ED. So I think just
9 understanding that interplay would be helpful.
10 DR. CROSSON: Bruce, did you have a point on this
11 point?
12 DR. PYENSON: Just on Paul's point on the
13 corporate practice of medicine in emergency departments,
14 and I'm wondering if there's any visibility into which
15 hospitals have outsourced their EDs and which haven't.
16 We often are looking at national averages, but it
17 could well be the case that there's regional variations or
18 other variations, but in particular variations based on
19 who's managing and perhaps the question whether you think
20 the role of physicians in determining the level of facility
21 billing. I don't know if you know the answer, but who is
22 it, and how is it done?

1 DR. ZABINSKI: Yeah. I think that's probably an
2 important factor to find out. I don't have an answer right
3 now.
4 DR. CROSSON: Okay. I just want to interject a
5 second. We're now almost an hour into the discussion, and
6 we're still on clarifying questions. And we've only gotten
7 halfway through the Commission.
8 We have got lots of time. We could stay here,
9 but I do want to suggest that we get through the questions
10 so that we can actually provide some advice in terms of the
11 options that have been presented to us.
12 So, with that prolog, can I see hands for
13 questions?
14 [Show of hands.]
15 DR. CROSSON: All right. Let's start this way,
16 Bruce, and go down.
17 DR. PYENSON: Thank you.
18 A question on Slide 11. The emergency room is
19 often the gateway to an inpatient admission, and a question
20 on whether there's sufficient -- whether the reduction in
21 inpatient admissions that we've seen, especially for
22 medical cases, could account for some of the increase in

1 severity.

2 I think you compellingly had some compelling
3 information that ED departments don't account for -- the
4 urgent care centers don't account for that, but I'm
5 wondering if you have any insight into that, whether the
6 reduction in admissions and discharge home.

7 DR. ZABINSKI: I don't.

8 I will say probably on a related matter, the
9 growth of observation care might have had an effect. We
10 know that observation care has grown quite a bit, and to
11 get paid for observation care, the hospital has to code a
12 higher-level ED visit. So that might have some play into
13 this.

14 DR. CROSSON: Sue.

15 MS. THOMPSON: I want to go back to Zach, get off
16 coding for a little bit.

17 When you talked about strategies used to simply
18 work to reduce utilization, whether it be retrospective
19 audits or trying to education the patients or the
20 beneficiaries, and you called out from a commercial
21 insurance side that they had decreased -- Aetna had
22 decreased use of the EDs for non-urgent care. Do you know

1 what about any strategy they used that actually reduced?
2 Was it education to the beneficiaries? Was it plan design,
3 increased out-of-pocket? What do we know about that?
4 MR. GAUMER: So I only know --
5 MS. THOMPSON: And then how would you think about
6 that in the Medicare context?
7 MR. GAUMER: I only know a little bit about
8 what's been happening in the commercial world. We spent a
9 little bit of time doing it, but we haven't done any
10 interviews with insurers to dive deeper into it.
11 A lot of what we've learned has come from the
12 literature, studies done with commercial data and whatnot.
13 There are two large commercial insurers that have
14 taken the retrospective audit approach, and they've been
15 well published and gotten a lot of heat for it.
16 Just looking at the other large commercial
17 insurers out there on their websites and what they are
18 talking about, there are extensive patient education pages,
19 videos that are trying to reach out to patients to say,
20 "Here's what you do. When you're having this big question
21 of where to go, these are the 20 conditions we think you
22 should take to the UCC, and these are the other things."

1 And they're very well done, and obviously, they've spent a
2 lot of time thinking about this. But we have not
3 interviewed representatives of these insurers yet.
4 DR. CROSSON: Thank you.
5 Jaewon.
6 DR. RYU: Two questions. One is getting back to
7 the scenario Pat mentioned where you have a beneficiary.
8 They go to the urgent care, and then they go to the ED
9 because the capabilities are beyond -- or the needs are
10 beyond the capabilities of the urgent care. Does that
11 beneficiary get hit with two different cost shares, 20
12 percent for both encounters?
13 So I think in the commercial payer world, this
14 has been one of the tools that have been used just to de-
15 risk that scenario for patients because otherwise they will
16 always choose -- or not always, but frequently, they'll
17 choose the higher-level service thinking that, "Well, if I
18 go to the urgent care, there's a chance I may get sent to
19 the ED." And that doesn't need to happen often for that to
20 shift their behavior.
21 So it might be helpful just to look at that
22 transition and how often that actually occurs and

1 strategies around how we might de-risk that.

2 The second question for you all is -- and I don't
3 know if there's any way to access this other than clinical
4 data, but it would be helpful if there was a way to
5 identify what the patient presented for, so the chief
6 complaint that they entered the ED for as opposed to the
7 discharge diagnosis, which is what we have on the claim.
8 And, again, don't know the feasibility of that, but that
9 was my question to you is, Do we have access to anything
10 along those lines?

11 MR. GAUMER: So the first question, we can look
12 at the subsequent ED visits. My understanding is that the
13 beneficiary does get hit with two copays in those
14 situations. If the beneficiary ends up getting admitted to
15 the hospital, then all of that, assuming it all happens
16 within the same system, gets bundled into the inpatient
17 payment under the 72-hour rule. But it's hard to say
18 exactly how that plays out. I haven't looked at it in the
19 claims.

20 The second question about the chief complaint,
21 that one kind of bounces off my forehead, and I think I'm
22 not aware of how that would work. I think we only have the

1 principal diagnosis code on the claim, but maybe --

2 DR. ZABINSKI: No. I am not aware of any way

3 that we can find that out, but we can definitely take a

4 look. That would be really a helpful piece of information,

5 I think.

6 DR. CROSSON: Karen.

7 DR. DeSALVO: So building on that, first of all,

8 what John said about the potential for there to be more

9 accurate coding, more detailed coding in the electronic

10 health record area, there is some data from both the

11 inpatient side and I believe the outpatient side, so we can

12 talk about that offline. I'll see if I can help track it

13 down.

14 I wondered if it is possible to access some of

15 that clinical data now for purposes that you're thinking of

16 helping to understand complexity in the ER, but also maybe

17 this chief complaint. And the place where we could think

18 about going wouldn't necessarily be the institutions, but

19 perhaps some of the stronger regional health information

20 exchanges in places like Cincinnati or Tulsa where they

21 have a pretty good master patient index and might be

22 willing to make that available.

1 The second thing I wanted to raise that's come up
2 in some of the conversation from Pat and Amy and others is
3 this struck me as this work was starting with a very heavy
4 focus on the cost implications, which is obviously
5 important, but there is a balance perspective here also of
6 the impact on the beneficiaries of the quality of care they
7 receive, where they're going.
8 Maybe you all can tell me where we are in trying
9 to understand it's not just about less cost, but it's the
10 right care at the right time.
11 Which brings me to my third, which is really the
12 question I have, and that is -- unless you can answer the
13 second -- when I read this, I was also thinking about our
14 discussion yesterday about primary care access, and some of
15 these codes that you all describe seem very appropriate for
16 the primary care environment. I don't know if this work
17 that you cite on page 5 by Corwin has looked at whether
18 some of these codes are appropriate in the primary care
19 environment and maybe thinking about this as an entire
20 continuity, not just a tradeoff between UCC and ER, but
21 also bringing and thinking about primary care access.
22 MR. GAUMER: Okay. So going in reverse order of

1 your questions here, so the access to primary care issue, a
2 lot of the studies we've seen do include the physician
3 office in their analysis to see where these non-urgent
4 cases are bouncing around. So we can include more
5 information on that.

6 We also looked at that but for your benefit tried
7 to whittle down this thing to ED and urgent care. But we
8 have some information that shows generally that the growth
9 of non-urgent cases -- or all cases, even, in physician
10 offices has stayed pretty constant. Most of the non-
11 urgents go to the physician office. That's the bulk of
12 them, 77 percent or something, and that has stayed pretty
13 constant.

14 It seems as though there has been some shifting
15 from the physician office to the UCC and also from the
16 hospital ED to the UCCs, and also retail clinics are
17 involved in this as well. They've grown rapidly within
18 Medicare. So we can look into it is my point.

19 In terms of the quality, I think the only thing I
20 can offer at this point is kind of the same thing that I
21 said to Amy, which is we've only looked at it
22 superficially, and we can dive into it a little bit more.

1 But it looks like so far, the overall message is quality is
2 still good at urgent care centers, but we need to better
3 understand how they make those determinations.
4 DR. DeSALVO: Yeah. This was mentioned, but is
5 it possible to track beneficiaries within seven days of a
6 visit to a UCC to see if they also went to an ER and/or had
7 an inpatient admission, something like that?
8 MR. GAUMER: Yes.
9 DR. DeSALVO: Thank you.
10 DR. CROSSON: Okay. Thank you.
11 So we have two issues on the table, the issue of
12 non-urgent care being seen in emergency rooms, and I guess
13 it's a cost issue as well as a question of whether that's
14 the best place for continuity of care for folks, and then
15 the question of ER upcoding and what would be the best
16 approach to dealing with that problem. So I think those
17 are the two issues, and you can find the setup for those on
18 pages 8 and 15, respectively.
19 We'll start the discussion with Paul.
20 DR. PAUL GINSBURG: Thanks. This is a very
21 stimulating paper that you prepared, really well done,
22 obviously generated very rich clarifying question rounds,

1 which I think is why it took so long. There was a lot in
2 it.
3 I find your evidence convincing that, you know,
4 increasing UCC visits don't explain the coding change,
5 probably don't explain -- also don't explain the volume
6 change you would have expected if a substitute for
7 emergency departments, that ED visits would be going down.
8 But, of course, they've gone up quite substantially. I
9 guess there were suggestions of ways to be more
10 sophisticated in the analysis that probably are worth doing
11 because establishing the point before we wade into the
12 coding discussion is very important, saying, no, this isn't
13 just the easy patients being siphoned off.
14 When it comes to coding, I was thinking about the
15 single code idea and that, you know, the obvious problem is
16 hospitals in areas where the population has a lot more in
17 the way of problems, et cetera, you might expect higher
18 acuity ED visits, but there's something else that could
19 balance it, that EDs do a lot of primary care in those
20 areas. I don't know how that comes through, but I was
21 thinking that the Commission has been, I think,
22 successfully grappling with a lot of situations where

1 efficiency or quality is influenced by the environment that
2 a hospital is in. We've done the groupings. I'm wondering
3 whether that approach could work here in the ED thing so
4 that you actually do analysis of this by area, by
5 socioeconomic areas surrounding a hospital, and perhaps
6 come up with adjustments that could be used if you went to
7 a single code.
8 The other thought I had is that, again, in DRGs
9 and I think in some other areas, Medicare when it has
10 perceived upcoding, does an upcoding adjustment. It seems
11 to be accepted by the field. They don't like it but, you
12 know, CMS is going to do it.
13 What about the possibility of, in the course of
14 considering improvements in coding, whether there should be
15 a CMS upcoding adjustment to the rates paid to EDs? I'd
16 like to put that on the table as another option.
17 DR. CROSSON: Thank you, Paul.
18 Further discussion of the options on the table?
19 Kathy.
20 MS. BUTO: Okay. I've been trying to get my mind
21 around UCCs, and I can't decide whether we think UCCs are a
22 good idea or a bad idea. I know they're out there. They

1 are maybe not as good for an individual patient as her own
2 physician because that person has more continuity. They
3 serve a useful purpose because they are there where minor
4 problems occur, and it might be difficult to get an
5 appointment.

6 Then I thought, along the lines Paul was talking
7 about, that maybe this is a future opportunity to generate
8 another site of primary care and for patients who don't
9 have a regular doctor, potentially more of a bundled
10 payment approach to primary care management.

11 So I think there are possibilities here, but I
12 have to say I think right now, if we thought they were
13 saving money, I think they're probably costing money to the
14 system. There's additional usage. Much of it is needed.
15 But I don't believe in the substitution effect here where
16 there are fewer encounters with -- necessarily related to
17 this UCC existence, use of EDs.

18 As I was looking at the paper, it occurred to me
19 that we are beginning our thinking already about things
20 like site-neutral payment. There are a number of comments
21 about the comparison of ED costs to UCC costs. I think we
22 have to be careful there for the reasons that Pat has

1 already raised, which are -- and others have picked up on,
2 which is until we look at the data on referrals from the
3 UCC to EDs and actually back to physician offices, I think
4 it's hard to say whether site-neutral payment in, say, the
5 ED setting to a UCC is making the difference where it
6 counts. In other words, it may turn out to be the greater
7 cost is in the fact that the urgent care center cannot
8 provide all the necessary follow-up, and so there are a lot
9 of other services that could be generated as a result.
10 So I think we should proceed cautiously and do a
11 lot more analysis of referral out of the UCC before we make
12 any judgments about this is a $1 to $2 billion saving if we
13 could just pay the ED at the UCC rate.
14 Thanks.
15 DR. CROSSON: Bruce.
16 MR. PYENSON: I wanted to talk a little bit about
17 the single-code issue, and I know in the past MedPAC has
18 not supported the single code, and in commentary last
19 month, we did not support CMS' proposed consolidation of
20 E&M codes.
21 I'm wondering if this is a different situation
22 for the emergency departments. One of the reasons not to

1 support consolidation of E&M codes is that physicians might
2 avoid more complex patients. That is perhaps not possible
3 in an emergency room because of some of the other
4 regulations. There's certainly things to consider about
5 fairness and regional distribution or the behavior of
6 physicians' billing and their activity with respect to
7 choosing to admit a patient or not.
8 But I think this might be a very different kind
9 of situation than with respect to E&M codes. And I think
10 it might also be possible to use some form of risk
11 adjustment to reflect the different environments of
12 hospitals, but to use a single code.
13 One thing that would accomplish is also have a
14 relatively higher cost sharing for low acuity and
15 relatively lower for high acuity. So I think that would
16 perhaps be a good policy to have to avoid the lower --
17 encourage avoiding the lower-acuity visits.
18 Finally, this is all Part B, right, the emergency
19 room and urgent care centers. And I'd welcome some insight
20 into whether this matters, whether in the budget and
21 projections and the annual updates of reimbursement,
22 whether that process is budget-neutral or indifferent to

1 shifting the money around. I hope it's not, but I'd
2 welcome clarity on that. For sure, better equity in
3 reimbursement is a good thing even if it doesn't have an
4 effect on spending.
5 Thank you.
6 DR. CROSSON: Thank you, Bruce. Sue.
7 MS. THOMPSON: Well, I think by my question I'm
8 interested in work that will help us create a system where
9 patients are cared for at the right place at the right time
10 with the right amount of services. I think we need to
11 understand and learn from the commercial payers about how
12 to work with the beneficiaries, if necessary to self-select
13 into that right category.
14 I really, until we spend more time on this, which
15 I understand we will be, struggle with thinking about one
16 code and would go on record saying that at this point in
17 time, that seems very problematic to me. But I am quite
18 intrigued looking across this continuum, because we tend to
19 look at each of these sites of service in a silo. And I
20 think what we need to think about is how do we think about
21 this pre-acute care, whether it's primary care, urgent
22 care, emergency services in a more cross-continuum way,

1 but, again, working with the beneficiary to choose the
2 right point of service.
3 So those would be my comments, and I think we do
4 have a lot to learn if we could interview some of the
5 commercial payers in this space.
6 DR. CROSSON: Jaewon.
7 DR. RYU: Yeah, I think the single code, I think
8 it's intriguing on several levels, but I think it would be
9 a very tortuous path at this point until we have the
10 additional analysis that many have talked about.
11 You know, yesterday we spent a lot of time on
12 inpatient psych, and 80 percent of the cases there were
13 psychosis. And we said even with that, there's difficulty
14 unpacking within that because there's some heterogeneity
15 within what gets classified as psychosis.
16 The ED I think is the hallmark of heterogeneity
17 in health care. It is where the spillover effects between
18 primary care, inpatient, outpatient, and everything in
19 between hits in that one spot. So to manage that kind of
20 variety through a single code seems really, really tough
21 and gets us back to the guiding principle of trying to
22 match payment with resource use and cost. I think that

1 would be really challenging.

2 DR. CROSSON: Warner -- sorry. Karen.

3 DR. DeSALVO: I think the idea of pressing on the
4 emergency departments through something like a single code
5 won't necessarily solve the problem, at least until we
6 understand more maybe from the data, because to me one of
7 the key inputs here is the primary care system and access
8 to appropriate care there. And one set of mechanisms could
9 be to help steer beneficiaries, as Sue was talking about,
10 through shifts in co-pay, et cetera. The other is when
11 they go to that door of primary care, if it's appropriate
12 for their level of acuity, they make sure the door is open.
13 And that just sort of brings you to a whole world of either
14 differential payments for primary care access after hours
15 in a way that Massachusetts Medicaid did years ago to try
16 to steer the open door so that there was a place to go
17 aside from the ER, or the broader opportunities that come
18 with some of the value-based payment models, whether that's
19 a patient-centered medical home or some other kind of
20 accountable entity, because in those worlds where there's
21 more financial and other risks, when there's shared,
22 aligned incentives, there's more innovation for telehealth

1 or after-hours care or other ways that people can access
2 services that might help get them to the right place at the
3 right time.
4 So I'd like us to think a little more broadly
5 about how to align the incentives but not just focus on the
6 ER and closing that door, but really thinking about making
7 sure we're opening other doors and getting people to want
8 to go towards them.
9 DR. CROSSON: Thank you. Warner.
10 MR. THOMAS: So I would concur with everyone
11 else. I think the single code for ED for all the reasons
12 that have been mentioned just does not make a lot of sense,
13 and I think, again, you have a lot of entities, and I think
14 you'd have patients that would be harmed kind of going
15 through that process. I just think it's complicated.
16 On the urgent care, I just would come back to --
17 I agree with Dana's point that I think that some of this is
18 out of convenience, that, you know, people, instead of just
19 waiting to see, go to urgent care, so there is some
20 increased utilization there.
21 But I think the other thing, I think we ought to
22 continue to challenge ourselves, that this is a replacement

1 for lack of access to primary care. And if we had an
2 amazing access to primary care, you probably wouldn't see
3 as big of a demand for urgent care. My guess is if you had
4 urgent care for psychiatry and mental health services, it
5 would be busy like all day.
6 So, you know, I think we just have to understand
7 that this is a substitute for the lack of access in primary
8 care, and it's probably going to be increasing not
9 decreasing going forward.
10 Now, with that being said, I think there's -- I
11 still think we're better off having urgent care versus
12 having people go to lower-acuity ER visits, and we may not
13 -- you know, it would be even better if they could go to
14 office-based primary care. But if we don't have that
15 access, I think that's going to be problematic.
16 So those are just -- I think we need to look at
17 that continuum of primary care and E&M, and I know you said
18 you didn't really see a downtick in E&M codes, and you may
19 not because there's probably, as we see in the aging of the
20 population, going to be a need for more of those types of
21 visits going forward, not less. So just another viewpoint.
22 DR. CROSSON: Thank you.

1 Okay. Coming over here, we'll start with Dana.
2 DR. SAFRAN: I'll be really brief. So picking up
3 exactly where Warner was and, you know, triggered a little
4 bit by, Kathy, your comments, I was pulling back a lens
5 thinking, you know, there's a lot not to like about urgent
6 care. You know, we're pretty convinced it's raising costs.
7 It's certainly fragmenting care, disrupting, you know,
8 longitudinal relationships. And it's also tying us to a
9 bricks-and-mortar mentality about health care.
10 So it has made me wonder whether there's more we
11 could be doing with respect to payment to primary care that
12 would motivate more use of telehealth and virtual care to
13 solve the access problem that the UCCs are solving. So
14 that was one thought.
15 And the other was I know that oftentimes some of
16 the non-urgent care that's seen in the ED, we know from
17 commercial patients anyway, there's this sense of comfort
18 and security for some reason going to a hospital, being in
19 a hospital. And so that I think is going to be a kind of
20 intractable mind-set for a lot of consumers. And I
21 wondered whether our hospital incentive model that does use
22 total cost of care as one of the incentives might be

1 leveraged to try to start to have hospitals understand that
2 a way to succeed on that is to create on-site urgent care
3 so that a patient who comes into the ED door who doesn't
4 need an energy room level visit can be triaged to urgent
5 care, seen at a lower cost, they win, the system wins, you
6 know, the beneficiary wins.
7 So those are my two thoughts on this -- oh, and I
8 also agree with all the points made about the single code.
9 I'm not in favor of that.
10 DR. CROSSON: Thank you. Jon.
11 DR. PERLIN: Thanks. Again, thank you for just
12 really a thought analysis. I want to add one more concern
13 with the single code that extends beyond socioeconomic
14 status. It extends to the characteristics of the services
15 that a particular facility offers. You know, you might
16 have a facility that actually happens to be the trauma
17 center or the stroke center, the heart center, the sepsis
18 center, you know, cancer center, et cetera. It may not be
19 in a disadvantaged area, but it has an extraordinarily
20 complex set of patients there, and I think that would be
21 problematic. I could actually see some shifting of
22 workload, you know, to elsewhere if there were a single

1 payer, and so I worry about adverse incentives there.
2 I do want to come back to the unspoken. The
3 problem with no standards is that there is no standard, and
4 you heard my theory and my question that I think the ACEP
5 has offered a bit of an implicit standard, but not an
6 explicit standard. You know, if there's heterogeneity,
7 that is a soluble problem. I just would suggest that it
8 not be overly onerous, you know, that it not lend itself a
9 recapitulation of the sort of MAC level interpretation and
10 the RAC level adjudication as has been seen in prior.
11 To really get to understand this, though, I'd
12 also commend us to do the further research that's been
13 suggested and just to consolidate that around urgent care
14 centers. I think Pat's and others' comments on the market-
15 by-market analysis really lets us unpack those questions
16 of, you know, the geographic maldistribution of UCCs,
17 whether they're good, bad, or otherwise, they happen to
18 exist in higher socioeconomic status areas. Many don't
19 accept government payers. They have limited hours. They
20 may, in fact, not be a substitute for ED but, as Karen
21 suggested, for primary care.
22 I think these data are really tricky around

1 primary care because you may -- I may say I didn't really
2 have a problem getting -- finding a new doctor, but maybe,
3 you know, if you've got something that's sort of middling,
4 it's just awkward or difficult to get seen or get seen
5 timely. Urgent care solves that, and I totally agree with
6 Dana that the extension of it, certainly with the newer
7 generation of Medicare beneficiaries, increasingly will
8 rely on virtual tools for solving certain problems. And so
9 we should make sure that our policy is future-looking, not
10 retrospective.
11 With respect to the hospital emergency
12 departments, I would also agree with my colleagues that, in
13 terms of unpacking this toward our best policy
14 recommendations, we need to specifically evaluate the
15 effect of observation status, the effect of the EHR, and
16 the effect of changes in therapy as they relate to even the
17 same nominal diagnosis.
18 Thanks.
19 DR. CROSSON: Thank you. Pat.
20 MS. WANG: On your specific question around
21 guidance on national guidelines, it seems like it could
22 make sense, given that there aren't any, and it's unusual

1 in the Medicare payment system for organizations to have
2 their own coding guidelines. So just in the interest of
3 standardization, it seems to make sense as long as it's not
4 too onerous.
5 But to Paul's point, if the main issue around
6 guidelines for coding is the belief that there is upcoding
7 without fundamental underlying change in the condition, I
8 think Paul's suggestion might be like the most direct to
9 either rebase the rates or have some sort of coding
10 adjustment. With DRG creep, there's no underlying kind of
11 sort of deep dive into are these the right coding
12 guidelines. It's just something that CMS does. So that
13 might be the more straightforward approach.
14 Dana raised an important point about shouldn't
15 hospitals be urged to have urgent care centers on-site. I
16 do want to know. A lot of hospitals, at least in my
17 market, have either open urgent care centers or have
18 developed close relationships with nearby urgent care
19 centers to try very much to head off folks that can be seen
20 there versus going into the hospital and was pretty
21 explicit.
22 In my area, anyway, the urgent care centers are,

1 if anything, increasing the specialization of the types of
2 services they provide and try to move away from the sort of
3 more primary care types of services because they are not a
4 substitute for PCP. They are not a substitute for primary
5 care. They are emergency room light. It's transactional.
6 It's a one-shot. There's no evaluation of somebody who
7 walks in and whether they might have an underlying
8 metabolic condition, and they don't pretend to. They don't
9 want to.
10 The ones that we deal with are very clear about
11 that. We have no intention of displacing PCPs. It's a
12 one-shot, decant the emergency room. That's why we're
13 here. But it's a dilemma. So I think that the issues that
14 people have raised about PCP are a much bigger issue.
15 I also have to say this is -- and I'm not
16 suggesting. This might be chasing too much down a rabbit
17 hole, but the overall observation that the increase in
18 urgent care visits has not affected the overall level of
19 primary care visits is again subject to this large market
20 versus small market phenomenon. In my market, anecdotally,
21 PCPs, it's like cabdrivers' reactions to Uber. They're
22 getting put out of business. Some of them don't have the

1 office visit volume anymore. Their patients have been
2 decanted. Anecdotally, it's had an impact on them.
3 So I would again caution about making
4 observations from a national database where the supply is
5 really lumpy.
6 DR. CROSSON: Can I just ask a question here?
7 Pat, you brought this up, and Dana as well, of the process
8 of kind of triaging certain patients from ER to urgent care
9 centers.
10 It seems to me in the past and in my previous
11 life, we ran into EMTALA issues there. Is that generally
12 the case? I just think if that's a direction that we think
13 is a good direction -- and, personally, I do -- there may
14 be some need to take a look at EMTALA.
15 Sue, has that been your experience as well?
16 MS. THOMPSON: That's been our experience because
17 we do have an urgent care just probably 20 yards down the
18 hallway from the emergency department, but if the patient
19 self-selects to go to the emergency room, despite the
20 medical screening exam and stabilization and all the
21 component parts of meeting EMTALA regulations, they have
22 chosen to be an emergency patient.

1 But is there an opportunity there to rethink that
2 component of EMTALA? I don't know, but we definitely have
3 experienced that.
4 MS. BUTO: I don't think EMTALA would preclude
5 you once you got a stabilized patient from allowing that
6 handoff. You'd have to look at it, but you're saying you
7 think --
8 DR. CROSSON: We absolutely had that problem,
9 yeah.
10 MS. BUTO: Because you can hand off a patient to
11 another facility after they've been stabilized, period,
12 another hospital.
13 DR. CROSSON: Yeah. I mean, I can't remember. I
14 don't want to distract you. I can't remember the level of
15 stabilization, but I --
16 MS. BUTO: That's the whole point of EMTALA.
17 DR. CROSSON: Yeah.
18 DR. SAFRAN: But I think your point is an
19 important one, Jay, in that in order to encourage this,
20 there has to be clarity on whether it is or isn't on the
21 wrong side of EMTALA.
22 DR. CROSSON: Right.

1 MS. WANG: I also think that there are things
2 that people can do short of that thing of somebody has
3 walked through the emergency room doors and they need to
4 get triaged and telling them go down the hall. I think in
5 the relationships that exist, the urgent care centers will
6 probably display that they are affiliated with XYZ
7 hospital, and there's a patient education component of it
8 as well as "This is available to you, if you want to get
9 seen more quickly than waiting for a couple of hours."
10 DR. SAFRAN: Would it be a lower copay?
11 MS. WANG: I don't know about that. Yeah, it
12 would be a lower copay. It would be a lower copay.
13 And I think the ones that I'm familiar with are
14 the ones who frankly are moving more in a straightforward
15 way towards a population health ACO risk-based model. I
16 mean, they are trying to sort of sort their patients,
17 decant their emergency rooms which are crowded, and create
18 a better experience. That's an experiment that there might
19 be some interesting information about in the coming years.
20 DR. CROSSON: Brian.
21 DR. DeBUSK: Again, a great chapter. It's nice
22 to see us work on this. I do think we should work on

1 establishing national guidelines. I think there's
2 something there.
3 The other thing, obviously, from my question, I'm
4 a huge proponent of site-neutral policy there.
5 The other question I had, though, if you had a --
6 and I'm on a limb here -- if you had a national guideline
7 that called for certain coding standards and that guideline
8 called for certain would-be E&M visits or would-be
9 emergency visits to be recoded at E&M visits, so just to
10 say you must code it this way, does that sidestep the 603
11 exemption that they would have to site-neutral policy?
12 Because they're the ones coding it under those guidelines.
13 It's not like we're imposing a site-neutral payment on
14 them.
15 DR. ZABINSKI: I'm not -- sidestep. I'm not
16 sure. I don't feel comfortable answering that off the
17 cuff. I can think about it and get back to you.
18 DR. DeBUSK: It just might be a nice way to
19 sidestep the whole issue of their 603 exemption.
20 DR. ZABINSKI: Yeah.
21 DR. CROSSON: Okay. Seeing no further
22 discussants, I think we have opened up a good set of issues

1 here and look forward to future work.

2 Zach, Dan, thank you for the presentations.

3 That concludes our October meeting.

4 We now have time for public comment. If there

5 are any members of our audience who would like to make a

6 comment, now is the time to come up to the microphone, so

7 we can see who you are.

8 [No response.]

9 DR. CROSSON: Seeing none, we are adjourned until

10 our November meeting, which I believe begins on the 1st of

11 November.

12 [Whereupon, at 11:05 a.m., the meeting was

13 adjourned.]

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