MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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10:43 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:43 a.m.]

DR. CROSSON: Okay. I think we can reconvene.

[Pause.]

DR. CROSSON: Okay. I'd like to welcome our guests to this opening session of the 2019-2020 MedPAC season. Some of you may have been here before; some of you may be new.

Each September when we begin our discussions, we ask ourselves the fundamental question: Why? What is the status of the Medicare program? What's the nature of the problem we're trying to address? Because later in the year we will get to some very specific proposals and ideas and discussions, but it's always useful to come back and remember the nature of the issue that we're trying to address, both for solvency, long-term solvency of the program, but also for the benefit of beneficiaries, and for the promotion of high-quality care and a stable situation for the providers of services to our beneficiaries.

So we're going to start off, as we generally do, with a context chapter. Jennifer is going to present that, and then we'll have discussion.

MS. PODULKA: Thank you, Jay, and good morning, everyone.

As Jay noted, part of the Commission's mandate in law is to consider the budgetary impacts of its recommendations and to understand Medicare in the context of the broader health care system. One of the ways we meet these elements of the mandate is to include in the March report to the Congress an introductory chapter that places the Commission's recommendations for Medicare payment policy within the context of the current and projected federal budget picture and within the broader health care delivery landscape.

These recommendations appear in other chapters of past reports. The context chapter is intended to summarize these recommendations at a high level and frame the Commission's upcoming discussions regarding payment updates and policy recommendations that will appear in the rest of the March report. And while there are no new recommendations in this chapter, we seek your comments today on its scope, substance, and tone.

Please note that, as usual, some of the numbers we'll present today are preliminary and will be updated as

data are published over the next few months.

In today's presentation, I will discuss the main topics of the chapter, which include: health care spending growth, Medicare spending trends in detail, Medicare spending projections, Medicare's effect on the federal budget, the burden of Medicare and health care spending on households, and evidence of inefficient spending in the health care delivery system and challenges faced by Medicare to increasing its efficiency.

For decades, health care spending has risen as a share of GDP. From 1975 through 2017, total health care spending -- shown here on the top line -- more than doubled while private health insurance, Medicare, and Medicaid spending all more than tripled. As a result, in 2017 total health care spending accounted for about 18 percent of our GDP. Government actuaries project that over the next decade health care spending will continue to increase for all payers.

Taking a closer look at Medicare, growth in per beneficiary spending tends to differ across the three program components -- traditional fee-for-service, Medicare Advantage, and Part D. These lines look a bit noisy, but

keep in mind that we're showing year-to-year changes. From 2011 through '13, growth was fairly slow across all three, generally because of decreased use of health care services and restrained payment rate increases. The Affordable Care Act in 2011 began lowering payments to MA plans to bring them more in line with fee-for-service spending and then in 2012 reduced annual payment rate updates for many types of fee-for-service providers.

More mixed trends emerged between 2014 and 2018. Part D was quite high in both '14 and '15, and then fell beginning in 2016, in part due to hitting a temporary peak in spending for hepatitis C drugs. Note that the recent decrease in growth rates doesn't mean that the Part D spending growth problem has been solved. The growth is already beginning to pick back up.

Government actuaries note that a health care spending slowdown affected the year 2009 through 2013, shown here in the first blue bars. The slowdown affected settings differently. For example, outpatient hospital remained high. Most setting grew more quickly following the slowdown in the year 2013 through 2018, shown here by the yellow bars. However, physician and skilled nursing

facilities experienced lower growth or even a decline in the later period.

Here we compare across the decades. On the left side of the graph, the upper blue portion of the bars indicate that per beneficiary spending growth has fallen from average annual rates of 5.5 and 7 percent to just 1.5 percent so far this decade. Looking ahead to the next decade on the right side, the trustees and CBO both project that per beneficiary spending growth will pick back up to an average annual growth rate in excess of 5 percent.

In addition, the continued aging of the Baby Boom generation is causing an increase in enrollment growth. It's almost 3 percent so far this decade. It's shown here in the yellow bottom portion of the bars. Higher-than-usual enrollment growth is projected to continue throughout the next decade; hence, the trustees and CBO project growth in total spending -- shown in those numbers above the bars -- to average almost 8 percent annually over the next decade, which will exceed projected average annual GDP growth by more than 3 percentage points. This means that the size of the Medicare program will nearly double over the next decade, rising from more than $700 billion in

total spending in 2018 to more than $1.5 trillion by 2028. And while spending is growing, Medicare's financing is growing more strained. Workers pay for Medicare spending through payroll taxes and taxes that are deposited into the general fund of the Treasury. As Medicare enrollment rises, the number of workers per beneficiary continues to decline.

I want you to note that those steep curves of both lines are happening in real time. The number of workers per Medicare beneficiary has already declined from nearly four and a half around the program's inception to just three today. And by 2027, when most Boomers will have aged into the program, trustees project there will be just two and a half workers for every beneficiary. These demographics create a financing challenge for the Medicare program.

So, looking more closely at that program, the Hospital Insurance, or HI, trust fund covers just 41 percent of Medicare spending. It includes Part A services and is financed by that dedicated payroll tax. It is projected to become insolvent in just seven years, by 2026, because payroll tax revenues are not growing as fast as the

Part A spending.

The Supplementary Medical Insurance trust fund accounts for the remaining 59 percent of total Medicare spending. It includes services under Parts B and D. It is financed by general tax revenue transfers, which, of course, includes deficit spending. These cover about three-quarters of spending, plus beneficiaries' premiums cover the remaining quarter of the SMI trust fund. Premiums are reset each year to match expected Parts B and D spending.

Since by design SMI income grows at the same rate as spending, its trust fund is never expected to go insolvent. This doesn't mean that it doesn't also face major financing challenges. It does, which the next slide shows.

The line at the very top of this graph depicts total Medicare spending as a share of GDP. The layers below the line represent sources of Medicare funding. Working up from the bottom, all the layers up to the very skinny purple layer in the middle represent dedicated funds collected specifically to finance Medicare spending, such as payroll taxes and beneficiary premiums.

At the top, that pink area represents the Part A deficit created when payroll taxes fall short of Part A spending. And the big orange layer represents the large and growing share of Medicare spending funded through general revenue transfers. That share is over 40 percent today, and keep in mind again that general revenue includes both general tax revenue as well as federal borrowing.

Of course, these same dollars in deficit spending could be used to fund other federal programs. And there is great competition for these tax and borrowed dollars. The black line at the top of this graph represents total federal spending as a percentage of GDP, and the layers below the top line depict federal spending by program. The dashed line represents total federal revenues.

Working up from the bottom, Medicare spending is projected to rise from about 3 percent of our economy today to about 6 percent by 2049.

In fact, by 2041 -- shown by that white vertical line -- spending on Medicare, Medicaid, other major health programs, Social Security, and net interest will reach about 19 percent of our economy and by themselves exceed total federal revenues.

Shifting to the burden of these costs, many Medicare beneficiaries are not exempt from the financial challenges of the program's ever-growing cost-sharing liabilities. In 2019, SMI -- which is Parts B and D -- premiums and cost sharing will consume about a quarter of the average Social Security benefit, which is up from 7 percent in 1980, which, of course, didn't include the yet-to-be-created drug benefit.

The Medicare trustees estimate that these premium and cost-sharing costs will consume 30 percent of the average Social Security benefit in just 20 years. And note that, on average, Social Security benefits account for more than 60 percent of income for seniors. For more than one-fifth of seniors, Social Security benefits account for all of their income.

The burden of out-of-pocket costs falls on those with private insurance, too. In the last decade, per capita health care spending and premiums for employer-sponsored health insurance have grown much more rapidly than median household incomes.

Starting at the top of the figure, from 2007 to 2017, premiums for individual and family plans grew by 49

and 55 percent, respectively. Then per capita personal health care spending grew 43 percent. But the median household income grew just 22 percent.

Thus, in 2017, families' spending on health care, including premiums for employer-sponsored health insurance, consumed a greater share of their household income. And note that the dollars shown here are current-year unadjusted dollars.

On average, since 2009 premiums for employer-sponsored insurance -- shown on the graph by the pink line for HMO premiums and the dotted blue line for PPO premiums -- have grown more than twice as fast as Medicare costs, which is shown at the bottom yellow line.

One key driver of the private sector's higher prices was provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers in negotiating higher payment rates.

Medicare's slower cost growth is partially attributable to restrained increases in Medicare's payment rates. And while commercial insurers usually negotiate prices with providers, Medicare sets prices for many of its services.

Over the same time period, combined Medicare per capita costs, represented by that bottom line, grew by just 15 percent. If fee-for-service Medicare had followed growth in commercial pricing, Medicare costs would have grown substantially more.

Despite Medicare's lower price trend, there are opportunities for further savings in the Medicare program.

There is strong evidence that a sizable share of current health care spending in Medicare is inefficient, providing an opportunity for policymakers to reduce spending, extend the life of the program, and reduce pressure on the federal budget.

For example, services that have been widely recognized as low value and even harmful continue to be provided.

Also, the U.S. spends significantly more on health care, both per capita and as a share of GDP, than any other country in the world. However, despite this higher spending, studies consistently show that the U.S. ranks below average on indicators of efficiency and outcomes. Notably, Medicare beneficiaries' gains in longevity are outpaced by their peers in other

industrialized countries. And note that not all Medicare beneficiaries are experiencing gains in life expectancy.

So to sum up, the Medicare program as well as the health care system more generally face a number of challenges in achieving savings.

For example, Medicare has a fragmented payment system across multiple health care settings, reducing incentives to provide patient-centered, coordinated care. And Medicare's benefit design consists of multiple parts, each covering different services and requiring different levels of cost sharing.

The Commission works to address these challenges with the tools available to the program. The paper includes an inventory of recent Commission recommendations that are designed to address some of these challenges.

So, with that, I'll conclude. The presentation only covered a portion of the information included in the mailing materials. I welcome your questions and comments on any of the issues discussed in the presentation or the mailing materials and look forward to your discussion.

DR. CROSSON: Thank you very much, Jennifer.

So we'll start with a round of clarifying

questions, if there are any. Jon.

DR. PERLIN: First, Jennifer, thank you very much for a very thoughtful presentation and to the entire team for putting together an incredibly important and, frankly, sobering chapter. You know, I think there's no rational adult who can look at a picture that shows the growth of expenses relative to the national revenue and not really want to dive into this.

I have a specific question on page 14 or Slide 14, where you showed the relative growth of Medicare versus employer-sponsored insurance. I understood the way you presented it here differently than it appears to be written in the chapter on pages, I think it is, 21 through 23. There in the chapter -- and this may get at your request on tone -- it seems to state that the employers -- the increases in the reimbursement from employer-sponsored insurance is creating an incentive -- or are forced to pull up the Medicare reimbursement, and that if it continues on that trajectory, that it would bifurcate care to Medicare providers and non-Medicare providers. I'm just wondering what data support that, because that seems to be in direct contradiction to the way you present it today, which is

that, frankly, the economists, the employers, and others would see the employer-sponsored insurance cross-subsidizing the care of the Medicare beneficiaries.

MS. PODULKA: Jonathan, I'm sorry. I'd have to go back and look at the text when I'm referring to this figure in the chapter. I know we have discussion about crossover effects. I don't recall -- it would have been a misstatement if we said it was directly drawing this up based on this figure. That's not our goal of including this information in either the presentation or the paper, so I'll have to go back and check on that.

DR. PERLIN: Thanks. I think there's something that seems to be at odds with the general interpretation of the cross-subsidization.

MS. PODULKA: Okay.

DR. PERLIN: Thanks.

DR. MATHEWS: And, Jon, just on this point, I think one implication of the paper, if I recall correctly, is that given the increased, you know, leverage that providers have in certain markets, particularly markets where there has been substantial consolidation and the providers have gotten the upper hand on negotiating with

insurers, that has the effect of increasing the commercial payer margins and the effect of making Medicare margins look that much worse and is implicitly putting pressure on the Medicare program to increase its payments to keep up. I think that's the point that's made in the paper, if I recall correctly.

DR. CROSSON: Yeah, and beyond that, I think there's the question of whether market consolidation, market power in any setting, virtually in any industry, has the effect over time of increasing the cost structure.

DR. PERLIN: Well, I just ask us to go to the data in the sense that, you know, let's look at all reports. There's a brand-new report from Charles River Associates that shows that, in fact, consolidation held down the costs and the reimbursement that the payers pay. And, you know, it also -- I mean, Medicare is the big kid on the block, and the shadow policy and shadow pricing tends to flow from Medicare to the commercials rather than the other way around. So I just have some trouble with that paragraph in terms of wanting it to be --

DR. CROSSON: So I think there's room for debate there.

DR. PERLIN: Well, let's go to the evidence.

DR. CROSSON: Okay. Dana.

DR. SAFRAN: Thanks. I'll echo Jonathan's praise for this chapter. It's really very well written and powerful.

I have three questions. One is related to the slide you have on the screen. I'm wondering about the choice of using premium on the commercial side versus cost. Since premium here is not going to capture buy-down, you know, in some ways, this underestimates the gap because premiums don't include the buy-down that employers are doing in order to be able to afford their share of the coverage. So can you just help explain why premium and not commercial costs, the same way you've got Medicare costs, grow?

MS. PODULKA: The really short answer is we agree with you. We understand the limitation here, and lack of a better data source encouraged us to go with premium. But you're right. It's absolutely understating some of the cost growth that's occurring through deductibles and cost sharing and other total cost burden.

We'll continue to investigate a better

alternative to capture total cost, if that's available.

DR. SAFRAN: Thanks.

MS. PODULKA: Sure.

DR. SAFRAN: My other two questions are about figures that were in the chapter that you didn't put here. One was on page 12 of the reading materials, and that was a set of pie charts of the kind of then-and-now view of the pieces that make up our total health care spending.

Both of these next two questions about figures are going to ask for whether there's additional information you have found that you maybe could build into the chapter that I think would set us up to better drive towards solutions. You don't do a fantastic job establishing the fact base.

But I feel that, like, for example, what I'm wondering in this figure is, Do we have data that would enable us to parse out growth in price versus growth in use on a population basis for these different segments so that we could understand kind of what's really changing, what are our levers of opportunity for addressing the picture today?

MS. PODULKA: I will definitely go back and check

and see if that source breaks it down. I'm not sure that it does, which will lead to a search for some additional sources to build out the picture.

DR. SAFRAN: Okay. Then, similarly, on page 51, where you're doing the really compelling international comparisons, those are always so compelling. I was wondering in that table there whether we could similarly present what do the prevalence and cost for these conditions look like in some of the OECD nations that you on the previous page compares to on more macro issues.

MS. PODULKA: So that would be tying in those leading causes of death to the international?

DR. SAFRAN: You're looking at the prevalent chronic conditions?

MS. PODULKA: Yes. Okay.

DR. SAFRAN: Okay. And so I'm just curious. In other OECD nations, do you see a similar prevalence of these conditions, and do you see a similar cost for treating these conditions? And then you'll know where I'll want to go after we see that there's a different cost for treating these conditions, trying to understand what's different in the way these conditions are being treated in

these other countries.

I think getting a little bit under the covers with this kind of information could help us really think about where are our levers to intervene in our population.

MS. PODULKA: I love where you're going with this. Let me see how much we can delve under the covers there that you're mentioning and still not break the binding of that March report, because I think this is fascinating. It's just trying to summarize and address it at a high-enough level.

DR. SAFRAN: Yeah. Thanks.

DR. CROSSON: Okay. Marge.

MS. MARJORIE GINSBURG: I just have a couple small questions.

On page 59, halfway down, where we're talking about features that make the program vulnerable to inappropriate care, it says "which include fraud and abuse but not overuse," and I didn't understand the distinction there on why overuse is not considered part of that.

And then I have a second question as well.

MS. PODULKA: This is more semantics. The "overuse" is grouped with patient selection, steering, and

overuse. There is genuinely benign, not necessarily poorly intentioned overuse. Providers can be practicing medicine in the best way they know how, and maybe they're missing a lab finding or something. And it makes the most sense at that moment to do the test again so that it's there to treat the patient. That is more overuse.

That is really separate, I think, from the intention behind fraud and abuse, like setting up a billing number fraudulently and billing for services that never occurred.

So we didn't want a group, particularly the actors and the beneficiaries who are part of fraud and abuse with those who are part of overuse. I think the approaches for dealing with them would be really different.

MS. MARJORIE GINSBURG: It may or may not be worth a footnote just to explain that.

MS. PODULKA: Yeah. It's coming up.

MS. MARJORIE GINSBURG: The second question, on the list of recommendations on page 62, 63, which are really fabulous -- and I love this summation of all the areas that MedPAC has been working on. My question is there's no reference on this list of things that have

actually been implemented in terms of what -- this isn't focus on the fabulous success of MedPAC, of course, but it might be worthwhile to at least footnote the changes that have actually come about based on the recommendations.

MS. PODULKA: Thank you.

DR. CROSSON: Warner.

MR. THOMAS: Two quick questions.

One, on page 16, it's Figure 5, where you kind of show the MA and fee-for-service trends, and we tend to indicate that MA is more expensive on a per-beneficiary than fee-for-service. Do we look at or have we looked at the markets where there's more MA penetration than just the cost of Medicare in those markets generally? I mean, it seems like Medicare -- or Medicare Advantage is more prevalent in markets that are generally more expensive for Medicare beneficiaries. I mean, I don't know if that relates to any of the costs.

MS. PODULKA: As I'm glancing over here at our MA experts, it's not something that we've undertaken recently.

Jeff will address market base as long as he's not -- yes, he's nodding. It is coming up.

MR. THOMAS: Okay.

MS. PODULKA: You will be hearing about market effects.

MR. THOMAS: Okay. Because I think if, in fact, that's the case that there's more MA penetration in higher-cost markets, I think that would be something to indicate in this area when we're kind of referencing MA.

The second question -- and it's really just a general one -- is on Slide 9 of the presentation. We just kind of mention -- you mention the Trust Fund will go insolvent in 2026. What implications does that have just generally for the program or for beneficiaries just in general? What does that practically mean?

MS. PODULKA: It's unclear. Basically, it means there will be insufficient income into the Trust Fund in that year to meet its expenses. That's unprecedented. So it's unclear what would happen.

Hopefully, what happens is that the impending date causes sufficient change from the Congress or potentially CMS to push out that date.

Literally, it could be paying bills up until the fund runs out of cash. It could include paying pennies on the dollar. Since we haven't been there yet, it's unclear

what would happen.

DR. PAUL GINSBURG: If I could add something. Historically, there have been a number of cases over many years where the Trust Fund was getting close to insolvency, and that just served to force congressional action on Medicare spending and payroll taxes.

I think many people expect that's going to be the case going forward. So the Trust Fund exhaustion is a forcing device for Congress to basically force itself to grapple with this.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Well, Jennifer, I really like the focus on mortality. As an actuary of a certain age, it was very meaningful to me.

[Laughter.]

MR. PYENSON: But that's because when I was training as an actuary, we had to do mortality table construction.

I'm wondering if it would make sense to look at dual versus non-duals and the mortality impact of that, which strikes me as one of the socioeconomic factors that we can observe in the data. Perhaps there's others as well

because we're -- mortality, I think, is an important outcome of health, and often if it's socioeconomic, it's not directly related to health care but other issues. And that would help us understand better, I think, the medical versus nonmedical issues.

MS. PODULKA: I love this idea. I always seek opportunities to include the under-65 whenever I've got the 65-and-older because it's incredibly frustrating to leave out this really significant portion of the population.

And I'm hoping as an actuary, you can point me to the data source to use, because I have trouble isolating the under-65 and what their morality would be if they're Medicare beneficiaries. So if you have something to follow up, that would be really helpful. Thanks.

DR. CROSSON: Bruce, just for your benefit, your colleague commissioners will be keeping an eye on what you eat for lunch.

[Laughter.]

DR. CROSSON: Further questions?

[No response.]

DR. CROSSON: Seeing none, we'll proceed with the discussion, and then our opening comments are going to come

from Brian.

DR. DeBUSK: First of all, thank you, yet again, for a very well-written chapter.

This is my fourth year as a commissioner of seeing this. It doesn't get any easier to read. Each year, it is very sobering. I think that's the word I used even last year.

The one thing that really jumps out at me when I read this chapter is the word "unsustainable." We are continuing to erode federal budgets. Health spending is going to continue to erode federal budgets, state budgets, and even household incomes, as you call out in the chapter.

On this topic, it's sort of difficult to say something that hasn't already been said, but it's also difficult to convey a sense of urgency without sounding like a demagogue here because I think there's a balance that has to be struck.

What I get out of the chapter -- I'm going to make an attempt to do that today, and I think what I get out of the chapter is it makes a really, really good case for change. Basically, what I read is we need to do something differently.

So I'd like us to focus a little bit more -- and this is feedback on the chapter itself -- on how do we fix this, even if it's toward the very end of the chapter.

I think, for example, on pages 60 through 63, you do a really nice job of talking about some of the ongoing maintenance and improvement that we've made to fee-for-service -- readmission reductions program, site-neutral payments. I think that's appropriate that we should say look at the good work that's being done to maintain this program.

I do hope that we can speak a little bit to alternative payment models. I think that probably deserves its own area of recognition.

Also, I hope that we can speak a little bit to -- and maybe it's this chapter or maybe it's flowing into another chapter -- of opportunities to innovate in MA too.

But, as you talk about the case for change -- and I want to take a moment and sort of talk a little bit about on the innovation side -- for some reason, health care attracts all these car analogies, right? It's changing the tires on a moving car. It's rebuilding a car that's going 60 miles an hour on the interstate.

Everyone here has seen this before, and I've seen it four times. I am going to attempt to re-create part of it here, and I know I'm going to butcher it. But my favorite car analogy is the one that our chairman uses for new commission orientation.

So you guys are going to remember it, and yes, we have props.

[Laughter.]

DR. DeBUSK: What does he do? He pulls out a 1965 -- he pulls out a '64; I pull out a '65 -- Ford Mustang. It's an instant classic, and that date isn't chosen by accident. That's the date -- '65 is the year that Medicare started. It's a timeless classic. It's a vehicle that has gotten us a very long way, over half a century. It's also a vehicle that requires us -- and on the commission, one of our duties -- and I think this is the sobering message that Jay sends us -- is we have to make sure this vehicle stays in top working condition.

I mean, this is the vehicle that got us here, and so the ongoing maintenance of this vehicle is important.

Now, part of what I get out of the context chapter, though, is or ability to maintain this vehicle and

the cost of maintaining this vehicle is slowly exceeding our ability to pay for it. That's what I'm getting out of the context chapter. This is the proverbial boiled frog.

So what Jay does is he pulls out some exotic super car and sets it next to it -- and I've had a lot of commissioner feedback on this, Jay, by the way, and I'm going to share it with you, which is this is an environmentally irresponsible car, and it's also very, very overpriced. And I think it was maybe Karen that gave me the first idea: Shouldn't we really be talking about a Tesla?

[Laughter.]

DR. DeBUSK: I mean, don't we want to be environmentally responsible, financially responsible? So what we're going to do from this point on is we're going to talk about the Tesla.

And my thought here is -- and I think the context chapter is our first change to really convey this -- I think we need to send a message we're going to keep doing incremental improvements. The maintenance is an absolute must, but ultimately, it's going to take a new car. And I think that's a sobering thought.

Maybe it is something coming out of the MSSP program. Maybe it's innovation on the Medicare Advantage side. I wasn't super encouraged with that after seeing the next chapter. But maybe it's a Next Gen ACO. Maybe it's one of the new contracting models. But I think this context chapter is our opportunity to say it's going to take a new car. So that's one of the first points that I want to make for feedback on this chapter.

The second point is a little bit more controversial, and it's something that I've talked to a number of commissioners about, and it's a question. This isn't an assertion, and I'm not saying this is the way things are or have to be. But I'm asking a legitimate question. So far, every time we set out to build this car, whether it's BPCI, MSSP, Next Gen, every time we set out to build this car so far, we start with the frame from this car, and the frame being the fee-for-service chassis. Every alternative payment model that we've done so far has been derived from the fee-for-service chassis. It's a highly inductive engine.

I mean, a number of you have made comments in the past. You're starting with an engine that inherently

induces volume, and all of the alternation payment models going forward are designed to try to tamp that inductive effect down. That's what we spend our energy on, whether it's through a benchmark or a capitated payment or a BPCI settle-up. It's all about tamping down the induction from this frame.

And I think one fair question -- and I don't know if this is context chapter or if it's in the next chapter -- is, Should we be exploring models that don't necessarily rely on this frame? Are we limiting our design? My question would be, Is the fee-for-service engine -- is that chassis a fatal flaw that propagates into downstream models?

Later, we're going to look at something. We're going to look at MA, and I personally don't see a lot of innovation in MA, but what have they had? You give for decades. We've given hundreds of companies prospective capitated payments with favorable benchmarks and a great enrollment mechanism. We've given them all the things that should create an atmosphere for innovation, and as far as I know, I haven't seen it happen.

My question would be, Has that fee-for-service

fatal flaw propagated into that program? Can you just simply not get there from there? I'm not saying you can. I'm just asking the question. But that's my take on the context chapter, and thanks again for a very well-written chapter.

DR. CROSSON: Okay. Thank you, Brian. I've got Karen and then Kathy.

DR. DeSALVO: Okay. And I don't have any props or --

[Laughter.]

DR. DeSALVO: So this person --

[Laughter.]

DR. DeSALVO: I'm going to be much more pedantic than that, but I appreciate your comments. I'll start with tone, maybe, which is the house is on fire. Thank you for yet again alerting us to that. We need to scream it a little more loudly, because we've got some significant challenges, not just for the program but for the country. And so we have important work to do and we need to do it, with a sense of urgency. And the more you can elevate that, I think keep pushing the tone, it's not unimportant. It's really quite important for the whole country.

I just have a couple of scope comments that I wanted to make, and I'm not trying to break the binding on the March report. But it seems that it would be helpful to have a bit more understanding of the delivery system and where we are in terms of quality of care and safety of care, and just generally some comments about access to services, if relevant, maybe geographic differences for rural and urban but also I think some of the issues that the Commission has been looking at, like access to primary care as one example. So some thinking about how we could build in the supply side of the equation.

And I just had a couple of comments about the emerging pressures, challenges, headwinds that you talk about in the mortality section, I think a little more. So there are probably some headwinds to start to consider around the social determinants of health, not only how they're affecting morbidity and mortality but given the latitude that Medicare Advantage plans have now to pay for supplemental benefits in the context of social determinants, given the work that CMMI is doing to look at addressing social determinants, the accountable health community's models and other mechanisms, and there's some

discussion about whether they could be a part of a fee-for-service schedule.

So since you talk about it in the challenges to the beneficiaries, and there may be some solutions, but those solutions may come with costs. That and then the technology piece, and I would include in that bundle technology not only which you talk about a bit, about drug cost and development but precision medicine, and then just the whole range of other technological options that are on the horizon, that may or may not land in the fee schedule and/or in some of the expectations of payment.

But it was a great chapter. Thank you very much, Jennifer.

DR. CROSSON: Thank you, Karen. Kathy.

MS. BUTO: So I want to highlight, in the mailing materials, Jennifer, something that I've been reading this chapter for six years now. So I went back and looked, and this graph has been in the chapter for all those years, I believe. I went back a couple of years. And it's Figure 14 on page 33, which is innocuously titled "Health care spending growth impacts future debt levels."

I think this one is the bending-the-cost-curve

graph. So if you look at, as you've shown on the graph, a 1 percentage point lower growth rate will really bend the cost curve. And so if there's a way that we can amp this section up a little bit and then tie it to, I think, something that -- possibly to Figure 6, which is sort of, for major segments in Medicare what are the growth rates, what are they looking like.

And then really what Dana was talking about, on page 51, if we're going to do an OECD comparison and say look at the difference, these are some areas where we might have opportunities to actually reduce the growth rate by 1 percent. One percent is a lot of Medicare, but it's not a lot in a way, if we can think about how a big a significant difference it could make as we look through the other chapters in the course of the year.

So I really like this graph and I realize that it's been overlooked. I don't think it even made the slide show. But it's a big deal.

DR. CROSSON: You know, it's an interesting comment, Kathy, because, you know, if you juxtapose that, what you just said, with some of our, you know, previous discussions about the success of various programs, and 1

and 2 percent savings and all of this -- and I realize one is cumulative and other is not necessarily -- but, you know, were we, overall, successful, year over year, in reducing Medicare expenditures by 1 percent, as you point out, it could make a tremendous difference. So thank you for that.

Okay. So that's -- Dana. Dana. Sorry.

DR. SAFRAN: Yeah. Thanks. And just building on the previous two comments I think that my comment is really that I'd like to see this chapter tee us up to talk about solutions, and so that point has already been made. But to put a finer point on it, I think that what Kathy started to point to is, you know, what can we say about what it would take to avoid the catastrophe that you've shown us in the visuals, you know, including, on page 31, that we're facing economically. What would it take?

And then in the kinds of initiatives that you show, and that we were talking about earlier in the late part of the chapter that we've already done, can we do something to say what have those accomplished? And maybe is the framework of what have they accomplished on the

financial side. Since this is a criterion that CMMI is held up to, what have they done to either reduce cost growth without harming quality, improve quality without increasing costs, like what -- how do we calibrate what those are yielding, or expected to yield?

And then beyond that, just teeing up some discussion about like what are our levers to make the kind of change of like 1 percent per year or something, to give some sense of hope and empowerment to act, as opposed to just these incredibly sobering facts of what we face.

Thanks.

DR. CROSSON: Thank you. Jon.

DR. PERLIN: Yeah. It's interesting. A couple of things that I think we should add to the context, which I think would be very defining and relate to the high utilization of Medicare beneficiaries in certain periods during their tenure as Medicare beneficiaries.

We always think of end of life, that we hear the statistics about the last two years, the last six months, and the last two weeks. That's true. But there's another period where utilization is very high, and that's at the advent of becoming a new Medicare beneficiary. And if I

recall the health services research, it's really during the first seven years. That, of course, is directly related to variable access to health care services prior to eligibility of becoming a Medicare beneficiary.

So Medicare inherits not only, you know, variable access to health insurance, access to care of new beneficiaries, but also the chronic disease burden that is part and parcel of the current context.

So my two suggestions for enriching the context and thinking globally about the solutions, there are two areas. First, the need to call out the accelerated burden of chronic disease. The numbers are very obvious. It relates to care and the terrific comments about social determinants. And the second is variable access to care that precedes eligibility for Medicare.

Thanks.

DR. CROSSON: Thank you, Jon. David.

DR. GRABOWSKI: Great. Thanks, Jennifer, for a great chapter. When I first joined the Commission I was sort of puzzled as to why we did this. Don't we already know this? Now I find it, like everyone else, really sobering and very necessary and flat-out scary. So I do

think it's a necessary exercise.

To Brian and Dana's point about wanting to tee things up for our kind of agenda going forward, I really think connecting those challenges you had on Slide 16, and also in the chapter, with kind of what are the different levers that we have. Brian focused, in his remarks, on do we want to think about the fee-for-service chassis and do we need to break that. How do we incentivize more innovation in MA? I think you could look at every one of those challenges that you have there and think about the policy agenda, whether it's, you know, Medicare is just one payer in the overall system. How do we think about Medicare vis-à-vis these other payers?

One area I've been particularly interested in is the duals. How do we think about models that can sort of address some of the disconnect between Medicare and Medicaid and their treatment? I don't want to break the binding here, but how do we think about kind of teeing up research to sort of address all these different challenges? I think just better kind of pairing in that latter part of the chapter would be really helpful, rather than just listing out here's all the things that MedPAC has

recommended, but actually trying to do some connections with these different challenges.

Thanks.

DR. CROSSON: Thank you, David. Jonathan.

DR. JAFFERY: Yeah. Thanks. So thanks. I want to echo that it's a great chapter and I appreciate your enthusiasm for taking on a whole other laundry list of analyses and looking for data sources and whatnot.

I think, you know, I agree with Kathy to eliminate that particular figure that shows what the impact of that could be, but also maybe thinking about is there a way to model how that impact may differ on beneficiaries and beneficiary costs. The affordability for beneficiaries is woven through here but it's not quite as prominent as the system overall.

And then the other, maybe, idea builds on the idea that the analysis that Dana had brought up on Table 6 on page 51, talking about comparing how chronic conditions and whatnot and spending in other countries. And I think, you know, you hear a lot -- we all hear a lot about people saying, you know, are there comparisons in other countries? And over the years, and still continuing to this day, you

see a lot of people, once they get their hands on claims data or whatnot they start to dig into it and they immediately try to go to what are the top conditions. And then they always come up with the same answers.

So I wonder if, in addition to thinking about just the prevalence of these other conditions in other countries and the total spending, thinking about that spending as a percentage of total spending. So in other words, if, in some other similar -- other countries you've got similar prevalence, you know, we can anticipate that the spending will be lower because of a variety of things, but if they're spending less as a percentage that might help, I think, systems or people think about what other ways -- are there ways to try and tackle or look to other countries to look for some ideas about different ways we might model care around a particular condition? Otherwise, it feels very broad.

MS. PODULKA: So focusing more on this very specific allocation of resources by those conditions. So like the dollar figure by itself is not going to have a lot of meaning unless you put it in that context.

DR. JAFFERY: Right, and understand that it's a

percent of total per patient, per beneficiary spending.

MS. PODULKA: Okay.

DR. JAFFERY: Exactly.

DR. CROSSON: Thank you, Jonathan. Pat.

MS. WANG: Okay. I think that I appreciate all of the information that's always in here about demographic shifts, changes in the profile of beneficiaries in the program. This report points out, you know, many things, and others have mentioned the importance of highlighting increased incidence of chronic disease, multiple chronic disease, social determinants of health. I would add things like BMI.

And the reason that I say this is that one of the scary things, I think, in the chapter is the highlighting of the demographic shift in the proportion of workers per beneficiary because of what's happening with the aging of the population, and the burden on a much smaller number of working people to fund the Part A trust fund.

I feel like the chapter could spend, or maybe in the future could spend more time on beneficiary characteristics as they go into the Medicare program, because Medicare doesn't just sort of start at age 65.

It's the culmination and the spending, et cetera, of everything that has happened to somebody up until that point and what people bring into the program with them. And I just think that there are going to be implications in the future, given the changing demographics, for the structure of the benefit, beneficiary responsibility. I don't know.

You know, you point out, in a very sort of neutral way characteristics of the Medicare program -- any willing provider, et cetera, et cetera, et cetera. I suspect that, you know, one of the interesting things, if one were to delve into that comparison of the OECD countries, is just how do benefits differ in terms of what people have ready access to. You know, I want this, I want that, I want that. Can you get that here? Can you get that over there? Is that a factor in the lower spending per beneficiary with equivalent outcomes?

I just think that one of the things that's kind of missing from the report -- I mean, this is MedPAC. I understand it's payment commission. But I think we have to include the beneficiary somehow a little bit more actively in the discussion about how the country is going to take

care of a very large number of people who are going to be younger, who are booming in now, and who are going to be older, at the other end. It's a long-term responsibility.

So I think sort of having more of a presence or what are the implications as people are coming into the program -- I don't know, but I think my impression is with characteristics that may make them more prone to chronic disease, such as overweight, things of that nature, that it somehow has to get built in here, whether this time or in the future.

DR. CROSSON: Thank you, Pat. Now I've got Warner, Marge, and Amol, and I think given the time that will be the discussion. So Warner.

MR. THOMAS: So I'm like Kathy. I'm going into my last year here so it's the sixth time I've seen this report. And I would just say that personally I don't think we are operating with a great level of urgency, given what's happening here. In some ways, on reflection, I feel like I've failed as a commissioner because I don't think we've taken bold enough steps to kind of move this curve.

I would agree with Kathy that I think the idea of building up, in the report, specific actions that could or

should be taken to blunt the increase, and whether it's 1 percent or we put it in 1 percent increments so that we can start to normalize that curve, I think is important.

And I think we need to maybe even change the title of the report, because it's kind of talking about a context. Actually, it's more than context. It's about urgency and moving quicker. I think this concept of, you know, what happens when -- you know, if 2026, the trust fund does go bankrupt or is exhausted, I think, you know, Paul's point is, well, we'll just raise taxes. I guess that's one thing. But we don't know what's going to happen. So I think that's the reality right now. We don't know.

For the new Commissioners that are coming on, when you are in your sixth year you'll be one year from this happening. So best of luck to you there.

[Laughter.]

MR. THOMAS: And we kind of laugh about it a little bit but it's really not -- this is serious. We're talking about millions of people that are counting on us to make the right change, and I think we've got to take it in that context and push harder, and push with the right level

of urgency.

So I think the report is well written. It always is. I think the tone should be amped up significantly, and I think the title should be considered, you know, changing, given the magnitude of the issue.

DR. CROSSON: Thank you, Warner. Marge.

MS. MARJORIE GINSBURG: I'm a little concerned with all the fabulous suggestions about what we need to add to the report, that regardless of what it does to the binding that no one will read it. That if we have too much stuff in here, too many things that have to be done, too many urgent things, then people just flip to the last page and move on.

So my only suggestion, actually, was there is a section here on the opioid epidemic, and I didn't think it belonged here. If it didn't make the list of leading causes of death then let's save it for something else.

But the bigger message is we really need to hone in on what is it we want to convey in this chapter and what's the best way to do that without overwhelming people with too much information and too much date and too many to-do lists.

That's all. Thank you.

DR. CROSSON: Thank you, Marge. Amol, last comment.

DR. NAVATHE: So, first off, thanks for pulling together this pretty impressive compendium of facts. I want to agree with many of my Commissioners and also disagree on a couple of points.

I think it's clear that there's a sense of urgency that obviously there's sort of a call to arms here. I think as we think about adding different things to the chapter, the chapter could indeed become the book, and I don't know that we necessarily need to do that. I think, in some sense, we can make a crisper articulation of the urgency if, in fact, we don't try to solve everything with this chapter also.

And what I might suggest instead -- because I think often times we think forward and we say, okay, we have to curb spending growth, we have to improve quality, we have to improve life expectancy, we have to address social determinants of health. And I think those components are right, but I don't know that we know what that goalpost looks like.

And I think what might be helpful instead of trying to tie to specific solutions is, in fact, maybe to look and say, well, what are the scenarios under which this works? How much, if we need to cut down on acute hospital spending, how much would acute hospital spending have to go down if we were to curb this growth from that particular category? Across the entire sector, across different components of spending in Medicare, what does this have to look like? What are the different scenarios under which we actually do solve this problem, and what does spending look like in that scenario? What does sustainable look like?

I think if we can get to some sense of scenarios then we kind of understand a little bit more about what that goalpost is, then we can move toward, you know, what are the solutions to get us to that goalpost. I think right now we all viscerally understand that, yes, there's a challenge here and we're about to run to insolvency. But I don't think we have a good -- at least I don't have a concrete picture of what spending distributions look like or what options we have, what we're trying to solve for.

So I thought that might be helpful, is at the end of this chapter, instead of trying to get to these are the

specific actions that we're recommending, here's the specific scenarios that we might potentially shoot for as sustainable.

And then I think to the extent that we want the chapter to become the book, if we end up going down that route, then I think it would be helpful to think, and potentially structure the second half of this chapter into cost drivers. So what is driving the cost?

You know, Dana had made the suggestion about disaggregating across price changes and utilization or use changes. I think that might be helpful, and that might actually lead us to more a vessel of a solutioning piece, because I think right now, to me, at least, when I read the chapter the recommendations of site of service and such, while they certainly resonate and make sense -- we've read them in prior reports -- they're a little bit disconnected from the fact base that we're showing. And I think it might be helpful to actually draw a potential link there.

The last piece I'll leave with is I think we do a nice job, and you've done a nice job in the chapter of laying out here are some of the challenges, and I think we don't, however, articulate the potential opportunities, the

potential ways in which Medicare does have tools and opportunities that perhaps other payers may not, that perhaps if it weren't Medicare it may not. And I think if we can also articulate those that would be a more balanced way to look at not only our challenges and the limitations that we have but also perhaps opportunities that we have, and that might help us get a more concrete vision of how we get to Brian's picture of the future Tesla.

DR. CROSSON: Thank you, Amol. Very insightful.

Sue, last mini-talk.

MS. THOMPSON: Thank you, Jay. This is my fifth time with this chapter, and again, well written, and I would want to echo many of the comments of the Commissioners. But I feel like we haven't spent any time on the beneficiary.

I just want to call out that we do a lot of things to Medicare beneficiaries that are not helpful, and there's a lot of waste in this program. And in this fee-for-service chassis upon which this entire program was built there's an opportunity to identify what we're doing to Medicare beneficiaries that is not only not good for them, it's harmful to them. And in that waste I think we

have some opportunities as well.

DR. CROSSON: Okay. Very excellent comments. Thank you all. Jennifer, you've now got a very full plate -- a smorgasbord, as a matter of fact. So we'll see.

So let's move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. I'd like to introduce Professor Jeff Stensland who, by my reckoning, has just won the award for the most erudite chapter that I've seen in my time here.

Jeff, my only request is be gentle on the Commissioners as you make this presentation.

[Laughter.]

DR. CROSSON: Go ahead.

DR. STENSLAND: I'm not sure that's a good thing or bad thing.

I'll start off just by saying that for Medicare Advantage plans to profit, they're dependent on changing the practice styles of physicians or the coding behavior of physicians. And the physicians serving MA patients usually also provide care to traditional fee-for-service patients, and this raises the question of whether the changes in

practice style and coding that are induced by MA plans then "spill over" into the way those same physicians care for traditional fee-for-service patients. This could result in lower costs and/or higher coding of the traditional fee-for-service patients in areas where there's lots of MA penetration. And the purpose of this presentation is to test a couple hypotheses regarding the magnitude of these two different types of spillover. And, of course, this has some policy implications.

Some research has suggested that the magnitude of the spillover is so large it could justify paying MA materially more than fee-for-service. But this would only be the case if the spillover truly changes practice patterns and not just coding. Therefore, it's important to judge the magnitude of both the practice pattern spillover and the coding spillover.

First, let's be clear about what the two spillover hypotheses are.

First, in the case of a practice pattern spillovers, the hypothesis is that when MA plans grow in a market, they give incentives to physicians to practice more conservative medicine -- ordering less tests, maybe

shifting services to an outpatient basis. The hypothesis is that the physicians practice just one style of medicine and so their practice style will change for both their MA patients and their fee-for-service patients.

The MA practice style change partially spills over into the way fee-for-service patients are cared for. And note I say "partially" because there are some volume-reducing tools that MA plans have, such as prior authorization or limited networks, that wouldn't spill over into fee-for-service, or even some of the fraud and abuse limitations they can implement.

The HCC coding hypothesis is similar. MA plans may give physicians incentives to code more completely and train them on how to fully code the HCCs. Physicians then may adjust their coding patterns for all of their patients, including fee-for-service patients. The MA plan coding patterns may then partially spill over to fee-for-service.

Let's see. So we have this slide, and before I start talking about spillover, I want to talk about how most studies measure changes in risk-adjusted spending when they're measuring spillover.

Most studies use fee-for-service risk-adjusted

spending which is the spending divided by the HCC score, and that's just the equation that you see there up on the slide.

MA plan penetration could affect fee-for-service spending through practice patterns -- that's the numerator -- and that would generate some real savings.

MA plans could also affect HCC coding, and this would create an illusion of savings just by increasing the denominator and then causing a decrease in the ratio.

So we're going to try to quantify how much of each type of spillover there is. But before I do that, I just want to go over some general descriptive statistics, and this first one kind of addresses the question Warner brought up earlier.

The general idea there is, well, if MA plans do really change the coding and practice patterns of physicians and then those practice patterns are more conservative and they spill over quite a bit into fee-for-service, then in areas where we see lots of MA penetration, we should see some lower overall cost growth. And that's just kind of intuitively is this what we see here.

So we took a long look at the data from 1991 to

2014 looking at how much Medicare spending grew on an annual percentage basis -- and this data comes from the CMS actuaries -- and compared that to statewide MA penetration in 2014. So this is over a 23-year period we're looking at growth.

Over this period, there was a large growth in MA penetration from 4 percent in 1991 to 28 percent in 2014, with some areas growing to quite high levels of MA penetration. So the question is whether the growth in MA penetration to a high level -- say 30 percent, 40 percent, or 50 percent -- was associated with slower overall Medicare spending in the state, and the answer is no.

There was not a statistically significant correlation between Medicare spending growth and the ending level of MA penetration. This suggests that the effects of MA spillover on fee-for-service were not large.

However, this is just raw spending. There could be other factors such as changes in beneficiary health status or changes in prices that may also affect changes in Medicare spending. For example, if you look down in that lower right-hand corner, you see Nebraska, North Dakota, South Carolina. Many of these states with the largest

spending growth were states with large rural populations that may have received above-average price increases.

So now we're going to try to control for some of those things. Let's control for health status and prices and see where we end up.

In this graphic we look at relative service use in 2016 in 335 metropolitan areas. This is spending adjusted for local prices and for HCC risk scores, and here we're just looking at a snapshot in time. The question is whether fee-for-service beneficiaries' service use in 2016 was correlated with the level of MA penetration.

It's hard to see from the scatterplot, which looks almost random, but there is a slight, statistically significant negative correlation between HCC-adjusted service use and MA penetration. It implies that MA penetration may have a slight effect on either physicians' HCC coding and/or physician practice styles when they start caring for fee-for-service patients. And we'll try to disentangle whether the spillover affects HCC codes, practice styles, or both.

But before we leave this scatterplot, we should pause and discuss a second takeaway point from the slide,

and that's that MA penetration is not a dominant factor in the variation of fee-for-service spending across markets. For example, we see some high-MA-penetration markets such as Rochester, New York, with low service use. But we also see some low MA penetration areas such as Farmington, New Mexico, that also have low service use.

Similarly, we see similar levels of fee-for-service use in both Pittsburgh and Allentown, and while the fee-for-service use is similar, they have very different levels of MA penetration.

Also, for many years, we've seen high levels of MA penetration in both Miami and Honolulu, but they tend to have very different levels of spending.

So, in sum, MA spillover may be playing a small role influencing the care received by fee-for-service beneficiaries, but it's not a dominant factor in explaining the regional variation in service use that we see here.

So when examining changes in spending, we have some concerns with the existing spillover literature. First, not all the literature controls for different rates of growth in Medicare prices in different regions, and his is important because areas with strong MA growth have

tended to be also areas with slower Medicare price growth. If prices are not controlled for when measuring spending, spillover will be overstated. We control for prices but are limited to looking at urban areas because CMS price-adjusted data is not adequate for rural areas. For example, CMS data does not control for the changes in prices paid to critical access hospitals and rural health clinics, and it doesn't account for things like the shift of rural physician practices to rural hospital-based health clinics. And this can understatement of the price growth in rural areas, and rural areas also have less of an incentive to code given they are paid costs rather than some prospective payment rate that's dependent on coding for risk adjustment.

We also want to examine HCC spillover. Some of the literature assumes that MA penetration will not affect coding practices. In contrast, if MA coding practices do spill over to fee-for-service patients, then not factoring in coding spillover into the equation would result in an overestimate of practice pattern spillover. Rather than assume no coding spillover, we'll try to estimate how much coding is affected by MA penetration.

Our method for evaluating changes in practice style and coding is as follows.

To control for prices, we look at price standardized spending in 319 urban markets.

To avoid the need to adjust spending by HCC scores, which might be changing due to MA, we look at changes in spending for a constant cohort of Medicare fee-for-service beneficiaries. That way we don't have to adjust for HCCs.

We also control for changes in ACO penetration.

The question we then ask is whether price-standardized spending -- for a constant cohort of beneficiaries -- grew slower in markets with higher starting levels of MA penetration or higher growth in MA penetration over those years.

So let's just look at a descriptive statistic on the levels of spending in high-penetration and low-penetration markets. We assume that MA penetration will affect fee-for-service HCC scores and practice styles with a lag. Therefore, we just examine 2015 MA penetration and 2016 price-adjusted spending.

High-penetration markets had MA penetration that

was 39 percentage points higher than low-penetration markets, and fee-for-service spending per month was $14 lower. This would imply that a 39 percentage point difference in MA penetration was associated with a 2 percentage point lower level of spending in 2016.

Of course, this could be different due to different levels of health status in different markets. And to control for that, we want to shift from just looking at levels to looking at how spending grew over time.

Here we examine whether changes in MA penetration are associated with slower growth in spending for a constant cohort of beneficiaries. We find no effect of MA penetration on the growth of spending -- the growth of MA penetration on the growth of spending, excuse me. This is a bit odd given the earlier finding, and this could be that either the effect of MA penetration has a long lag or using a one-year lag in this model; or it could be that after the initial effect through 2012, additional MA penetration really had a small marginal effect on spending.

However, this is only a simple univariate model, and next we want to shift to a multivariate model that controls for other factors such as the concurrent growth in

ACO penetration.

Now, this time we examine changes in spending and in HCC scores. In this case, we control for starting level of service use to adjust for regression to the mean effects and anti-fraud efforts. We also add in a variable to reflect ACO growth since we think that can affect fee-for-service spending. We discuss several other covariates in your mailing materials.

The parameters in our model suggest that a 10 percentage point higher level of MA penetration in a market is associated with about a 0.4 percent greater increase in HCC scores over the three years we're talking about here. This means that as MA penetration grows, it appears that HCC scores grow a little faster.

The models also suggest that a 10 percentage point higher level of MA penetration is associated with a 0.7 to 0.9 percent slower price-adjusted spending growth. This suggests that higher MA penetration is associated with practice styles that lead to slightly slower cost growth.

We did not see any statistically significant effect of the growth of MA on service use. And as we mentioned earlier, this is a little bit odd given the other

finding. But it could mean that the effect of MA occurs with a significant lag, or it could mean that, given initial effect of MA penetration, additional marginal MA penetration doesn't have much effect.

Finally, I want to caution that these are just rough estimates, and it's going to differ widely from market to market. For example, if fee-for-service spending is already very low, adding more MA penetration in a market is probably not expected to reduce fee-for-service spending much.

In contrast, if you are in a really high-service-use market, then there may be more room for practice styles to change in a way that reduces spending.

So, in summary, first we want to reiterate that the regional differences in price growth and HCC growth can affect spillover estimates, so it's important to control for different rates of price growth in different regions and important to control for how MA can affect HCC scores.

When we take these two factors into consideration, we find that MA plans appear to have a small effect on coding practices and spending.

The finding that spillover is small should not be

surprising because I think we and others have concluded that the direct financial incentives provided to ACOs by providers have only reduced spending on the order of 1 to 2 percent after several years. Therefore, we should not expect the indirect effect of just spilling over the MA practice patterns to really have a large effect on fee-for-service use.

So this gets us back to where we started with the policy implications. First, we should probably recall that every year when Scott and Carlos talk to you about the relative cost of MA plans, we note that MA plans' costs are more than 5 percent less than fee-for-service in some markets, but more than 5 percent greater than fee-for-service in other markets. And the magnitude of spillover we see in this study is just too small to change the conclusion that MA costs less than fee-for-service in some markets and MA costs more than fee-for-service in other markets.

Now I'll turn it back to Jay for discussion.

DR. CROSSON: Thank you, Jeff. Very elegant. As I said, we're hoping for clarifying questions. Pat.

MS. WANG: I'm not embarrassed with my -- you

know, it was a very interesting paper to the extent that I, you know, understood an obviously sophisticated analysis that you did. So this might be -- so forgive me if this is like a really stupid question. I don't understand whether and how the MA benchmarks affect the findings that you had. So just simplistically, like on page 8, if all of these -- and, you know, again, Jeff, I may be -- my question just may be completely off, so feel free to --

DR. STENSLAND: Is this Slide 8 or is it --

MS. WANG: Slide 8.

DR. STENSLAND: Okay.

MS. WANG: -- shut me down. But if all of the plans that are -- or I guess the plans in the highest penetration markets were all doing business in benchmark counties where the MA benchmarks were greater than 100 percent, then wouldn't the fee-for-service spending -- wouldn't that automatically mean that the fee-for-service spending was less? And, conversely, if all of your plans were 95 percent benchmark counties, wouldn't that automatically mean that the fee-for-service spending was greater? Like how, if at all --

DR. STENSLAND: In general --

MS. WANG: I'm confused.

DR. STENSLAND: There's a couple of things. Here we're mostly looking at what's happening to the changes in fee-for-service spending. So that's different than looking at the comparison of MA costs to fee-for-service costs. But if you're looking at the comparison of MA costs to fee-for-service costs, then the general trend is that if your benchmark is 95 percent of fee-for-service, then generally those are the markets I'm talking about where MA costs more than 5 percent less than fee-for-service.

On the other hand, if your benchmark is 115 or 120 percent of fee-for-service and you're bidding 105 percent of fee-for-service and then you're also adding on some extra benefits, those are clearly markets where you're going to end up spending more on MA than on fee-for-service.

MS. WANG: Okay. But on this Slide 8, this is sort of a point in time, isn't it? The next slide, 9, is growth, but isn't Slide 8 just a point in time?

DR. STENSLAND: Yes. This is looking at the fee-for-service price-adjusted spending per month. So this is only the fee-for-service beneficiaries. So it's fee-for-

service beneficiaries in the lowest MA penetration markets compared to the fee-for-service beneficiaries in the highest MA penetration markets. And we aren't comparing their costs to MA costs. We're just comparing their costs to each other, like how much does fee-for-service cost in one market versus another.

DR. CROSSON: On that point?

DR. DeBUSK: On that specific point, when you're comparing fee-for-service to MA cost, when we say it's 5 percent higher or 5 percent lower in a given market, is that before or after we account for the rebate that we give them that they can spend on extra benefits? So would money spent on extra benefits count against the MA plan on that comparison?

DR. STENSLAND: When I'm doing it, yes. You probably could find some markets where it's still over 5 percent more without the extra benefits. But when I'm thinking about it, I'm thinking the total costs for the program, what it's sending out the door.

DR. DeBUSK: Do we know the average price of the extra -- or the average cost, weighted average nationally, of the extra benefits?

DR. STENSLAND: I do not, but there might be some smart people on the sideline here who do.

DR. DeBUSK: I mean, if you're saying it's plus or minus 5 but there's actually 6 points' worth of extra benefits spent, national average, arguably it could actually be -- shift at six, it could actually be one less -- you're sort of saying that could actually shift the whole spending calculation, couldn't it?

DR. STENSLAND: Yeah. I think if you look like in the chapter, when they talk about this, on average across the whole country, MA costs less for the basic A, B benefit, and then you add on the cost of the extra benefits, and it costs about the same, maybe slightly more than fee-for-service.

DR. PAUL GINSBURG: If I could just follow on this, what about quality bonuses? How do you account for them?

DR. STENSLAND: Well, quality bonuses are in, because in the end the comparison is just how much money are we sending out the door per person in MA versus fee-for-service.

DR. DeBUSK: To that point, but you're also

comparing apples to oranges, too. I mean, if you look at what we're sending out the door for standard fee-for-service and they're getting A and B, we're sending -- let's say we're sending the same amount of money out the door just coincidentally to an MA plan, but they're getting some transportation services and a gym membership and a wellness visit and everything else, you really aren't comparing the same benefits. They're getting more for the same amount of money.

It would be interesting to look at the pre-rebate -- you know, please don't read into this analysis --

[Laughter.]

DR. DeBUSK: Please, please. But it would be at least intellectually interesting to look at the difference pre-rebate MA cost so that you're truly looking at the statutory Part B -- A and B benefit versus the true A and B spending.

DR. CROSSON: Okay. Where are we? David.

DR. GRABOWSKI: Great. Thanks, Jeff.

I had a couple of questions, and the first one really builds off of, I think, a point Pat was making.

I found it also somewhat confusing that you kind

of went back and forth in the chapter and the presentation across levels and growth in MA. When I think about spillovers, I often think about growth and what then spillover does that have to fee-for-service.

So I'm wondering why the kind of back-and-forth, and am I right in thinking about spillovers in terms of growth?

DR. STENSLAND: I think spillover on this practice pattern is easiest to think about growth, like how much our MA penetration grew. It grew by X amount, and our practice patterns change, so our spending grew slower or something like that.

But I think levels can often matter, especially in the HCC growth because we're saying if we have a whole lot of MA people and they're all coding a lot, then we're going to see this more rapid growth in HCC scores for the patients over time. This is kind of like the Rick Kronick stuff or the stuff that Scott and Andy have done showing that, over time, we see people getting code. It looks like they're getting sicker, these MA people, faster than the fee-for-service people. And we can see how that could be affected by the level.

DR. GRABOWSKI: My concern with the level is just that it's more susceptible to the issue of reverse causality that you raised, that there's something different about those high kind of penetration markets. I just find it easier to think about spillovers in a growth perspective, but I see where you're going with the HCC.

The other question I had was on the regression. I don't want to get us too far in the weeds here, but just understanding, you said a little bit more about it in the chapter. But the unit of analysis is the 7.8 million Medicare beneficiaries. Is it one observation per -- or do you have multiple? Explain to me just the sampler.

DR. STENSLAND: It's just that growth over time. So there's one observation per person, and then we end up clustering them based on the market that they're in, using the MedPAC markets. So we use all those beneficiaries, but after you cluster them, the results aren't that much different than if you just looked at the averages for the market growth over the time period.

DR. GRABOWSKI: Maybe this is a -- I should save this for the second round, but why not think about this in more of a panel data framework of kind of a difference?

You have certain markets that are expanding in terms of their MA penetration, others that aren't, and comparing what's happening. Why is this group -- like basically aggregating up these individual data.

DR. STENSLAND: I can talk to you about it later, but I think it kind of functions like a difference in difference because you're looking at the different rates, comparing the different rates of growth over these different people, depending on how different the MA penetration is.

We don't have the pre-period data, where you're not looking at pre-period, and are you going to assume the pre-period trend continues kind of thing? That would be another possibility.

DR. GRABOWSKI: Jay, I'm going to try to get this really in the weeds. No.

[Laughter.]

DR. GRABOWSKI: We can pick up offline. Thanks.

DR. CROSSON: Bruce.

MR. PYENSON: Jeff, terrific report.

A question about what practice pattern means. I think when I read that, I thought about this concept of

physician practice pattern. Often in vendors' claims of savings and the impact of managed care, there's also other impacts that might arguably fall in, like sentinel effects because of payment denials or steerage or things of that sort.

Is it the case that those other -- I mean, we're not just -- I think you're not just measuring physician practice, but all these other potential effects that could be going on or might be.

DR. STENSLAND: Anything that changed the numbers, it's in there.

DR. CROSSON: Thank you, Bruce.

Jaewon.

DR. RYU: A couple questions, and I think maybe it touches a little bit on where David was going. Have we looked at whether there's a strata or a critical threshold component to this? Because it seems like the correlation analysis was just an all-in, and if you had a certain level of MA penetration, I just wonder if there's a critical threshold dynamic to actually change practice behavior and have a spillover effect. And so different ranges of MA penetration, that correlation might look different than the

all-in correlation. So I think that was one question.

And then sort of the mirror image of that was -- and you reference it, I think, at Slide 6. At the starting point of what the total cost is, I also wonder if there's a strata. And I think you kind of allude to the fact that places that had a higher fee-for-service total cost, there's probably more likely that you can reduce the cost because there's more waste, presumably. But there seems like there's something to this strata idea where different segments or cuts might behave a little differently as far as the spillover effect.

DR. STENSLAND: Yeah. I don't remember how my strata stuff turned out, but there was an article by Johnson and colleagues, I think, that I reference in the paper where they looked at the different strata. And I think their conclusion was that they only found an effect in the highest strata. That places that had really high levels of MA penetration, when their MA penetration grew, then there was a slowdown in this risk-adjusted fee-for-service spending.

My interpretation of their data was a little different than theirs. To me, it looked like it was all

coding spillover that was driving their results from that highest strata.

In terms of the starting point, we tried to look at that to see was there something different about the point you were starting at by looking at the starting level of service use in these different markets. We generally do find that the starting level of service use in all these markets affects where you end up, and that could just be regression to the mean.

Then there was the question of, well, maybe this combination, this interaction of your starting level and your change in MA penetration, maybe that interaction term would have some effect. Like once you're at this high level of service use and then you grow with some MA, then you're going to see more spillover in the fee-for-service.

When we ran those models, the interaction terms generally had kind of the direction that you would expect them to be, but the coefficients here are so small that when we added all these extra interaction terms, everything became insignificant after that went through. And I thought that could be due to some collinearity of the different variables once we start adding these other

variables that are correlated.

DR. RYU: Then I just have one other question, different topic. Is there any analysis on spillover effects with ACO penetration in a market? ACO versus non-ACO benes fee-for-service in the same market, because, especially with retrospective attribution, I think that would be more blinded, if you will, and so there may be more spillover effects because the delivery system truly doesn't know the difference between one and the other versus MA. I think you can make an argument, and I think you alluded to some folks who have said that once they're in the doctor's office, so to speak, physicians speak all of the patients the same, and yet there are programs, though, within MA, that there is a differential treatment, versus ACO, you know, truly is more blinded.

DR. STENSLAND: The thing that we do have in here is the ACO control variable, and that looked like -- and these are rough numbers. So I don't want people to like think, oh, this is the great point estimate, but it was for a 10-percentage-point increase in your ACO penetration, it looked like there was a 0.3 percent reduction in the spending of all the fee-for-service people in the market.

So if there was no spillover whatsoever, that would imply a 3 percent reduction in the service use for those ACO people, and we think it's probably less than that from our other research that used similar methods. So it implied to me like there might be a little bit of spillover, but I think that's all -- it feels that way. I would bet money that way, but I wouldn't tell you I'm sure it's that way, if that makes sense.

DR. SAFRAN: Jaewon, there was the -- over here, Dana.

[Laughter.]

DR. SAFRAN: There was a McWilliams and Chernew paper -- I think it was in the New England Journal -- on spillover into Medicare from the Blue Cross Mass commercial ACO program. So that's the closest thing I know of to looking at what you're asking about.

DR. GRABOWSKI: And McWilliams has definitely speculated that there's additional spillovers from the Medicare ACOs to other beneficiaries.

DR. NAVATHE: Yeah. On that point, I think that's right. To this point, it's been primarily speculation, no robust evidence.

Our research group actually has a couple of papers where we looked at impacts of MSSP on -- so ACO programs on post-acute care use and such and found no evidence of spillovers. So I think, thus far, if there is evidence, it's very weak that that might exist.

DR. CROSSON: Also on this point? No.

All right. So, next, I have Marge and then Amol.

MS. MARJORIE GINSBURG: I'll pass.

DR. NAVATHE: So, Jeff, thank you so much for putting this up. This is a very complex and challenging topic.

I had a question/suggestion that are intertwined, which is I felt like you actually laid out some of the limitations of the analysis quite well, and you were very up front about it, particularly in the context of needing an instrumental variable and then not really finding one. So I thought we may actually place the findings and, therefore, the policy implications in that context of perhaps some of the limitations.

The limitation I'm primarily getting at here, broadly speaking, is actually -- I can actually read exactly what you wrote here on page 37, because I think you

would do better than I probably would have done.

So the instrument, meaning the way to define treatment of a market with Medicare Advantage, must be correlated with Medicare Advantage penetration and not be caused by fee-for-service use or correlated with other variable that would affect fee-for-service use.

I totally agree that MA penetration here is, in economics terms, endogenous, and we're not measuring it, capturing it fully. So the reason that MA plans enter a market is not fully captured by the variables that we have.

So my question is, to the extent that you've thought about it, in what direction does this bias our analysis in the results? Are we reporting a worst-case scenario of spillovers? Are we reporting a best-case scenario of spillovers, or are we not sure?

I'll give you my two cents on it, which is my reading here is that because MA decisions or MA plan decisions to enter a market may in fact be correlated with other factors like, for example, avoidable use or something else, that is correlated with fee-for-service rates, what we may be doing here is actually almost a lower bound for spillovers. So I wonder if, therefore, we should be

interpreting it that way.

I've been thinking about this less than you have, so that's why I thought it's a question to you, which is, Do you have a sense of how you would sign the bias here, and should we be interpreting this as a best-case or a worst-case scenario of spillovers?

DR. STENSLAND: This would probably take more serious thought than I am going to have right here, but when I was going through it, my general -- the most important point that if I was speaking to a health service research audience to me was that I thought that probably the endogeneity problem probably wasn't that big of a deal now. I think it probably was a much bigger deal prior to 2010 when the payment rules were different.

In that case, if you had a bump-up in your fee-for-service spending, then you got ratcheted up and you stayed up forever, and it caused a great incentive for you to move into MA.

Now I don't see that that -- that clear incentive structure to me isn't there anymore. So I feel pretty confident that the endogeneity problem is less now than it

used to be. So whatever the difference was between OLD and instrumental variables in the past, don't assume that same difference continues into the future.

But in terms of whether it's a plus or a minus, I'm not sure.

DR. CROSSON: Okay. Kathy.

MS. BUTO: Jeff, I was wondering if it's possible to look at spillover effects related to outcomes, things like changes in readmission rates or effect on readmission rates. I think Amol just addressed post-acute care with ACOs, but I wondered even if the use of or the, I guess, sequential use of -- is the way I'm thinking about it -- post-acute care is something that might be affected by MA penetration in a spillover way with fee-for-service practice.

I just don't know. It seems to me that we ought to be able to figure some of that out, but to my mind, the payment system for MA is so structured in noncompetitive ways, I guess I'd say. It doesn't tell me a lot about the impact of Medicare Advantage of managed care in an area on beneficial care. It tells us a lot about spending, Medicare spending, but if there are other things we should

be looking at in the next go-round -- not this time -- to see whether there's an impact that might have, in some ways, greater impact on beneficial care and that we care about. So I just pose that question to you.

DR. STENSLAND: There are definitely things we could do. I think the spillover could very -- be real in outcomes. Certainly, with readmissions, some of the stuff that David has done suggested that you have some spillover from the readmission policy to non-readmission conditions and the other payers and lots of different types of spillover.

I can't remember the second part now, but --

MS. BUTO: The other was post-acute care or even the use of sequential post-acute care.

DR. STENSLAND: Yeah. I think that's something that could be done.

DR. CROSSON: Okay. Last question, Jonathan.

DR. JAFFERY: Yeah, thanks.

So just thinking for a second about the coding spillover question, there's something in the chapter where you talked about the implementation of coding improvement efforts through the MR and how that might make it easier to

do some of that coding enhancement or whatever you want to call it through a broader population. I guess just a practical thought is that -- and this may have changed over time as those have become more sophisticated, but it's actually, I think, relatively easy to focus those interventions on populations, even by payer. So it may be that over time, that was something that makes it -- it may reduce spillover from the coding perspective, in a sense, as people said, "Well, I don't want to overburden my physicians, and I'm just going to do it for these plans," and because there are discrete fields in the MR's office, it's actually not that hard to turn off for the other populations. So it's just something to consider.

DR. CROSSON: Okay. We are now going to change to the discussion period, and I think Paul is going to start.

DR. PAUL GINSBURG: Thanks, Jay.

I really like this paper, Jeff. I think you did a great job of -- besides being sophisticated with your techniques and reflecting the literature well, you reflected so many of the real-world nuances in both policy and the delivery system. And I think that was great.

I think what this paper needs to go on to the next step is at the beginning, before you get into the numbers, to really set up the policy context of why we care about the pattern of spillovers.

If we were having this discussion 15 or 20 year ago, spillovers were being discussed then. They were practice pattern spillovers, and it was often of the context of maybe we should pay more for Medicare Advantage if its' going to have spillovers that save us money, fee-for-service. And what your analysis has shown is that it's just much more nuanced today because we have coding spillovers as well as practice patterns, and they go in the other direction, whereas the policy context for the practice patterns might have been just a change in policy about payment.

Here, just to implement the existing policy of adjusting for coding differences, your results have shown that this isn't so simple. We may be under-adjusting, as you've said, and therefore, this would argue for having lower Medicare Advantage rates.

There may be other policy contexts for this too, but I think the discussion would be helped by just setting

them out in the beginning and then going through the work and then perhaps summarizing them.

DR. CROSSON: Thank you. Paul, Larry, Amol, Bruce, Karen.

DR. CASALINO: Yeah, Jeff, as you know I've long admired your work and this is another example. I just want to talk about the framing a little bit more, the framing of the paper and also this discussion, for the most part, although there have been a few comments in another direction, and you also have showed some -- that you understand what I'm about to say.

Framing the effects of Medicare Advantage in terms of changing individual physician behavior and practice patterns, it seems to me to be only to get at part of what Medicare Advantage, or any kind of managed care, or, frankly, any kind of population-based, value-based payments is supposed to do, because some effects on cost and quality may come from individual physician decisions, and there could be spillover or not in those.

But some, and I think nowadays probably more, would come from systematic processes that a provider organization would put into place to try to improve quality

and reduce costs. And it's not just like don't order MRIs when you don't need to. It's also more preventive kind of things, or more nurse care manager kind of things, or whatever.

So insofar, if at all, that Medicare Advantage generates a savings, it probably would come from some combination of those two things -- change in physician practice patterns and systematic processes.

The systematic processes part you would not expect to spill over to fee-for-service because those processes cost money for an organization to put into place, and in fee-for-service you can't really do that because you don't get a return on your investment. Theoretically you would in Medicare Advantage.

So I think this is not like a flaw in the analysis but it is a little bit, I think, a flaw of the framing and reinforcing people's assumption that it's all about individual physicians' decisions, which could spill over or not, and not about systematic processes from provider organizations, which kind of, by definition, won't spill over. And so, again, any savings would come from some combination of those two things, leaving coding out

for the minute.

And I'd just say one other thing about physician behavior. It could be that the effects on physician decisions were huge in the early days, and now are minimal. When I first started in practice it was routine to put patients with herniated disks, or even just low back pain, in traction, and keep them in the hospital for a week or whatever. And it was routine for patients to come in the day before surgery, you know, to get kind of some tests done and to get used to the hospital. And it was managed care, as it was called then, and it really was, a lot of it, Medicare managed care, what's now Medicare Advantage, that said, no, you can't do that anymore. And now no physician would think of doing that. I don't think that's because guidelines have come out that you don't need to put patients in the hospital the day before surgery. I think it's because managed care did change those physician decisions and individual physician practice patterns.

And so we saw bed days per whatever, 1,000 Medicare patients for a year come down from like 2,300 to 1,200, pretty quickly. And that was -- but to go from 1,200 to 1,100 turned out to be pretty hard. So it may be

that it did influence patterns in the past, and that did clearly spill over to fee-for-service, because you don't see fee-for-service patients being admitted to the hospital the day before their surgery. But it may be now that it's much tougher to do.

So this doesn't really change your analysis at all, but it might change your framing a little bit and to conclusions, the policy implications that you draw from it.

DR. CROSSON: Thank you, Larry. Amol.

DR. NAVATHE: So I'd like to tie a couple of comments together. So I think Bruce raised a couple of points that Larry has kind of picked up on and echoed, and Paul, I think, did a nice job of articulating the nuance that exists here with the coding pieces. And I do agree, I think you did a really nice job with addressing those and incorporating some of the payment pieces and coding pieces.

And so I guess every analysis has its limitations, so limitations notwithstanding, however, I think that actually there are a lot of implications here, and I wanted to propose some of the implications that I saw and kind of inferred from reading this chapter and test it out with the group more broadly, and certainly, of course,

with you as well, Jeff.

One thing is I wanted to actually try to put a finer point on what Larry and Bruce were saying, in terms of where savings may come from in MA. I largely agree but perhaps would say it slightly different and maybe slightly disagree with you, Larry.

So I would say, broadly speaking, we can think of this as, you know, the effects are either happening at the level of the provider, and those could actually be systematic processes. This may be, you know, how you have care managers in the hospital, how do you set up their networks to refer to. And if these are really changes that are happening at the provider level, and we, for a second, don't believe that they're being very aggressive about differentiating a Medicare fee-for-service from an MA beneficiary, then those provider-level effects that MA may be causing should be spilling over to fee-for-service. That's kind of Box 1.

Box 2 is what is the plan doing itself? So this could be prior auth, this could be benefit design, this could be other -- what I'm going to call here for a second management structures. So management structures to try to

influence value, care, spending, quality, et cetera. It can cut across the board. Those management structure types of interventions, they're not going to spill over because they're at the plan level. They're not at the provider level.

And so with that simplification in mind, I think what this is telling us, it's telling us that the spillovers are quite small on the provider level types of interventions. And if MA is actually as successful as many think it is, then probably it's really those management structure types of interventions that are really effective. It's actually not happening at the provider level, right? It's happening at the plan level or this management structure level.

That has deep implications for us, right? So, one, if you think about MA plans, you know, they're not dummies. So where they're directing their attention to try to drive savings is probably areas which are most appropriate or most suitable to having changes.

And I think that perhaps conveys to us, or suggests a certain level of caution about trying to roll out value-based models in the fee-for-service structure and

change practice patterns, and changing patterns at the individual clinician or provider level actually is probably quite challenging, in particular, because seasoned MA plans have decided to actually focus more of their attention and efforts on these management structures.

And I found that thought process to actually be quite sobering, particularly in light of our prior conversation. And I think it also has one other really big, important implication, or at least something that we should keep in mind, is that because we have these two types of potential ways that MA plans may be affecting the value of care, that this analysis should not be construed -- and it may be worth saying this explicitly -- should not be constructed as a, quote, "indictment" of MA plan effects. The fact that we don't find a spillover and systemwide provider-level changes in fee-for-service from MA penetration is not saying that that MA plans are not effective or the MA program is not effective.

I think we should be very clear to say that, because I think otherwise it may be easy to confound those two pieces. I think what it's really say is that these provider-level effects are not driving the changes, and,

therefore, not spilling over.

So hopefully that clarifies, and I certainly want your reaction, but others as well.

DR. CROSSON: Yeah, I want to make a comment on this point. So I just would emphasize what you said, and what I heard you say was that the provider-level effects in the face of -- I forgot what you said, but in the face of fee-for-service payment. I think that's what I heard you say.

DR. NAVATHE: Right. So these provider-level effects are that presumably MA plans may be creating some of those. Those are very small in terms of how they spill over, right? But these other management structure --

DR. CROSSON: No, no. I got that part. But I thought I heard you say the provider-level effects in the context of fee-for-service payment are small.

DR. NAVATHE: Correct. Right. In the context of fee-for-service payment, that is correct. I think the assumption that we would be making to elevate that inference a little bit is that unless providers are expending a lot of effort to differentiate between MA and fee-for-service beneficiaries -- maybe they are. But if we

assume for a second that they're not then that would suggest that these provider-level effects are also not the major mechanism for MA plan savings.

DR. CROSSON: Yeah, I understand that. But I was just --

DR. NAVATHE: I agree with your point.

DR. CROSSON: -- I was just hearing a little resonance between you and the car analogy over there, which essentially was --

DR. NAVATHE: Correct.

DR. CROSSON: -- we're going to have a hard time, you know, fixing that Mustang if it's built on --

DR. NAVATHE: Right. I think I understand your point better now. Yes, I think that's correct. I think it suggests a certain level of caution or circumspection, or just I find it quite sobering that if MA plans are not getting -- you know, focusing their efforts here, again, to some extent, then it does suggest that in the fee-for-service world, directing our efforts there may also not be as fruitful as we may have otherwise thought.

DR. CROSSON: And to me it impacts on this question we've touched on occasionally, which is should we

care about how MA plans pay their providers? And some have said no -- once we put them at risk they can do what they want -- and other Commissioners have said, "Well, of course we should. Why would we not care, in that modality of payment, when we do care when we're thinking about, you know, direct payment to providers?"

DR. NAVATHE: Yeah. I think it's a great point. My sense is it's going to take us down another path, so I'll resist the temptation to give my opinion here, but I think it's an important issue.

DR. CROSSON: That's going to be a path that's going to probably come somewhat later in our work schedule, would be my guess, if ever.

Okay. Sorry, Larry.

DR. CASALINO: Yeah. No, thanks, Jay. Amol, I think you're going to agree with this, but I still think it needs to be said. You had two boxes essentially. You had the provider boxes, I think as you call it, and the Medicare Advantage plan box. And I would just say, I think there are three, and I think you would agree with this. But it's one of the reasons that the word "provider" can be -- and I think you used it both to refer to individual

physicians and to refer to what I would call provider organizations.

So I would look at individual physician providers -- I'm sorry. I would look at it as individual physician provider organizations, like a medical group or an ACO or whatever, and Medicare Advantage plan, right? And so cost savings and/or improved quality could come from any or all of those three, and spillover, in theory, could happen to any or all of those three. So I think what we agree about is spillover could happen on the individual physician level but it's very unlikely to happen -- excuse me. Not only the managed care but the Medicare Advantage plan but also the provider organization can put these systematic processes in place, and often they both do.

So I think we agree that spillover isn't going to happen for the systematic processes whether the provider organization is doing them or the Medicare Advantage plan is doing them, probably. But it could, in theory, happen on the individual physician level.

DR. NAVATHE: Yeah. So I think I might disagree a little bit there, which is that provider organizations, to the extent that they, you know, put a structure in place

to take care of MA beneficiaries, if they're not differentiating between MA and fee-for-service, yeah, is there a reason that they don't spill over?

I don't disagree with you -- this is what your implication is, which is what I agree with, is that it's probably less likely an individual clinician is differentiating MA versus fee-for-service. Do provider organizations, some of whom are MA plans as well, do they differentiate and those structures that they put in, are they more differentiating? I agree with you that's probably more likely. So yeah, I think I broadly agree with you.

DR. CROSSON: Okay. I've got Bruce, Karen, Marge, Jonathan, Warner, and Pat, and I think that may be it.

Bruce.

DR. PYENSON: So I think this is about the first time where I was thinking about saying that Paul, Larry, and Amol have already said what I wanted to say. But really agree, this is really valuable and terrific work.

And just to push on the policy implications here I think are profound. We heard Pat and Kathy earlier

suggest that Medicare could adopt -- I think, Pat, you had mentioned a pre-payment review, and Kathy, prior authorization. So I believe that the reason there's no spillover effect, despite the substantially lower spending on care that MA plans have, is because they are affecting things that physicians don't affect. That is, is the actual hands-on process on claims, on prior authorization, and perhaps on patient behavior.

So following that trail, we have an opportunity, I think, to say, well, here's the particular tools that could work for the Medicare fee-for-service program or for ACOs, and I think Pat and Kathy identified a couple of those.

Unfortunately, it seems like a lot of the demonstration programs or innovations that we've seen have relied on an invisible hand of physician practice behavior, of physician practice. And I think that perhaps explains the modest results of some of those, whereas the different kind of innovation that more directly put its hands on the payment process would probably yield substantial results. So I see the implications of this and in laying out a hypothesis and a path forward.

My own relationship to physician practice concepts was when I was introduced to the Wennberg studies, you know, back in the, I guess, '80s and '90s, and the observed variation was attributed to physician practice differences. And that might be the case, but today we know that socioeconomics has a big impact as well. Perhaps it wasn't surprising back then that physician practice was seen as the cause for those differences. After all, it was physicians who were doing the studies.

But perhaps what we're -- so having some historical context for this concept of physician practice as a driver of variability I think would be useful, because it's something that has -- a concept that has pushed its way into everybody's thinking, but now this work is suggesting that that's perhaps not the only, or maybe the most important issue going on.

But again, thank you very much for this work. I found it incredibly interesting and well done.

DR. CROSSON: Thank you, Bruce. Karen.

DR. DeSALVO: I'll try to be brief. Larry launched what I was thinking as I read this chapter and I just want to underscore a couple of other frames for

thinking about it. One is I do think that there is a terrific opportunity in trying to leverage this analysis to understand more what kind of consumer facings, benefits and services and management structures are in those markets where there's more MA penetration. Maybe you'll find the same thing for ACO penetration.

So are those population-level efforts that are targeting consumers and not driving through the practice really making a difference in utilization and outcomes for beneficiaries, and it is that, for our future thinking, the way we should start to continue to want to hope that delivery system organizes itself as much more consumer facing?

Related to that, I think that market penetration doesn't equate to my revenue penetration as a doctor. You know, it wouldn't be equal, practice by practice, and in fact, to the earlier point, I very likely might be paid fee-for-service by Medicare Advantage and not discern a lot, patient by patient, on what's going to happen differently. But in the background that patient might be getting transportation benefits and other care, case management, and other prompts that might help keep them out

of the hospital, get their flu shots so they don't get pneumonia.

So I think there's some interesting work to understand more about what it is outside of the doc that's doing this, but, Jay, I don't want to lose the thread of -- somewhere in our dialogue we've got to get to the root of this issue that changing the behavior of the delivery system requires a line of incentives, and if the delivery system is still paying fee-for-service, even if there's background work that's managing a population, not everybody's aligned.

So not so much maybe for this -- I think you couldn't do physician attribution probably to see which -- to look at revenue penetration by doc or doc group, to figure out if there's more spillover effect based upon some threshold. But clinically I would tell you there's probably some number where I'm going to change my whole practice, based upon how much I have a value-based downside risk contract arrangement.

DR. CROSSON: Thank you, Karen. Marge.

MS. MARJORIE GINSBURG: I'm going to be the only one around the table that read this chapter, and I don't

understand where the "there" there is on this. I'm really lost as to overall what extent the degree of analysis is actually going to move things over. It looks like, if I may be blunt, we're sort of grasping at straws to try to figure out how we change everything. Maybe if we assess the way one group does it against another group, we'll learn something, and in fact, it doesn't look like the results are there. Having said that, I'm ready to be persuaded otherwise.

But I do have one comment or question. You raised that earlier, and it's something that's been plaguing me for a while. And that is the extent to which we've looked at MA plans and the differences in how they pay their physicians.

Of course, I'm very interested. You've got salaried physicians, and I don't know how many MA plans, other than Kaiser, have strictly salaried physicians versus physicians that are paid on a per-service basis, even though they're part of an MA plan; therefore, they have these other administrative oversight issues that compel them to be more conscientious providers.

So that's the question is, Have we ever looked at

the different ways MA plans compensate physicians? And if we haven't, why not? Because it seems to me we're always holding MA up as, in some ways, the target. What we're aiming for is to get more responsible physician practices. Then wouldn't we want to really understand how all these different MA plans actually function and in particular how they compensate their physicians?

So that's, I guess, kind of the question targeted to Jay and Jim about the question of compensation.

DR. CROSSON: Yeah. So, Marge, I just want to predicate my comments in one direction. I don't think we have in any way as a commission been holding up MA as the model that we're striving for. We have --

MS. MARJORIE GINSBURG: I stand corrected.

DR. CROSSON: Okay. SO we've said that MA is good. We've said fee-for-service is good. They both need to be fixed, et cetera, et cetera. I just want to be clear on that for the record.

I don't think we know -- I know that there are other -- and I think here at the table, there are other organizations involved with Medicare Advantage that pay their physicians a salary or something different from fee-

for-service, but it's the minority. I don't have the data, but I would bet it's the minority.

But I do think -- I've said this several times. I do think it matters.

Paul.

DR. PAUL GINSBURG: Yeah. I just wanted to say that I think a very common form of payments is the MA plan or any other plan pays a physician organization, such as a group practice, fee-for-service, and the practice pays its physicians salaries with various incentives. And that's probably the norm.

I agree with you that Kaiser is probably unusual because it's integrated, its delivery and its health plan, but for the most part, I think a lot of physician practices do deliberately insulate the individual physicians from the incentives out there to provide probably more functional, valuable incentives within the organization.

MS. MARJORIE GINSBURG: And is there any reason why we couldn't study this in greater depth?

DR. PAUL GINSBURG: Yeah.

MS. MARJORIE GINSBURG: Because it seems to me this would be very valuable for us.

DR. PAUL GINSBURG: I don't think we'd ever be able to get a good handle on all the nuances.

In a sense, I mean, I think that the point that I would make is that how the MA plan is paying physicians is a very different question from how practicing physicians are getting paid, and that we shouldn't worry too much about how the MA plan is paying because more and more physicians work for large organizations. And those organizations are transforming the fee-for-service or fee-for-service with incentives from ACOs into some other payment approach.

DR. CROSSON: That's helpful to me, Paul, because I would then alter what I said before, which is that I do think it's important how the physicians involved in MA are paid, which I think is closer to what you said.

On this point?

DR. DeBUSK: On this specific point.

To the operators in the room -- and I'm sort of staring at you -- do any of you have employed physicians who aren't on a productivity formula? Zero productivity? No RVU linkage? No nothing?

DR. RYU: Yeah. I mean, we've changed over time,

but two, three years ago, we removed all productivity from our component. So our primary care docs are panel-based, their compensation. There is an RVU component that comes into that, but it's at like a clinic site level. But beyond primary care, it's all productivity.

And I think there's a lot of that, where even if somebody is salaried, it's adjusted on an ongoing basis based on productivity.

DR. DeBUSK: And maybe I just live in the wrong part of the country, but I've never met a doctor that doesn't have a productivity component, even if it's only 10 or 15 percent of their salary.

But, again, I'm in Tennessee. That's why I'm asking. You're saying yours are all productivity except the primary care guys are less productivity? Eat what you can.

DR. RYU: Yeah. Primary care is generally not productivity, but --

DR. DeBUSK: And, Sue, do you have --

MS. THOMPSON: It's a combination of quality metrics, population health metrics, and there's certainly a good element of productivity.

DR. DeBUSK: So you do eat what you kill too?

MS. THOMPSON: We definitely do.

DR. DeBUSK: Jaewon, you don't?

DR. RYU: We don't. We don't.

MR. THOMAS: We don't refer to it that way.

[Laughter.]

MR. THOMAS: So I would say that we -- similar to Jonathan, in primary care, we've gone to panel-based and value-based incentives there. We have several other specialties that may be salary as well, and then there's the mix that are on productivity. But it's definitely a mix.

DR. CROSSON: If you were to journey west of the Sierra Nevada Mountains, you'd find something that you don't see in Tennessee.

DR. DeBUSK: I think that's what I'm running into.

DR. CROSSON: A lot of things, actually.

DR. DeBUSK: Yeah, a lot of things.

[Laughter.]

DR. DeBUSK: So what you're saying is the West isn't as good.

No, no. I do think that's -- I think that's where the geographic variation -- you know, most of my experience is Northeast, Southeast, for the most part, and that's still a productivity market.

DR. DeSALVO: I think most of the -- I mean, we know most of the physicians in the country are on a productivity-based driver, but this relates also back to the utilization. It's not just primary care that can drive admissions. It could be a cardiologist or pulmonologist who is on a pure productivity basis.

MR. THOMAS: But I think the take-home point is that -- think about a big funnel of all sorts of different payers, and that's filtered through some intermediary organization, with or without different aspects of productivity, and then there's provider behavior.

It takes me back to Jaewon's earlier point. What's the influence of ACO on that mix? Because there's a whole smorgasbord of things that are being filtered through whatever the intermediary organizations are.

DR. CROSSON: Okay. Jonathan, Warner, Pat, and then lunch.

DR. JAFFERY: Okay. Well, I'll be quick.

I just want to go back to some of the things that Amol was saying about the MA penetration and -- or the MA's ability to make changes with sort of their care management activities versus things that would drive behavior at the provider level, whether that's an individual provider or a provider organization.

What I heard was then that maybe what we're seeing in this data is they show that the changes at the provider level haven't been that effective, and that's why MA plans haven't -- haven't over time decided not to focus there, and then subsequently, we should think about that as we're thinking about some of these other change models.

And I guess I would just be cautious about extrapolating. If we do believe that that's true, extrapolating that to some of these other types of models as we think about different ways that systems may organize or ACOs or other delivery system changes, because I do think there's a fundamental difference from a provider organization standpoint if they're engaged and saying we're going to make these changes and we're going to enter into this contract, this ACO model, or whatever the case may be, whether it's commercial, Medicare, or whatnot, versus

managing through an MA plan.

And I'm thinking about the fact that we have over a hundred contracts. A high-penetration market may be that because there's one MA plan. It may because that has 60 percent of the market. It could be because there's ten that have six. And the way that a provider organization interacts with one plan is different than if it's interacting with six and how those systems work.

So I just want to be cautious about making those next connections.

DR. CROSSON: On this point?

DR. NAVATHE: Yeah, on this point. I think that's very fair. I think you're right. We should not over-infer. I think Larry helped sort of clarify, and there might be this third structure there. To the extent that we do make -- we just sort of extrapolate and make these inferences. Maybe what we should be thinking is that the new value-based payment models, whatever we're doing, should have strong enough incentives to create that provider system-level effect, because otherwise from what we learned from it, it probably isn't going to spill over.

DR. CROSSON: Warner.

MR. THOMAS: I'll be brief. I kind of agree with Marge. I was reading this, and I'm not quite sure what the policy implication is, like where we're going with it.

I mean, I think it's interesting, and I think it's something we can hypothesize about whether it changes practice patterns, whatnot, but I'm not -- I mean, I'm not sure what's actionable out of here for us changing policy or changing payments.

Once again, if I'm missing it, I would love to hear. I mean, I get the analytical and the educational analysis with it, but I'm trying to understand what the policy changes are we might be looking at.

DR. CROSSON: So I don't want to put words in Jeff's mouth, but I think Jeff was working off a supposition in the literature that there was a significant spillover effect based on the degree of penetration in a market by Medicare Advantage. And I think what he did, if I understand it well -- and I hope that I do -- was to say, "Yes, there is, but it's small. And it's also potentially affected by a counter-current spillover that has to do with coding."

Now, whether there's a policy implication from

that finding that we want to take on as a commission was the basis -- actually, it grew out of in the latter part of this discussion, and we've heard a number of different ideas that I think Jim and the staff and Paul and I are going to have to take back and see whether or not we think that one or more of those ideas should be put forward.

DR. NAVATHE: Can I try to, on that point, sort of just clarify what I think the main policy point here is?

DR. CROSSON: Yeah.

DR. NAVATHE: I think the main policy point, in my mind, so are there benefits from MA in fee-for-service, spilling over to fee-for-service. If there are and they're fairly robust, then from a policy perspective, that makes MA a lot more attractive. That's really important for us to know..

And I think what we're learning from this is that, if anything, if any at all, the effects are probably quite small. So we probably shouldn't be promoting MA because we think it's going to benefit fee-for-service, and that's the important point, I think, that we want to take away.

DR. CROSSON: Thank you.

On that point?

DR. DeBUSK: On the same issue of the coding spillover, this was already in the weeds enough, but I guess since we're talking coding spillover, we'll get into the weeds a little bit more.

There is a circularity issue here, I think, and, Jeff, please, I'm ready to be set straight. But let's for a moment say that there is coding spillover. The more complete coding in MA spills over into fee-for-service and now fee-for-service is more fully coded, each year when they recalibrate the nine-compartment model to determine the HCC coefficients, that spill over, because it has occurred into fee-for-service, would automatically lower the MA payment because basically the coding intensity adjustment at 5.9 percent wouldn't change. But the coefficients in theory would have a reduced impact.

So there is a circular self-correcting mechanism here in that if the spillover does occur, MA plans automatically get a reduced payment. Is that correct?

DR. STENSLAND: I think that's if there was 100 percent spillover on the coding, but we're not saying there's 100 percent spillover.

Andy came up with what? 7.2 percent coding adjustment?

DR. DeBUSK: Mm-hmm.

DR. STENSLAND: And so what that means is we think the fee-for-service coding is maybe going up because of MA, and MA coding is actually 7.2 percent above that. If it wasn't for spillover, Andy would have a bigger number than the 7.2 he found. So you're right that there is some correction. So like maybe without the MA spillover, you would have seen an 8 percent differential in coding, but now because of MA spillover and then that increases the HCC scores of fee-for-service, you only see a 7.2 percent differential between fee-for-service and MA.

DR. DeBUSK: We're on the same page. It's a second-order effect that actually would self-correct for coding spillover, but it would only be a partial correction, not a complete correction.

Thanks.

DR. CROSSON: Okay. Pat, last comment. No pressure.

MS. WANG: I simply want to add a little bit more texture from my perspective to the sort of framework that

Amol and Larry set up with the boxes, and you can put it in whatever box you want. But I would add to the system change box that Larry described. Something that Larry mentioned with provider systems that have developed their own care management in population health structures, but in the system box, for many MA plans, there is a very close relationship between the MA plan's systems and how they work with their doctors who are taking value-based payments, capitation, whether it's on quality.

The system effects of the additional transportation benefits, benefit design, zero copay for primary care, transportation benefits, some MA plans work very closely with capitated and other at-risk physician groups to make that work even better as opposed to the plan is kind of like over here in a box doing its thing. Providers are in a fee-for-service box over here doing their thing, and then there are providers in a third box that are trying to figure out how to make their way through ACO land.

I think that there is another scenario where MA plans are looking for partners that are extremely interested in working in value-based environment and

particularly with MA plans, and there's a ton that gets done there. I'm sorry that we don't have comparable -- we don't have the ability to measure quality across fee-for-service and MA because the systems are just so different, but I think that one of the spillover effects for the value propositions would emerge if we were able to actually see that for Medicare Advantage beneficiaries.

I think it has implications for the thinking that we might do about fee-for-service, value models, ACM models, what have you. There is kind of a third way where the sum of two things, which is a willing MA plan and a willing provider group, whether they're a group or an IPA or just community documents or a big hospital system, is very, very powerful. And it's more than the sum of the parts.

DR. CROSSON: On this point, last comment, something else?

DR. PAUL GINSBURG: Yeah. Pat's comment gave me a thought. Increasingly, I believe that MA plans informing their networks are trying to basically steer Medicare beneficiaries towards more efficient providers. So the degree they succeed, that, in a sense, is another spillover

by, in a sense, leaving the less-efficient providers to specialize in fee-for-service. So, in that way, MA success in their own world is driving fee-for-service costs higher and may be a third mechanism.

DR. CROSSON: Okay. Well, that was a pretty rich discussion, I would say.

Again, Jeff, thank you so much. You probably got a lot more than you thought you were going to get. So you're leaving much richer than you came in.

[Laughter.]

DR. CROSSON: We will now break for lunch, and we'll be back in -- oh, sorry.

We do have an opportunity for public comment, if any of our guests would like to make a comment based upon the material presented today. If you do, please come to the microphone.

[No response.]

DR. CROSSON: Seeing no one at the microphone, we will reconvene at 2:15. Thanks, Jim.

[Whereupon, at 1:06 p.m., the Commission was recessed, to reconvene at 2:15 p.m., this same day.]

AFTERNOON SESSION

[2:15 p.m.]

DR. CROSSON: Okay. I think we can reconvene.

Okay. So we'll begin the afternoon session. The first discussion is going to be on competitive bidding for durable medical equipment and other supplies. We're going to take a look at the success with diabetic testing supplies and then raise the question for the Commission about whether the competitive bidding model should be expanded. And Brian and Eric are here. Brian, it looks like you're ready to start.

MR. O'DONNELL: Good afternoon. This presentation focuses on Medicare's payment policies for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS.

In particular, I'll focus on two topics: examining the effects of competitive bidding for diabetes testing supplies and expanding the products included in Medicare's DMEPOS Competitive Bidding Program. But before I get into these topics, I'll walk through some background.

DMEPOS as a category comprises a wide variety of products, such as oxygen equipment, wheelchairs, and CPAPs.

Medicare pays for DMEPOS products in two basic ways: through a fee schedule or through the Competitive Bidding Program, or CBP.

Medicare's fee schedule is largely based on supplier charges from 1986 to 1987 -- updated for inflation -- and other information, such as unadjusted list prices.

Many fee schedule rates are excessive. For example, fee schedule rates are often far higher than private payer rates for the same products. Excessive payment rates increase Medicare and beneficiary expenditures and encourage fraud and abuse.

In response to rising expenditures and cases of abuse, Congress required CMS to implement the CBP. CMS phased in competitive bidding starting with the highest-cost products in 2011.

The CBP operated in 99 large MSAs and nationally for mail-order diabetes testing supplies through 2018. The mail-order program is of particular interest to us today, and I'll talk more about it in a few slides.

CMS suspended competitive bidding for 2019 and 2019 and is making technical changes to the bidding rules. This means that there will be a temporary gap period

without competitive bidding.

During the gap period, any willing supplier can furnish DMEPOS products to beneficiaries at payment rates that are based on those established under the CBP.

For most products, the next round of bidding is scheduled to start in 2021. However, to date, CMS has not announced the next round of bidding for mail-order diabetes testing supplies.

The results of the CBP are often evaluated based on three key criteria: how the program affected Medicare's payment rates, utilization, and beneficiary access to needed products.

The CBP substantially reduced Medicare's payment rates. For example, among the 25 highest-expenditure products in 2017, payment rates have declined by a median of nearly 50 percent since competitive bidding began.

The CBP has also substantially reduced utilization. Some industry stakeholders have suggested that utilization declines represent access issues. However, the available evidence, including reports from CMS and the OIG, suggests that the CBP did not disrupt access to needed DMEPOS.

This next slide shows how Medicare spending has changed from 2010 -- the year before competitive bidding began -- to 2017.

Looking at the top row of data, you can see that the total spending on products included in the CBP has fallen from $7.5 billion in 2010 to $2.8 billion in 2017, a decrease of 62 percent.

The decrease in expenditures has been particularly dramatic for diabetes testing supplies, the category highlighted in red. Expenditures for this group of product fell by 88 percent from 2010 to 2017.

Given this dramatic decline in spending, we conducted further analyses to determine whether beneficiaries were negatively affected by including diabetes testing supplies in a round of competitive bidding known as the National Mail-Order Program.

The National Mail-Order Program began in July 2013. As the name implies, the program covers the entire country, including both urban and rural areas, but only applies to items supplies beneficiaries receive through the mail.

The Mail-Order Program substantially reduced

payment rates for diabetes testing supplies. For example, from 2010 to 2017, Medicare's payment rate for blood glucose test strips -- the highest-expenditure product in the diabetes testing supply category -- went from about $33 to just over $8, a reduction of 75 percent.

Even while the National Mail-Order Program was in place, beneficiaries could access test strips through any willing retail supplier, such as a local pharmacy. However, as of July 2013, the payment rate for retail test strips was set equal to the rate established under the National Mail-Order Program.

Looking at the geographic distribution of retail suppliers, we found that nearly all beneficiaries lived in a county with one or more retail test strip suppliers in 2017.

Given that beneficiaries can access test strips on a mail-order basis or through retail suppliers, this slide shows total utilization of test strips from 2010 to 2017, stratified by mail-order versus retail supplies. As you can see, total utilization -- the light blue line -- declined after the implementation of the National Mail-Order Program in July 2013.

Looking closer, you can see that the entire decline is due to a drop in mail-order test strip users, which is represented by the green line. In fact, the number of retail users -- the white line -- actually increased after the Mail-Order Program began.

Some industry stakeholders have suggested that this decline in mail-order test strip utilization represents an access issue and that the decline in use negatively affected beneficiary health outcomes and shifted costs to the hospital setting. However, our analyses suggest otherwise, as the next slide begins to show.

This slide displays monthly all-cause hospitalization rates for beneficiaries with diabetes, stratified by the type of diabetes and insulin use.

We paid particular attention to trends among Type 1 diabetics and those who use insulin because our conversations with clinicians suggested that these beneficiaries are likely to be more negatively affected by disruptions in the supply of their test strips.

However, as you can see by looking at the trends before and after July 2013, we found no evidence that the implementation of the National Mail-Order Program affected

monthly hospitalization rates for any of our subpopulations studied.

We also ran similar analyses looking at all-cause mortality and emergency department use rates, total Medicare Parts A and B spending, and diabetes-related hospitalizations and emergency department use. While not pictured on this slide, the figures for these outcome metrics look nearly identical to the hospitalization figure, with no discernable changes after the National Mail-Order Program began.

At the national level, our trend analyses suggest that the Mail-Order Program did not negatively affect health outcomes for beneficiaries in total or for certain subpopulations of potentially vulnerable beneficiaries.

Nonetheless, we conducted further analyses on multiple sub-groups of beneficiaries who could have been negatively affected without necessarily moving the national average.

One of the sub-groups that I'll discuss today is beneficiaries who stopped receiving test strips after the National Mail-Order Program began. The concern is that health outcomes could suffer if beneficiaries stop using

test strips.

We found a large decline in the number of beneficiaries who received test strips after the Mail-Order Program began. However, again, we found no evidence that this large decline negatively affected health outcomes or shifted costs to the hospital setting.

So just to summarize the evidence I've discussed so far and that was included in your mailing materials, the National Mail-Order Program dramatically reduced Medicare and beneficiary speeding on diabetes testing supplies. Beneficiaries maintained broad access to both retail and mail-order test strips. And despite declines in the use of test strips, beneficiary health outcomes remained stable after the Mail-Order Program began, even for particularly vulnerable beneficiaries.

In aggregate, these findings suggest that the National Mail-Order Program did not negatively affect beneficiary health outcomes and likely reduced abusive billing practices for test strips, such as billing for test strips for beneficiaries who did not need them or use them.

So now I'm going to switch gears a bit, and I'm going to talk about spending trends for products excluded

from the competitive bidding program or non-CBP products.

Using the same table I showed you before, I'd like to emphasize how different the spending patterns are for CBP products versus non-CBP products.

Over the same time when spending on CBP products was falling by more than half, spending on non-CBP products increased from $3.3 billion to $4.7 billion, an increase of 44 percent.

Much of the increase in spending for non-CBP products over this time was due to utilization increases. In some cases, the additional volume was due to abusive billing practices, one of which I'll highlight in the next slide.

In particular, this slide highlights a recent case of widespread abuse among non-CBP products and how Medicare's excessive fee schedule payment rates encourage such abuse.

In April 2019, the Department of Justice announced charges against the owners of dozens of durable medical equipment companies and others who took part in an alleged nationwide fraud scheme for off-the-shelf orthotics, a category that includes products such as knee

and back braces.

The alleged scheme involved suppliers being paid over $1.2 billion for fraudulent claims for braces, caused confusion and anxiety for beneficiaries who received unwanted products, and exposed beneficiaries to harassment by aggressive marketing firms.

Off-the-shelf orthotics were likely more susceptible to such abuses because Medicare's fee schedule payment rates for these products are excessive.

For example, in the June 2018 report to the Congress, the Commission found that Medicare's payment rates for off-the-shelf orthotics ranged from 20 percent to 50 percent higher compared with private payer rates.

Given the spending increases and abuses among non-CBP products and our positive findings with regards to the CBP, we examined the 100 highest-expenditure non-CBP products in 2017 to determine if any were good candidates for competitive bidding.

We looked for products that were furnished by multiple suppliers and that were not custom produced for a single individual, such as certain prostheses.

In 2017, we identified about $1.4 billion in

Medicare spending associated with products that are likely good candidates for competitive bidding.

We think many of these products would be good candidates for the CBP because Medicare's fee schedule payment rates for some products are substantially higher then private payer rates. CMS has already successfully included similar products in the CBP, and some products have experienced rapid utilization growth or fraud and abuse, as I just discussed.

While CMS can include some additional products in the CBP, the agency lacks clear authority to include other products in the program. Therefore, one option for policymakers to consider is expanding CMS' authority to include products in the CBP.

This last slide quickly summarizes our key findings from today.

We bound CBP to be a success in that it reduced spending, and we found no evidence that the program negatively affected beneficiary health outcomes.

For non-CBP products, many fee schedule payment rates remain excessive, which increases spending and encourages abuse. To address these issues, policymakers

could consider expanding CMS' authority to include additional products in the CBP.

The staff are seeking feedback on these topics and also on direction for future competitive bidding work.

With that, I look forward to your comments, and I turn it back to Jay.

DR. CROSSON: Okay, Brian. Thank you, and thank you, Eric, as well.

We're now open for clarifying questions. Brian.

DR. DeBUSK: I have one on the diabetes program. The insulin strips, if I remember from the reading -- I'm trying to look at the chart. I guess it was on page 9 of the presentation. I noticed that when you did the analysis, it was only for Type 1 diabetics. Correct?

MR. O'DONNELL: No. So we looked at -- we stratified in our trend analysis by type of diabetes and where they use insulin. For the folks who stopped receiving test strips, that included all beneficiaries who stopped using test strips, including Type 1 and Type 2 diabetics.

DR. DeBUSK: Okay. Thank you. The reading showed that there were some Type 1 diabetics that appeared

to quit using test strips.

MR. O'DONNELL: That's right. So, in general, you know, maybe 90 percent are Type 2 diabetics, just in general, and I think that percentage was pretty consistent in terms of those who stopped using test strips. Maybe 90 percent were Type 2 and maybe 10 percent were Type 1. And I think in a broader perspective, when we looked at our populations, we saw that even well before competitive bidding, a substantial number of folks who we classified as Type 1 diabetics actually did not use test strips.

So it's a broader phenomenon than just the folks who stopped when competitive bidding was in place.

DR. DeBUSK: Okay. I was just curious, again, because I don't -- I'm not a physician. I was just curious as to what the alternative is if you are a Type 1 diabetic and you stop using test strips. Maybe one of the physicians here can help me, but I truly was confused in the reading because I didn't think that you could just stop if you were Type 1.

DR. CROSSON: Well, yeah, my grandson has Type 1 diabetes, and he has a device attached to him which reads the glucose and sends it to his parents' phone. Now, his

care is not entirely without test strips because periodically the device has to be calibrated and they have to do that actually from the blood. But there is an alternative which could dramatically reduce the use of test strips. That's just me talking.

DR. DeBUSK: Okay. I was just curious, because, you know, I always thought that Type 1, you had to test.

DR. DeSALVO: Yeah, I think the place where clinical practice has evolved is in the need to use it for Type 2, and some of that is because of better availability of oral medications that don't cause hypoglycemia. And so over the course of time, we've had to rely less on insulin and then be less concerned about hypoglycemia for Type 2 diabetics.

DR. CROSSON: Larry.

DR. CASALINO: Yeah, two questions. One is just to follow up on this. It shouldn't be that hard to look, I think, and see when you might expect trends in practice to change, for example, because of oral hypoglycemics where you don't have to test or don't have to test very often, or because of the kind of monitors that Jay mentioned, just to be sure time-wise that those kind of changes didn't occur

at the same time as they're decreasing the use of test strips.

But the other question I had was -- this is not a program I want to criticize because it seems great. But, you know, diabetes has not only short-term consequences like hospitalizations in the short run, but also the long-term complications are probably more important. And, obviously, you couldn't check on those, but do you think you should maybe at least acknowledge that there's a possibility of long-term consequences that you weren't able to test for?

MR. O'DONNELL: Sure. So two things. In response to the change in practice and continuous glucose monitors, in the time period that we studied I don't anticipate that the continuous glucose monitors affected our numbers much. In 2017, Medicare kind of changed the way it paid for those products, so in the future, that's something that we'll definitely keep in mind.

And for the long-term consequences, I think you're completely right that, you know, we talk to clinicians, and there's basically two types of outcomes; the short term, where you might go to the ED for low blood

sugar, and then these long-term type of outcomes that we couldn't study in our analysis because they take, you know, years or decades to accrete. But we can certainly add that context in the report.

DR. CROSSON: Dana -- Sue, on this point?

MS. THOMPSON: While we are on the technology equipment category, what do we know -- and I'm assuming the test strips we're talking about are the strips that we use a monitor or some sort of a device. Do we know anything about what happened to the price of those devices while this particular unit of product was going down?

MR. O'DONNELL: Right, so the monitor that the test strips are used with was excluded from competitive bidding, so the price really didn't change before or after the program was implemented.

DR. CROSSON: Dana.

DR. SAFRAN: Yeah, one really small question and then another one.

Back on Slide 6 -- sorry, 8, with the hospitalization trends, it looks like there's some kind of seasonality thing that happens with diabetes and admissions. I'm just curious. Is that true?

PARTICIPANT: Influenza.

DR. CROSSON: Influenza.

PARTICIPANT: Holidays.

[Multiple inaudible comments.]

DR. SAFRAN: But it doesn't look like it's happening -- well, as much in the general population. Okay. All right.

Anyway, the other question I had, which probably has more policy relevance, is --

[Laughter.]

DR. SAFRAN: Quite a lot of policy relevance, actually --

DR. DeSALVO: Because what they need are flu shots and pneumo vax's.

DR. CROSSON: And every Commissioner needs to get the flu shot this fall.

DR. SAFRAN: CVS right across the street, I happened to notice.

Okay. The other question is -- you know, the impact of this on price and spending is really quite remarkable relative to, you know, the conversation we were having this morning about the peril that the program faces

and the small effects we're looking for and differences made by the various delivery system and payment reform programs. So I'm just curious whether there are criteria for which kinds of goods and services -- carefully including services here -- we think competitive bidding works.

MR. O'DONNELL: Yeah. So I'll give you a little answer and then kick it back to the Commission. I think, you know, on a very basic level, when we look at the products, there has to be competition, and so for some products that rules you out, when there's only one manufacturer, one supplier, one local provider of a service. So that's kind of the baseline, and you need that for that competition to work.

And then there are things you can start to consider about whether it's easy to put in competitive bidding, about, you know, whether it's more of a commodity-type product or whether it's more custom fitted, which I wouldn't draw a bright line against those that are more custom, but I do think it probably would be a little bit harder to bid out.

MR. ROLLINS: I think another consideration would

be that you are looking for an item or a service where the beneficiaries were sort of times to sort of evaluate their options and make a choice. I mean, obviously, if you're in an acute medical situation that is not the time to sort of really think that competitive bidding is going to be a, you know, useful mechanism.

DR. SAFRAN: But -- help me out with that. I mean, I get the sort of shoppable moment thing, but this is not like the consumer or the beneficiary deciding. It's CMS setting prices, right?

MR. ROLLINS: Right. But I thought you were talking about expanding into other potential settings like services. And so I was thinking in the context specifically for services, that might be a factor to keep in mind.

DR. SAFRAN: Yeah.

MS. BUTO: I might just add to that, depending on what the service is, that, you know, availability is an issue. So if it involves going somewhere, and not just mail order, then I think the availability of potential suppliers would be a consideration.

DR. CROSSON: Bruce.

DR. PYENSON: Also, on Slide 8, perhaps off topic of this chapter, but it's quite striking that there appears to be a downward trend, not only in all non-diabetes admissions, bottom line, but all the categories. And, of course, we are all used to hearing about chronic diseases is deriving utilization and other things, but this seems to be going in the opposite direction, and I wonder if you could interpret that. It looks very much like diabetes is not driving hospitalization as much -- in the recent past as much as further back.

MR. O'DONNELL: Yeah. I think there are a couple of things to note. One is, at the very kind of basic level, is that, you know, diabetics are not immune to the secular shift away from hospitalization and towards more outpatient care. So, you know, that's pretty clear. In terms of whether chronic conditions are driving an increasingly lower share of admissions, I think that's going to beyond the scope of this slide to make that conclusion. But it's certainly interesting to look at the slope of the decline for the different types of diabetics relative to non-diabetics.

DR. CROSSON: Jonathan, on that point.

DR. JAFFERY: Yeah. So does this include observation stays?

MR. O'DONNELL: This is just inpatient use, so it doesn't include observation.

DR. JAFFERY: Well, so if that's not being counted there may be people who are sitting in the hospital and it very much looks like a hospitalization for up to a couple of days, and it's not counting these rates, and that might obscure the data over time as well.

DR. DeSALVO: Maybe really relevant in this population if they're hyperglycemic enough to be held, or hypoglycemic enough to be held.

MR. O'DONNELL: Yeah, and we looked at, for the -- so we didn't present it here but we looked at ER rates, and we included ER rates that were just outpatient care and those that resulted in inpatient care. And again, the trends weren't as downward-sloping as they were for hospitalizations. But we certainly looked at things that -- not directly at hospital observation care, but we looked at, you know, a lot of ER care will obviously result in observation care. But we can look at observation care in the future.

DR. CROSSON: But just to be clear here, unless I'm getting confused, the rate of hospitalization for diabetics can be coming down, but as the proportion of individuals with diabetes in the population as goes up, since the rate of hospitalization for diabetes is higher, the total impact on hospitalization rates could be going up. Correct?

DR. PERLIN: On this point, Jay?

DR. CROSSON: Yeah.

DR. PERLIN: It probably is. We don't see a bright line demarcating the beginning of observation status determination. So I think Jonathan's point is absolutely right, but, you know, the first test would be do you see a drop-off in hospitalizations concomitant with the introduction --

DR. CROSSON: I wasn't arguing that point. I agree with that point. But I'm just saying from an analytic point of view, we don't want to confuse the two.

DR. CASALINO: The same topic, Jay.

DR. CROSSON: Yeah.

DR. CASALINO: I just want to emphasize, I think probably for hypoglycemia, and even hyperglycemia, it may

be that there are going to be more observation and/or ED visits than there are going to be hospitalizations. And so for the kind of short-term complication you might expect from not using enough test strips, those would probably be more relevant than hospitalizations, and to the extent that you can look at those you might think about including one or, ideally, both.

DR. CROSSON: Very good. Karen.

DR. DeSALVO: You have on Slide -- I have to put on my glasses. Sorry. I don't know why I'm apologizing. I'm just aging. It's just a function of that. It’s better than the alternative, right?

So on Slide 12 you have a bullet there that says Medicare's excessive fee schedule rates for off-the-shelf orthotics are likely encouraged alleged abuse. And, oh no. Maybe I circled the wrong one. I'm sorry. It was the one about harassing -- apologies -- it's the one about harassing the beneficiaries.

MR. O'DONNELL: It's on the same slide.

DR. DeSALVO: It is. Okay. And it made me think about this figure that you all had in the paper, Figure 7, where there's this little spike in use. And I just wanted

to hear -- and the reason I'm asking is just thinking about policy options in addition to price, looking at price, thinking about marketing directly to beneficiaries. And there's good in that because, you know, you want them to have choice, but then if it's excessive and abusive, you want to protect them also at the time of switching, and make sure that the reflection is good and not just because they're being pressured.

So I just wanted to hear a little bit about whether, in this policy frame, there's any options to be more prescriptive about what can be pushed to consumers, in terms of marketing.

MR. O'DONNELL: Right. So there's already an anti-solicitation rule in Medicare, which basically says if you're not -- as a supplier, if you're not already supplying a beneficiary with a product you can't kind of cold call them to get them to use your products. Obviously, the allegation is that this was a pretty widespread violation of it. When we look at the glucose monitors, I think, you know, the spike doesn't concern me in the sense that I don't think it was driven by suppliers trying to market their glucose meters, because I don't

think there's whole lot of money to be made on the meters themselves. I think the money is really in the test strips. And I think, as Eric mentioned, that before the program was implemented CMS, you know, sent a letter to beneficiaries alerting them to this change. And so they may have proactively done it. So I think that's probably more likely the reason for the spike, as opposed to, you know, supplier solicitation.

MR. ROLLINS: And since a lot of the monitors are designed to work with only one type of test strip, since you are constricting the number of suppliers of the test strip, it was probably inevitable that some chunk of your beneficiaries were going to need to get a new monitor.

DR. CROSSON: Jon.

DR. PERLIN: Just a question from a beneficiary perspective. Are there situations where a couple of products might be nominally identical but in practice aren't driving the consumer, the beneficiary to have to pay more out of pocket? Example, you know, competitive bidding for test strips but this particular beneficiary's provider is using an electronic health record that accepts uploads of glucometer data but only from a particular glucometer

manufacturer, rendering, you know, the least expensive choice, not the choice for that particular beneficiary, because of their particular alignment with provider system and their EHR.

MR. O'DONNELL: So I'm not aware of what you're talking about in terms of glucometers hooking with the EHRs, but we can look into it.

DR. CROSSON: Okay. Good. I think we'll move on to the discussion. Kathy, I think you're going to begin.

MS. BUTO: Thank you, Jay, and thanks for this paper. It's, I think, remarkable, and we have an example of Medicare trying something that seems to work pretty well across the board, in terms of saving money, maintaining or improving quality, and also reducing abuse, potentially. So it was encouraging to see this. I remember, in the '90s, when this idea first came up, I was still with the agency. It gives you some sense of how long it takes to get something like this going.

I also just wanted to point out that to me this raises a larger issue, the fact that we're kind of coming up against sort of a moratorium of use, now that it has been successful, that the agency doesn't have enough

authority to move ahead when it's successful. It's sort of the CMMI issue. And that one of the things that I'd like us to think about is, as we look at this issue not only look at can it be expanded to other categories of DME, which I think you pointed out in your paper is something that can be done once you apply certain criteria.

But I think when this was originally thought of in the agency, we were actually looking at MRIs. So I don't know how many of you remember the days when one of the anecdotes that you heard was "there are more MRIs in the city of Philadelphia than in the whole country of Canada," and that's how we started looking at competitive bidding, with the idea that, wait, most people don't get multiple MRIs. They may get an MRI, they may get another MRI sometime down the road. You don't really care where you go as long as it's within a reasonable proximity of where you are. So that was my point about accessibility. If it's something like an imaging service you might want to be aware of availability.

But the point is, competitive bidding is an approach that can be used on a wide variety of things, including setting MA payment rates down the road. And

there was an experiment or two on that as well.

So I guess I would say as we look at this, if we can think about the potential of broadening the authority, maybe with certain criteria, and we can suggest what some of those are, that would make it more likely and a better tool for the agency. I think the agency is really hamstrung by not being able to move ahead when they see an opportunity like this.

Some years ago there was a legislative proposal to extend this to clinical lab services, and the laboratory industry got very exercised about that and made a big price concession. I've forgotten what the percentage off was, but they met whatever the number was that Congress was trying to achieve in savings, and got out from under competitive bidding. And it comes up from time to time. A lot of concern about small labs and so on, and physician-owned labs, and so on.

But there ought to be criteria that allow Medicare to operate, it seems to me, a little more flexibly without having to go back every time to Congress and then letting, you know, whichever industry is concerned to come and actually get that authority stopped or a moratorium put

on, or whatever.

So I would really like us to think of this as a broader approach than just durable medical equipment, and the kind of criteria that we might want to suggest be applied and that they be given broader authority. In this age of, you know, value-based purchasing there ought to be more purchasing power, more ability to make those judgments.

Thank you.

DR. CROSSON: Yeah. Paul wants to add on.

DR. PAUL GINSBURG: Yeah. I'm glad that Kathy brought up these points, and I see a lot of virtue for CMS being given more authority to move into areas beyond DME.

And, actually, that also brings up the point as to whether there are some other areas, like MRIs, you know, outside of DME, where maybe even the Congress should be directing a competitive bidding process for that category of service. I'm not going to get my hopes up that that's going to happen, but if there are other candidates that are important we might want to suggest them specifically.

DR. CROSSON: And just to be clear, Kathy, when you were talking about MRIs, were you talking about

machines or procedures?

MS. BUTO: It was paying for the procedure.

DR. CROSSON: No, no, no. But, I mean, the comparison between Canada and Philadelphia. Was that numbers of machines?

MS. BUTO: Oh, that was numbers of machines.

DR. CROSSON: Machines. Okay.

MS. BUTO: You don't remember that statement?

DR. CROSSON: No, I do. I do. But now I think, Paul, you're talking about competitive bidding for the service.

DR. PAUL GINSBURG: For the service.

MS. BUTO: Yeah. It's for the service.

DR. CROSSON: Yeah, okay.

MS. BUTO: But the point was -- the shorthand for that was there was enough capacity in the city of Philadelphia to meet the needs of the Medicare beneficiaries in Philadelphia.

DR. CROSSON: Right.

MS. BUTO: You could do competitive bidding there. You wouldn't do it everywhere, but you could be selective and do it in large urban areas.

DR. CROSSON: Right. I've got that. So I think -- I'm going to guess here that a lot of the focus now, in the rest of this discussion, is on this issue, and it has to do with the depth and breadth of expanding CMS' authority, depth meaning deeper into DME and the rest of these -- what do you call them? -- DMEPOS. And then the breadth would be, you know, to what extent CMS should be empowered categorically or generically to expand competitive bidding into other areas.

So if that's what we're going to discuss, and it seems to me like it's a pretty good thing, I'm going to ask you -- Brian and Eric, I'm sorry to put you on the spot here -- could you give us a little bit more depth in terms of the barriers that CMS has at the moment?

MR. O'DONNELL: For DMEPOS, in particular?

DR. CROSSON: Well, start with that, yeah.

MR. O'DONNELL: Right. So I think that when the statute was written in 2003, certain products were statutorily prohibited. So there are certain products that CMS just can't include. There are other products where the statutory authority seems a little bit nebulous to me and, you know, CMS would likely face pushback if they were to

include those products going forward.

So for DMEPOS I think those are the two kind of limitations that the agency faces right now.

DR. CROSSON: So it's relatively specific to this product versus that product, or this kind of product versus that kind of product, as opposed to some other kind of limitation. Is that right?

MR. O'DONNELL: That's right.

DR. CROSSON: Okay.

MR. ROLLINS: And the authority to conduct competitive bidding for a DME also addresses some of the issues that some of the other Commissioners have talked about, for specific set-asides to guarantee that some of the contracts are awarded to small suppliers. There's limitations on how much of the market will allow any one firm to sort of say it can supply. So, you know, some of these tradeoffs have already been kind of wrestled with, at least in sort of a DME setting.

MS. BUTO: And, Jay, I think this is not the last time we're going to talk about this, just knowing our way. So one thing for, I think, that would be really helpful is to think about the kind of criteria that we would see in

any broader authority. That would be helpful.

DR. CROSSON: Okay. So let's move on. Brian?

DR. DeBUSK: First of all, thank you for a well-written chapter, and I'm glad we're exploring this subject. I want to speak specifically to the orthotic industry. I mean, obviously that's the industry that I know and know intimately well.

I think one of the issues that I'd like to see us address, even in the published work, that particular industry is a mix of some very, very bad actors and some very, very good actors. For example, I was really excited to see the billion-dollar bust come through. Watching those ads on television were one of the banes of my existence. I hated that -- you know, get a brace at little or no cost to you -- because it was obvious that what these guys were doing was fraudulent. So again, I'm glad to see enforcement actions like that.

Here's my one concern, and Brian, I have expressed this to you over -- I guess over a couple of years now. When you take the good actors who have a fundamentally lower cost structure -- and in a moment I'll explain exactly why they do -- and you commingle them with

the good actors -- you know, I'm picturing an overseas call center that buys the absolutely least expensive brace they can get and ships it to a patient that they've never seen -- versus an orthopedic specialist who is really trying to do a work-hardening program, say, for someone's back, to avoid drugs or surgery, I mean, there's a pretty dramatic contrast there in that they are operating under two fundamentally different cost structures.

My concern is when you throw them all into competitive bid, even if you get that 30 or 40 or 50 percent price reduction, which I think would be good -- good for the program, good for beneficiaries -- the challenge is here you haven't really deterred the bad actor. They still have plenty of margin left over. The person that you're really hurting is the person who has the higher cost structure, the good actor.

So in no way am I saying don't competitively bid this segment. So I'm on board. But my one ask would be -- and I'd like to see this in future work -- I'd like to it also, in concert, I'd like to see us improve the L code descriptors so that the codes themselves are better defined. I'd like to see us look at using more PDAC

letters, making it a little bit more difficult to simply just make a brace and offer it. I'd like to see us do some face-to-face requirements, or require an E&M code to coincide with the billing of a brace or we simply don't pay for it.

And I think there are some practices that we could use to deter a lot of the bad actors, so that once you're left with these good actors, with reasonable but still competitive cost structures, then you put that into competitive bid, and I think you discover the real price of these items. But I do have a concern about commingling the good actors and the bad actors prior to competitive bid.

And this isn't a multi-year delay. I mean, I think a lot of the fixes, if you will, for this industry are things that could be implemented in a matter of months. So I don't think it derails or even delays the competitive bid process. But I would strongly, strongly encourage you, do the cleanup first, because the bad actors are not going to be affected by this process.

MR. O'DONNELL: Can I tease out a little bit of that?

DR. CROSSON: Just one question. The PDAC

letter, what is that?

DR. DeBUSK: Excuse me. Go ahead, Karen. It's good.

DR. DeSALVO: I looked it up. Pricing, Data Analysis, and Coding.

DR. DeBUSK: There is a process, basically, for certain categories, and it's already out there for certain categories that if you want to be reimbursed on that item.

You know, a couple years ago, I brought props. I wanted to show you what a wrist and forearm splint could be, and the -- I love props. But the lowest-end wrist and forearm split, which still qualifies for payment, looks dramatically different than, say, a high-end wrist and forearm split. I mean, you're not talking about a 20 percent price difference. You're talking about probably a 2-, 3-, or even 400 percent price difference on the item. So there's a process for basically submitting your product to make sure that it meets certain requirements.

And you would really be appalled if you knew how many items. I mean, literally, you and I could go home and sew something up in a lot of these categories and declare it a particular L code or, I guess, technically recommend

it, an L code, and just start shipping it to customers. I mean, these are Class 1-exempt devices, and a lot of them don't have PDAC requirements. We literally could enter that business this afternoon and start producing Medicare-billable devices.

And I think all those loopholes need to be closed because, again, you're commingling some very bad actors with some very well-intended people who are trying to avoid drugs and surgery.

DR. MATHEWS: And so just to be clear, Brian and Eric are not going to be doing that, so --

[Laughter.]

DR. CROSSON: Brian, I mean, "actors" is one way of putting it, but I think underneath what you're saying is that there needs to be a process somehow in here to assure that there's appropriateness, that the Medicare beneficiaries who need it are getting it, and what they get is appropriate and safe and effective.

DR. DeBUSK: Absolutely. I think that's -- again, if we could just figure and figure out. It's not that hard to do. If we could just push the bad actors aside and let the good actors competitively bid, I think

you're going to -- I think you're going to get the best result.

MR. O'DONNELL: Would you include prior auth in that list of improvements?

DR. DeBUSK: I think prior auth would be wonderful.

DR. CROSSON: I'm sorry. But just to be clear, prior auth in this context is the same as having a face-to-face visit, or in addition to that?

DR. DeBUSK: I would turn to Brian on this. I think there's a number of solutions that are already out there for some of these devices.

MR. O'DONNELL: So CMS already does prior auth for a good swath of DME, and they have a list of products that could be subject to prior auth. And I believe some L codes are on that list, and so I was just making sure that he was -- he wanted to include that prior authorization in his list of --

DR. CROSSON: But that's a separate concept of having --

MR. O'DONNELL: That's correct.

DR. CROSSON: -- of having patients see a

provider and having authorized.

MR. O'DONNELL: That's correct.

DR. DeBUSK: There's an effective tool set out there. We just need to access it prior to basically throwing the good and the bad together to bid.

DR. CROSSON: Dana, on this?

DR. SAFRAN: Yeah. Just a question on this, Brian. You've referred to it multiple times as "prior to the bid," but what if it was done as part of the bid?

One of the things in the chapter that was striking was this information that a lot of times, the lowest bidder then when they get the contractor or whatever backs out. So wouldn't it be possible as part of the process to then do this validation of the ones who are coming in as the low bidders and throw them out and then reset what the prices are?

DR. DeBUSK: I think that is another alternative is to be even more stringent on the people, on the would-be bidders.

It will probably be a little difficult. I mean, Brian, maybe you could speak to that. Would you rather put a set of requirements in place that push the bad actors out

and then open the competitive bid process, or would it be more feasible to just let everyone bid and try to sort the good bidders from the bad bidders?

MR. O'DONNELL: So I haven't thought that through, but the prior auth process, you could certainly do it at the same time as competitive bidding. The prior auth process happens at the MAC, and so I don't see any kind of reason why that couldn't happen at the same time.

DR. DeSALVO: I have a question on this. Back to that product itself, just sticking with like a sling or something, the Medicare program actually sees and touches the product and decides if it's quality or not somewhere in the process?

DR. DeBUSK: There are some products that are subject to PDAC letters. There are other products that are not subject to any sort of prior approval. I mean, literally, on the box, it can say this is the recommended L code, and you could just start billing.

These L code descriptors that describe the code to be billed in some cases are very, very loose. I mean, Brian, you may want to elaborate on that. They're very vague descriptions at best.

DR. DeSALVO: I'm sorry. I just don't -- so a letter means you as the manufacturer describe it and send that into Medicare who then decides based on your description?

DR. DeBUSK: If the product requires a PDAC letter, yes.

What I have to do is take physical samples of my product --

DR. DeSALVO: You do. You have to bring samples for them to touch.

DR. DeBUSK: -- submit it, and then I have to receive a letter back that says, "Your product meets this."

DR. DeSALVO: Thank you.

DR. DeBUSK: Yes.

DR. DeSALVO: So it just doesn't cover all categories, and maybe that's an opportunity to ensure better quality.

DR. DeBUSK: Absolutely, absolutely. That's one of the many arrows in our quiver to clean this up.

DR. CROSSON: Okay. Topic is CMS's authority to go deeper into -- DMEPOS? Is that how we say it?

DR. MATHEWS: DMEPOS.

DR. CROSSON: -- DMEPOS, one.

Two, expanding beyond that into other areas where they could exercise competitive bidding, and if so, where would that be?

Marge.

MS. MARJORIE GINSBURG: Yeah. I just have a background question. Did CMS ask us to do this analysis, and have they done their own analysis? Did we take this on, on our own, because we thought it was rich for our input? I am curious, the relationship between CMS, since we're right in this midpoint now, of them moving on to bigger and better enterprise in this area. How did we get involved?

MR. O'DONNELL: So the work, we started the work on our own, and so CMS does conduct a health outcomes monitoring system. So they have an algorithm that monitors, for instances, hospitalizations at the MSA level, and so like, for instance, for folks with diabetes, it tracks the hospitalizations in each MSA. And it looks whether there's an increase over a certain amount in each MSA, and it can flag it for CMS. And they can go check it.

So CMS does this program on its own, and I think

what we're doing is that we've heard complaints from industry suggesting that their monitoring system is perhaps missing some things, and so what we wanted to do was to take a deep dive into this one product and look at it more carefully.

DR. CROSSON: Yes.

DR. DeBUSK: I'm glad you brought up the Health Status Monitoring Program too. That's another thing that I would really like a better look under the hood. It's an interesting idea, but I've heard a lot of criticism that it's a blunt instrument.

Here's my question: Are we ready for the HSM to be a precedent for other programs? Would we eliminate, say, the six protective classes in Medicare Part D and use the Health Status Monitoring Program? Would we, for example, completely redo Part B drugs and, say, step therapy and utilization management and just use the Health Status Monitoring Program? Are we setting a precedent there that we're willing to live by for other tough decisions we have to make in Medicare?

MS. BUTO: So, Brian, just a question back to you. I mean, I think in most of our minds, doing something

up front like eliminating six protected classes but not necessarily the Health Status Monitoring System or some of the other things you suggest, making the decision up front to do something versus monitoring afterwards is less effective. I'm just trying to understand where you're coming from on this.

DR. DeBUSK: My question, we do face a lot of tough policy decisions, and the impact, potential impact on beneficiaries is a little bit uncertain.

The Competitive Bid Program has enjoyed for years this ability to say, "Oh, don't worry. It will be okay, because we're going to do Health Status Monitoring after the fact. So if we break anything, we'll detect it." My question is, Is that program so robust that we would use it, say, in Part D or on Part B drugs or on some other necessary service? Because I would say if it's robust enough to decide whether or not someone is going to be receiving oxygen therapy, for example, adequately, it probably ought to be adequate to use in other really tough policy situations. And my suspicion is it's not robust enough.

MS. BUTO: Okay. I think we should have a longer

discussion about that because it really depends on the issue, how well you can actually monitor or look at real-time data versus monitor afterwards. So I'm not sure exactly where you're going with this, but I'm not sure what the alternative is. And I guess we probably need a longer discussion.

DR. CROSSON: Well, I think so or in a different venue.

So are you suggesting that, Brian, this should be a cautionary tale in terms of expanding competitive bidding, or are you just bringing this up?

DR. DeBUSK: I'm not sure that when we do have concerns over access or access over unintended consequences of the program -- I'm not sure that the Health Status Monitoring Program is the definitive source of saying "Yes, this isn't a problem" or "Yes, it is a problem" or "No, it isn't."

And that was my question. I think it is a little interesting to me to see us supply such a blunt tool to something like this, and my question, I guess this is more of a rhetorical question. Would you be ready to see the Health Status Monitoring Program applied to other tough

policy decisions? And I suspect the answer would be no.

DR. MATHEWS: So without immediately getting into that broader question, again, as Brian said, the industry brought us some concerns about the effects of the Competitive Bidding Program, specifically with respect to this set of products, that were substantial enough that we decided to do our own independent evaluation.

If I am mischaracterizing our findings here, by all means, correct me, but when we did this very detailed, fairly granular assessment of the impacts of competitive bidding on beneficial access to diabetes testing supplies and outcomes -- you know, we have this slide here on hospitalizations, but we also in the materials have looked at mortality and emergency department use. Our findings pretty much corroborate CMS's assessments that have been consistent relatively since the beginning of the Competitive Bidding Program. That access has not been compromised, and that there have been no untoward health effects on beneficiaries attributable to the Competitive Bidding Program.

So, again, without getting into whether this is precedent, I think the results of our analysis corroborate

that it has, indeed, been accurate to the extent our blessing is worth anything, but that our analysis has corroborated what CMS has been saying.

DR. DeBUSK: And I agree with that. I do think that the staff work that you guys did on the diabetic testing supplies is compelling. I think it's good work, and I think it does support the idea that the National Mail Order Program didn't hurt beneficiaries or access.

DR. CROSSON: Okay. Jon.

DR. PERLIN: Let me come back to where Kathy started us off. There's a lot to commend this line of discussion. There's bang for the buck here.

As we think about the implicit question or the explicit questions, you know, is there opportunity to expand, I think there's a question that we're not asking that we have to define more sharply, and that's this related question of interchangeability of products. In the pharmaceutical area, we call it "therapeutic substitution."

Brian, you gave an example. I think there are two categories, the first of which is fitness for purposes. You gave an example of two things that would qualify as an arm immobilizer or sling. One may be simply you've broken

your arm, and you need something to hold it up so it doesn't dangle. Another is a more sophisticated piece of equipment that actually not only keeps your arm from not dangling but immobilizes certain finger movements as very much more therapeutically specified.

Right now, if I understand what you've laid out, it's those two things may be perceived as interchangeable when in fact they're not because they're fit for different purposes and not equivalent.

The second is that once you get something that's specified for a particular purpose, like, say, for example, it's a highly manufactured orthotic that not only provides the lifting function, the sling function, but also mobilization, then you need to be able to understand within that fitness for purposes, which is a better job, which does a better job in serving that purpose; that is, quality versus cost.

It leads me to -- and I say this with full respect for the depth of knowledge elsewhere, my lack of knowledge in this area on L codes, PDACs, et cetera -- that when we're thinking about therapeutic substitution in pharmaceuticals, we think of NDI and the ability to

specify. We know that it gets murky when we get into the biologicals with equivalents.

But it strikes me to really be able to take this to the potential expansion that could be beneficial, we need to have some degree of being able to specify with some precision what the specific purpose of anomaly interchangeable item is and then kind of do the fly-off of which is the better product at price point within that category. It just strikes me that's a requisite.

So I wonder, really, coming back and listening to the point you made that we think there is opportunity here, that that's the sort of set of specifications that allows one to really effect a meaningful competition.

Thanks.

DR. CROSSON: Okay. So I've got -- where am I? -- Dana.

DR. SAFRAN: Yeah. I guess I'm glad, Jon, that you brought us back to this because it's a little bit what I was hoping to tee up with my question on the first round is just can we either today or subsequently think more broadly about the kinds of services, not just goods, where competitive bidding might be a good thing for Medicare to

consider.

In my work on payment reform prior to my current job, I was a much bigger fan of global budgets than bundled payments, but you can't help but let your mind go there to think about competitive bidding for episodes. Those certainly are not commodities, but paired with the right quality and outcome measures, we could consider the idea of competitive bidding, moving beyond things that are straight-out commodities. So I think it's worth further consideration.

DR. CROSSON: Episodes of care. Amol.

DR. NAVATHE: Dana, just to clarify your point, are you thinking that -- so, for example, if you take the classic episode that we oftentimes think about as hip and knee replacement surgery and there, there's an artificial joint implant, and if you have a bundled price for that, then that has, at least in some of the work that we've done and others have done, seems to drive innovation and the acquisition of the implant cost itself. Are you thinking about this as these services also can be related to the types of DME or devices that might be related, or are you thinking about this? Are you taking it one step further

and saying let's abstract away from the concept of DMEPOS and just think about services entirely as a new construct here?

DR. SAFRAN: The latter, yeah. I'm thinking, you know, so if Medicare had -- needed in every market to be able to have a qualified provided for hip replacement surgeries, et cetera, and there was competitive bidding to get that business in different market areas, it seems worth a thought.

MS. BUTO: Cataract surgery. I don't know how many people remember, but CMS did do a demo on cataract surgery and bypass surgery. They were called "centers of excellence," but they really were competitive bids, if you will, for not just the procedure but the physician cost as well included and saved -- I can't remember what, but it was a considerable -- out of the total, a considerable amount of both physician and hospital cost, and quality was as good or better than before, so as good as we were measuring at the time.

So the point is you can do it by episode and particularly for something that's where the device costs are pretty low, I think, for cataracts and pretty uniform.

Then it's, I think, even easier.

DR. CROSSON: There's a crossover area between episode payment and global payment. For example, one episode could be the care of a diabetic for a year for all services.

I have a feeling we're getting a little far afield here.

DR. MATHEWS: No. We're --

DR. CROSSON: You like this?

DR. MATHEWS: Yeah, this is good.

MS. BUTO: This might solve our fee-for-service MA problem.

DR. CROSSON: Right.

[Laughter.]

DR. MATHEWS: But just to pick up on Dana's point here -- and this goes in the opposite direction from, Jon, what I think you were saying about the need to do a much more granular comparison in terms of clinical functionality for purposes of establishing bids, at the other end of the spectrum would be bidding to provide services for a defined population.

So a radiology benefits manager would bid on

providing all of the advanced imaging for a population in a given market, and that's the level of competition.

DR. CROSSON: Right.

DR. MATHEWS: There are different scales at which you can consider this.

DR. PERLIN: On this, I think the two are actually complementary because, even if you have bid out, if you will, a complex bundle of services, there's an expectation that then the individual that responds to that bid will compare products and provide the best quality, lowest cost, whatever. Then you could have a basis to make a reasonable comparison. So I think it still takes you back to having to define what's, in fact, truly interchangeable versus what's not interchangeable.

DR. CROSSON: Okay. I do want to -- sorry, Jim, but we sort of have two things on the table. And we're drifting off into a good area, admittedly, but it's a pretty broad one, which is how could we solve all problems in Medicare with competitive bidding.

[Laughter.]

DR. CROSSON: That's great, and I think we're picking up some good ideas. But we also have this on the

table, which is should CMS have expanded authority in this DMEPOS area, and I'm getting the sense that most people support it. Let me do a bobblehead here. Yeah, yeah. So that's over with.

Let's continue the rest of it. Warner and then -- I'm sorry. Larry was first and then Warner.

DR. CASALINO: Well, I wasn't going to say this until Jim said we're not going too far afield, but --

[Laughter.]

DR. CASALINO: Once we start talking about things like hip and knee replacements, it's hard to listen to a discussion about competitive bidding without thinking of the phrase "reference pricing." And I guess I just have a question. Is reference pricing just too, too far from the statutory authority that Medicare has to even enter any discussion that the Commission would ever have?

DR. CROSSON: Well, let me see. Does it sort of bring up the question of in a competitive bidding model what bid or set of bids do you take, which sort of then creates a reference price. Is that what you're saying?

DR. PAUL GINSBURG: Or you create a reference price without competitive bidding --

DR. CROSSON: Yeah.

DR. PAUL GINSBURG: -- on some other basis.

DR. CASALINO: And that would give beneficiaries the choice of going where they want to go. However, it would have beneficiaries paying different amounts for different things. But you do that now, anyway, to some extent with your co-payments, right?

DR. CROSSON: Right. Okay.

DR. DeSALVO: I wonder if somebody could shed a little light on how commercial plans handle D-M-E -- whatever -- DMEPOS. Dana? Anyone else? How a commercial plan handles pricing for DMEPOS.

DR. SAFRAN: Sorry, but I have no idea.

MR. O'DONNELL: I have a little bit of knowledge.

DR. DeSALVO: Okay.

MR. O'DONNELL: Before this, there have been studies looking at how private plans priced DMEPOS before competitive bidding, and private plans largely had substantially lower prices before competitive bidding, maybe 30, 35 percent. So private plans kind of recognized that Medicare prices were too high, and they kind of clawed back some of that savings beforehand.

DR. DeSALVO: That's interesting. Some of Brian's points, I wonder how they track on quality of products, you know, whether it's actually going to meet the needs of the member, and have a track after the fact for whether change in availability.

MS. BUTO: Brian, do you have a percentage of DME expenditures -- or not expenditures but use, Medicare versus private?

Because my sense is Medicare is the DME market, a large part of it, because of the age of the beneficiary and think about the last time, you know, kids --

MR. O'DONNELL: In Medicaid.

MS. BUTO: Yeah, in Medicaid. Kids will break legs, but beyond that, you don't get a lot of oxygen concentrators and things like that.

DR. DeSALVO: Yeah, I mean, Medicaid managed care might be another model --

DR. PAUL GINSBURG: Actually, Karen, I did a study a couple of years ago on Medicare Advantage plans and what they pay for different services, and they pay a lot less for DMEPOS than Medicare does, even though they pay very close to Medicare for hospital and physician services.

They pay less for labs as well.

DR. DeBUSK: To your question also about the mix, a lot of these DMEPOS items come through the ED, because, you know, the OR, the operative versions are typically packaged and bundled into the APC or into the DRG, so, for example, spine bracing and things like that. Through the ED, you don't see a really good Medicare mix just because a lot of the people who are going to have knees and ankles and some of those issues, a lot of those people are younger and active.

If I remember correctly, I want to say it's maybe 18 percent of the ED DME items go to Medicare.

MS. BUTO: If you look, though, on Table 2 in the reading materials, Brian, for Medicare anyway, the big -- the 900-pound gorilla is oxygen concentrators, followed by blood glucose test strips. And so, you know, when you think about the population --

DR. DeBUSK: I was being myopic and only thinking of orthotics. You're absolutely correct.

DR. CROSSON: Okay. Here I come again. There is a -- I'd like to nail down the DMEPOS piece first. So in the paper -- correct me if I'm wrong -- we do have a branch

point there. One would be to suggest that CMS be given greater authority categorically or by category, in other words, in this area, in that area, with this device, with that device.

The other approach which you had in the paper was to go further and say CMS should be given broad authority to use competitive bidding without specificity.

Is that right? Have I got that clear?

MR. O'DONNELL: For all DMEPOS, correct.

DR. CROSSON: I'm sorry. For all DMEPOS products. So is there an opinion on the Commission which of those two directions we would prefer?

PARTICIPANT: B.

DR. CROSSON: Let's go for the B's. Any B's?

[A show of hands.]

DR. CROSSON: We've got some B's.

DR. PAUL GINSBURG: Or just make B's all DMEPOS.

DR. CROSSON: I'm sorry. So to be clear, let's call A and B. A would be, we would suggest -- and this would have to be by statute. We would suggest that CMS seek through statutory authority to be able to expand competitive bidding to the following 25 products, listed,

right? Beyond what they have now. That would be one choice.

The other would be seek statutory authority to apply competitive bidding in the DMOS -- in the DMEPOS area at their discretion. Those are the choices.

PARTICIPANTS: B.

DR. CROSSON: I'm hearing B. I'm hearing B. B, B, B, going once, going twice. Good.

DR. DeSALVO: Just a point of clarification. Don't they already have more latitude than they're even exercising now even before statutory change? Did I read that --

MR. O'DONNELL: They have a little bit of authority to include extra products, but there's a whole other set of products that they can include.

DR. DeSALVO: The whole other world, okay.

MR. O'DONNELL: That's right.

DR. CROSSON: Okay. So we've got that. Now, as we're getting -- I'm sorry. You want to dissent?

DR. NAVATHE: No, I don't want to dissent per se, but I want to clarify, which is -- so could there not be an option where the statutory authority is essentially, yes,

you can expand "at will," but that there could be some sort of guidelines or safeguard provisions around, you know, here we need some uniformity of products, some therapeutic equivalence, you know, there is some guarantee of minimum quality, something like that to kind of reference some of the pieces that Brian -- because I think that Brian's bringing up --

DR. DeBUSK: I vote B because --

DR. CROSSON: Yeah, and it would -- I mean, I agree with you, and I think that sort of goes without -- I mean, it --

DR. NAVATHE: Okay. If that's part of it, then I'm cool with B.

DR. CROSSON: Okay.

DR. DeBUSK: Thank you [off microphone].

DR. CROSSON: Okay, so we want that part --

DR. DeSALVO: I want to belabor the existing statutory authority question, because -- do we have to separately weigh in on whether we want them to go all the way to the edge of what they have now and we want there to be additional authorities with safeguards? Because --

DR. CROSSON: I mean, I don't know enough to

answer that question. I'd ask Brian and Eric --

MR. O'DONNELL: Can you repeat the question?

DR. DeSALVO: Sure. Would we want to make a recommendation formally that Medicare extend all of its current statutory authorities in competitive bid pricing and also that, with appropriate guardrails, there's an extension of the DMEPOS?

MR. O'DONNELL: I think you could just say the latter, to say --

DR. DeSALVO: Okay.

MR. O'DONNELL: -- the agency has the authority to bid out, you know, all of DMEPOS with certain safeguards, including the products it already has authority to, and other products.

DR. DeSALVO: Okay.

DR. CROSSON: Yes, Larry.

DR. CASALINO: I think it might make good sense for authority [inaudible] it already has and so the recommendation could be [inaudible] already has and we think there should be statutory authority [off microphone].

DR. CROSSON: Okay. I'm seeing that, and I think -- now, the second part of that is beyond DMEPOS, what

other areas of competitive bidding have we talked about that CMS could take? And I think we've heard at least five or six different ideas, all of which I think have value, everything from competitive bidding in Medicare Advantage to a variety of episodic care from an episode as narrow as one procedure to as broad as care of an individual over a year or a population over a year or whatever. I think my message here to Jim would be there's a lot of support for that direction, that it might be useful to have the staff have this in mind as we're approaching, you know, the problems we face -- I'll get to you in one second, Kathy -- but I'm not sure we can adjudicate here in the next five or ten minutes what those ought to be.

Kathy?

MS. BUTO: I just want to add to that. We might want to, as the staff is thinking about this, frame it as these are some areas, for example, we would ask the agency to consider doing through CMMI and, again, if they're successful, roll them over to the regular program. So use that device because, otherwise, we're going to be going back to Congress again for more authority.

DR. CROSSON: Right.

MS. BUTO: And I think they need to be tested. In other words, I don't think you want to go for authority without seeing whether it makes any sense, whether it's going to actually work.

DR. CROSSON: Makes a lot of sense. Jim?

DR. MATHEWS: Yeah, okay. So without -- so a number of the people at the table here, based on their own personal experience or things that they've encountered out in the environment, have identified a number of examples historically where CMS has tried to competitive approaches. There was an MA competitive bidding demo. We've talked about, you know, advanced imaging. We've talked about clinical labs. I would suggest that before we as the staff start to highlight specific issues, maybe the first step that we'll do over the next couple of months here is think about a set of criteria to identify the kinds of services that are amenable to competitive bidding, and once we have those criteria, we can come back to you and say here is what we're thinking. You know, the products have to be widely available; they have to be comparable; they have to be products that don't materially result in differential outcomes if one is substituted for another. And as we

think about those kind of criteria, we can come back and say here are some things that could fit those criteria, and --

DR. CROSSON: That might be a first step.

DR. MATHEWS: -- or services. And do that kind of foundational work before we come back and say, well, here are the things and here is how CMS should execute it.

DR. CROSSON: And, once again, this is a -- I mean, this could be a long-term theme for a number of years here.

So two more comments, and then we'll move on. Pat?

MS. WANG: I just want to endorse what you just said, Jim, because the first part of the discussion about DMEPOS I think is solid, and we've had good discussion and there has been -- some of the other ideas range from "that's interesting" to, you know --

[Laughter.]

MS. WANG: And so I hope that that part of this discussion is not take as, yeah, let's go, and tell CMS to start doing all this stuff.

DR. CROSSON: Dana said earlier today we want big

ideas. We're getting them.

[Laughter.]

DR. MATHEWS: And I'm sorry, you know, to emphasize this, but I don't want folks to lose sight of, you know, the top-line message in this presentation, that the things that were subject to competitive bidding resulted in a 62 percent decline in Medicare spending without any observable compromise in terms of beneficiary access, in terms of beneficiary outcomes. And, you know, when we contrast that kind of performance with the kinds of savings that we've seen with respect to ACOs or other approaches that CMMI has been testing, it's hard to say that this is not a success, and that if there is an opportunity to transplant this experience into other areas of the program, I think we should really push this hard.

Obviously, we'll do it deliberatively and informed by data and your input here, but this is a program that has worked, and I think it is, you know, worth examining to see if it can be replicated.

DR. CROSSON: And you've got good support here.

MS. WANG: I have no disagreement with that, but just to reiterate the earlier point, I'm -- things that

lend themselves to competitive bidding are commodities. So we've talked about a lot of other things here, which include, you know, clinical services, and I just want to -- like my thoughts on this, to competitive bidding for MA, you know, those are very different concepts. So I just want to state -- so I completely agree with what you're saying, Jim, but when I think about the benefits, it's much easier for me to visualize when you have criteria and you move like, you know, it's solidly for something that's commodity-like. But as you start moving down the spectrum, I think we just need to...

DR. CROSSON: It's a long-term direction. Everything would have to be adjudicated over time.

Last comments, Warner and then David, and then we have to move on.

MR. THOMAS: Just very briefly, and I would agree with Jim that I think this has a lot of merit, and there's a lot of opportunity here. I think Pat's point here, especially as it relates to services or interpretations, you know, we've looked at a lot of -- some of the Centers for Excellence work and some of it being in the imaging area, and we've been approached many times because what

some of the big employers have found is that the interpretations on imaging are -- you see a 20 to 30 percent error rate in interpretation.

So I think it's one thing to do the MRI; it's another thing to actually interpret it and get the right diagnosis. I would just be thoughtful about it when we approach that.

One thing I would put on the table that I don't think we've talked about is actually pharmaceuticals. So, you know, should drugs be put into this category where you've got similar types of drugs and go through a competitive bidding process? Maybe this plays out in biosimilars as well. So I just would put that on the table as something to be considered, and certainly we saw these types of reductions there, that the magnitude of the savings would be very material.

DR. CROSSON: David, last comment.

DR. GRABOWSKI: Great. Jim, I'm glad you brought us back to the savings and just how positive this is. We get so few victories on this Commission that when we get one, let's appreciate it and savor it. So thank you.

Along those lines, I like where we're going with

the depth and the breadth here, and I also wanted to kind of push us along the lines of competitive bidding is not always competitive bidding. What I mean by that is just like we've had this discussion of an ACO has many features and what do we mean, do we mean prospective or retrospective or one-sided or two-sided? I thought the chapter did a really nice job of taking us through these different elements, and are the bids binding? Do we take the median price or the market-clearing price?

And I think economists were very critical of this model, and yet it worked really well. Shows you what economists know, maybe, but I think more importantly, I think as we move forward, we should weigh in on what the competitive bidding process might look like, because I think there's a role for us there as well in addition to where we could apply this. We could also think about what the model looks like, and I think we could actually be very helpful there as well.

Oh, and Karen wanted me to say, sneaking in a comment, this is a fee-for-service approach, and that's something to think about here. This is very different than --

DR. DeSALVO: Right, as we pull money out of the system, it lowers [off microphone].

DR. GRABOWSKI: Yes, there you go.

[Laughter.]

DR. CROSSON: You don't have to hide.

DR. DeSALVO: I wasn't hiding.

[Laughter.]

DR. CROSSON: Okay. Good discussion. Thank you. We're going to move on.

[Pause.]

DR. CROSSON: Okay. It's Jeff again, and we're going to see you tomorrow.

DR. STENSLAND: Yeah.

DR. CROSSON: I hope you're getting extra compensation for essentially carrying half the load for the meeting. You can talk to Jim later about that.

DR. STENSLAND: I assume the paycheck will come. We'll see.

DR. CROSSON: Okay. So Jeff is going to take us through a review of the Hospital Readmission Reduction Program, give us an update, see where we are. Thanks. Go ahead, Jeff.

DR. STENSLAND: Okay. So today, as Jay said, I am going to try to give an update of the evaluation we did of the Hospital Readmission Reduction Program.

Just to give you a little background first on how it all started, first there was some increased awareness of excess hospital readmissions. I think in 2008 the Commission and some others discussed how a lack of care coordination and some poor transitions between acute and post-acute care may result in more readmissions than were necessary. And there was a belief that care transitions could be improved and readmissions reduced, but also a belief that hospitals did not have a financial incentive to improve care that occurred outside their walls and coordinate with those people, like the medical directors of the SNFs, et cetera.

Then in 2009, CMS started to publicly report hospitals' readmission rates. In 2010, Congress enacted the Hospital Readmission Reduction Program, and in 2013, hospitals with above-average readmission rates during 2010 to 2012 had their payments reduced.

Now, Congress later mandated that MedPAC evaluate the success of the readmissions program. We assessed the

effects of the HRRP in 2016 and in our June 2018 report to Congress. We concluded that the readmission rates declined without causing an increase in risk-adjusted mortality following the passage of the HRRP, and today we're going to update that analysis.

We have three objectives behind today's presentation.

First, in the course of updating our work to 2017, we discovered an error in our calculations that resulted in an understatement of 2016 readmission rates. The error affected only one year of readmission rates and did not affect computations of mortality rates. This presentation corrects the 2016 data.

Second, we use 2017 data to update both the readmission and mortality findings.

Third, we explain how the conclusions regarding the decline in readmission rates without causing an increase in risk-adjusted mortality do not change with the updated data.

So, first, let's talk about the understatement of 2016 readmission rates. We understated those rates due to errantly not including the readmissions that occurred after

the end of the fiscal year when computing 2016 rates. Our mortality computations were not affected.

Originally, we reported unadjusted all-condition unplanned readmission rates declining from 16.7 percent in 2010 to 15 percent in 2016. The true rate of decline was from 16.7 percent to 15.6 percent in 2016.

This is the updated data. This slide examines the unadjusted and risk-adjusted rates for all conditions. What you'll notice is that unadjusted rates declined and then leveled off in 2014. The decline is consistent with reported efforts we've heard from hospitals about their mechanisms for reducing readmission rates.

Now, risk-adjusted rates continued to decline, according to our models. But as we discuss in your mailing materials, some of this might be coding. Whether one concludes that readmission rates are continuing to decline or just leveling off depends on whether you believe that some of the reported increase in patient severity is real and not just coding.

After examining a wide range of literature and some other data, we believe that some of the increase in reported severity was due to coding, and some of the

increase in reported severity reflects a real change in the mix of patients admitted to the hospital.

With respect to coding, CMS allowed additional fields for additional coding of morbidities in 2011. This may have contributed to the increased reported severity. In addition, providers generally have had increasing incentives to more fully code over time due to payment incentives and risk adjustment in the outcomes that are publicly reported by hospitals.

However, we think some of the increased patient severity is real, and there are several pieces of data that we looked at that are not dependent on coding that suggest the patients admitted are getting sicker while easier cases are increasingly treated on an out-patient basis.

For example, from 2010 to 2017, the number of heart failure admissions per capita declined by 9 percent, suggesting that less complex cases may be increasingly treated on an outpatient basis. In addition, from 2010 to 2017, there was an increasing share of patients discharged to either the hospice or the SNF, with fewer patients were discharged to home without home health care. And generally we think those who are discharged to SNF or the hospice are

going to be in worse shape than those discharged home. This suggests that patients really are getting sicker, but how much is a true increase in severity of illness and how much is coding is difficult to say.

In general, the combination of flat, unadjusted readmission rates, coupled with evidence that there has been at least some increasing severity, suggests risk-adjusted readmission rates have improved.

One concern is that if readmissions fall too much there may be a reduction in appropriate admissions. That may cause an increase in mortality, and this is a valid concern. To test this, we examine unadjusted mortality rates in this table. We highlight unadjusted mortality rates because they do not affect the coding issue we talked about before.

In this graphic I highlight heart failure mortality because this is the condition that has received the most attention in the literature. We measure mortality as death in the hospital or in the 30 days after discharge, and that's what you will see in this slide.

We see a slow increase in unadjusted heart failure mortality from 2008 to 2013. This increase

received the most attention in the literature. The concern was that the HRRP may have caused physicians to not admit patients that should have been admitted, and this maybe caused some harm.

However, our risk-adjusted numbers show a decline. A key question is whether the increased reported severity is real or simply due to coding, but as we discussed earlier we believe part of the severity is real and was not caused by a risk-adjusted mortality increase due to the HRRP.

We next turn to some other studies and what they have found.

The other studies that we looked at examined things a couple of different ways. When you look at how we looked at it, we first just looked at the time trend, and we found a slight increase and then a leveling off. There are some others who looked at it a little differently. They looked simply at the time trend and they found, in general, that risk-adjusted readmissions were going up according to their models, through 2014. And the two key differences are we looked at mortality during the admission and the 30 days after, and many of those other studies only

looked at the 30 days after.

The other thing is studies can look at this in different ways. The general studies that raise the most concern are those that say, well, the timing of these things coincide. We had the HRRP enacted, and then we had this increase in mortality, and they assume then that the timing of those two things seem to be causal.

There are some other ways to look at it, and we and some other people have said, well, let's look at this cross-sectionally. The places that had the highest growth, or the highest decrease in readmissions, did they have the most increase in mortality? Or when your readmissions go down did your mortality go up? And we and others found, no, that's not the case. The correlation actually went a little bit the other way. And that led us and some other to say that doesn't look like this timing of the two things moving together was causal.

There's another way of looking at this, and Professor Gupta from Penn looked at it by asking a different way. And said, well, let's look--he used an instrumental variables approach and look at hospitals that were expected to be most affected by the readmission

program. Did those hospitals then have worse outcomes, either in terms of mortality or anything else? And his conclusion was no. He actually concluded that the hospital readmission reduction program caused a reduction in readmissions and mortality.

So I think looking at the totality of that evidence, it led us to conclude that no, the hospital readmission reduction program did not cause an increase in risk-adjusted mortality. And also if you take a look -- this is also partially reassuring here -- if you just look at the raw numbers that we have we'll see there has been a slight decline from 2015 to 2017, where the rate now, in the raw readmission rate, not even including the risk adjustment, is back down to where it was in 2012.

Now let's shift from focusing on heart failure to other conditions. A new concern in the 2017 data is we see a slight increase in unadjusted COPD and pneumonia mortality. If you look at the chart you see two little arrows popping up at the end. Risk adjustment rates still fell, but the increase in unadjusted rates is nevertheless surprising.

The showed the uptick in pneumonia as the white

line up there, and the uptick in COPD as the blue dotted line. As we discuss in your paper, this appears to be due to a shift in coding instructions that caused more cases with both COPD and pneumonia diagnoses to be classified as COPD cases. On a combined basis, which is that dashed line there, the combined level of COPD and mortality was flat as you see, staying roughly from 14.2 percent in 2013 down to 13.9 percent in 2017.

So in sum we would say that mortality is an important indicator of quality, and asking whether the readmission incidents are so great that they've caused an increase in mortality is a valid concern, a valid thing to be researched. But after a broad look at the literature, coupled with an examination of data that is not dependent on coding, such as length of stay and patient discharge data, reductions in readmissions do not appear to be correlated with worse mortality.

So in summary, unadjusted readmission rates declined after the program was enacted in 2010, and hospitals with greater readmission declines did not see an increase in their mortality. We and others have found this. There are indicators that patient severity is

increased, and these include indicators that aren't dependent on coding. And finally, therefore, on a risk-adjusted basis it appears that readmissions have declined in 2010 to 2018, without causing a material increase in mortality.

The HRRP may have resulted in some improvements in readmissions, but that does not mean that the program is perfect. You may recall, in the past, MedPAC had some recommendations. Specifically, we had said initially the readmission program should move to all condition, and that would allow lowering the magnitude of the penalty for each individual readmission, and there should also be a prospective target.

When you look to last year, we combined our readmission recommendations into a broader Hospital Value Improvement Program, or the HVIP, and this was a system of payment incentives that was recommended in our March 2019 report to Congress. And the summary of the HVIP is shown on this slide.

In terms of the net effect, the net effect was to increase the incentive to reduce hospital morality across all conditions, increase the incentive for patient

satisfaction, bring down the financial incentive to reduce readmissions so that it is equal to the incentives for mortality and patient experience. And you could see this as leveling of the incentives between mortality, readmissions, and patient experience. There remained some incentives for reduced infections and lower episode costs.

So I think there is broad support for these directions, even from those that may have different view on the effect of the HRRP on mortality.

And now I will bring it back to Jay for discussion.

DR. CROSSON: Thank you, Jeff. Very clear. We are now open for clarifying questions. I see Jon and then David.

DR. PERLIN: Just a quick question. Thanks for this update. It's very, very helpful.

Did you look at the rates of observation stays or ER visits for those patients, and maybe you could give maybe a sentence or two on what you found?

DR. STENSLAND: Yeah. So in general we did see an increase in observation stays and ED visits that coincided with this decrease in the readmissions. But we

saw an increase in observation stays for people who were never admitted. So they were initially admitted for observation. It wasn't just the people who were admitted and then sent for an observation stay to avoid the readmission, suggesting this was a broader trend that was going on. And recall that this happened at the same time as the RAC audits, where the RAC started saying, well, if you admit somebody for a short period we might not pay you at all, and I think that was more likely a cause for the increase in observation stays.

We also see an increase in ED visits, but that increase in ED visits was broadly spread across individuals too, not just those who had an admission prior.

DR. CROSSON: David.

DR. GRABOWSKI: Could I ask you about Slide 5, just where you show the unadjusted and risk-adjusted unplanned readmissions. Does the risk-adjusted readmissions, does that cap the number of codes at 9, or are you allowing it to go from 9 to 24 in 2011?

DR. STENSLAND: So we're allowing it to go from 9 to 24 in 2011. We had a categorical model, so how much that affects the risk model may be different from like the

paper that you were involved with Chris Ody. But that effect will be in here, so we would expect some of the decline we see, especially in maybe that 2011 range, to be due to the change in the coding opportunities.

DR. GRABOWSKI: Yeah, and maybe I would need to dig in a little bit more on the categorical approach, but I wonder if there's a way to kind of tease out the coding. Like we just -- we capped it and showed this huge difference between capping it a 9 over time versus, you know, what happened. You know, coders are going to code, and that's what happened.

DR. STENSLAND: Yeah.

DR. GRABOWSKI: And I wonder if you could do something similar here with your categorical model, where you might limit that, and then we could take the whole coding issue off the table and see what actually happened with risk-adjusted readmissions.

DR. STENSLAND: Yeah. The coding, it should -- that thing should mostly affect that little period around there, and it was more straightforward. I think it's more -- I talked to Chris Ody about this and we kind of have a different opinion on whether that's a fully -- the basic

assumption, I think, from that model you're involved in was when there were only 11 slots they are going to have a certain amount of effort to fit all the most important things in those 11 slots. And then when there's 24 slots, they're going to have exactly the same amount of effort to fit the important stuff in the first 11 slots.

And my interpretation was that just seemed too strong, that some people might just start putting codes in and then after they have all the important codes then they realize they haven't run 24 slots, so they say, okay. But maybe when you only had 11 slots they get the 11th slot filled up and then they realize something else is important and maybe they go back and switch something.

So if somebody does that then I think this assumption that the coding of the first 11 slots didn't change when the rules changed I think is a little bit strong. When he did his analysis, the key thing in the appendix is to show that while the marginal effect of each additional code was pretty much similar before 2011 and after 2011, so maybe they're doing the same thing.

But I was concerned that there was some offsetting effect. The one effect was, oh, now you have

more codes and so maybe you're not so critical about these getting in the first 11 slots, and so that makes the effect go one way. But on the other side I think people were actually getting sicker. So I think you would actually expect the effect to actually go up over time on each one of these slots, and it didn't go up. It kind of stayed the same. And, to me, that's a long explanation but that's why I was a little reluctant to just assume that when you go from 11 codes to 24 codes the coding in the first 11 slots doesn't change.

DR. GRABOWSKI: And the final point on this -- I promise, Jay. Is there a way to rank order such that you get those most expensive codes up front? Just playing around -- it's what you said, they're fitting them all across the 24. Is there a way to mechanically do that in the post period?

DR. STENSLAND: You could do that, and we hadn't done that, and Chris didn't do that either. I asked him if he had done that but he has a lot of -- he's a smart guy and he has a lot of faith in the first 11 code method.

DR. CROSSON: Amol.

DR. NAVATHE: On that topic, so again, not to

belabor the point, but so if you look post 2011, does the number of -- because the average number of codes per claim, is that increasing over time? Or when you get that switch is it pretty static? Because I think if it's pretty static then you can essentially wash away your 2008 to 2010 pre period and the trend should still hold. If it's dynamic, which is what I think it probably is, is people are learning to code over time, then it's a little bit trickier here.

DR. STENSLAND: David does, but I thought it mostly one big change.

DR. GRABOWSKI: What we observed, Amol, is like a pretty big -- I mean, it happened very quickly. They were onto this and it exploded almost overnight. So that would be supportive of, you know, like --

DR. NAVATHE: So if that's the case then if we just ignore 2008 to 2010, the trend that comes after that should still be internally valid.

DR. CROSSON: Questions?

Seeing none we'll move on to discussion, and I think, you volunteered. No? Did I make a mistake? You misunderstood. Okay.

So did I get that wrong or did someone else volunteer to begin?

DR. CASALINO: [Off microphone.]

DR. CROSSON: There's a basic rule. You never raise your hand. Okay, so let's open it up broadly then. Jon.

DR. PERLIN: Again, thanks for this terrific work. This is an area where I think the data are interesting but not entirely clear, and I appreciate the research that you did.

I wanted to bring to your attention the recent work from University of Michigan, Karan Chhabra, who just notes that the decrease in readmissions actually preceded the initiation of the actual readmissions reduction program. In fact -- and you alluded to this in your data as well, that the major decrease occurred during the period where there was a specter of this coming, and then it kind of leveled off. He goes through some pretty elegant machinations to demonstrate that even the risk-adjusted hasn't really come down, and similar to what Mark notes, of course, it's in modern health care as well.

So I just wonder about the utility of measures

broadly, where there is sort of not a tight relationship to the -- let me rephrase that. There is accountability without necessarily the authorities or the data, or even the clarity of relationship to yield the best possible outcome.

And I mention that, too, you know, being on the hospital side, so put that on the table and full disclosure, is that, you know, if something happens the first week to 10 days, we didn't button something down, but goodness, from, you know, 10 days to a month, any number of other factors have been well reported as being, you know, responsible for a patient's change in health status.

I also said, when this came up the last time, that when I had the privilege of leading the VA Health System I actually refused to have a 30-day readmission measure other than for information, because I was worried about the incentives for not caring for patients until they got to some arbitrary, you know, period of time.

One of the principles of measurement, then, is that, you know, an actor has the ability to control the factors that would change the outcome for what's being measures. I think there's a real problem in the way this

has been implemented by CMS, and that's that, if someone looks, for example, at the CMS star ratings, the current star ratings are up. I would ask anybody, how old do you think the data are that are currently displayed under star ratings? Any guesses?

PARTICIPANT: Three.

DR. PERLIN: Three years. Great guess, but actually they go from the second quarter of '14 to the first quarter of '17. I sometimes say that lagging indicators are a little like driving your car by looking in the rearview mirror. This is like driving your car by looking in the rearview mirror of the car three cars behind you. It's just very difficult to operationalize.

So I think we have responsibility to really think about measures that drive, you know, the best outcomes, the greatest efficiency, the highest value, the highest safety, but also simultaneously abide by the principles of good measurement, which would include the ability to link definitive actions with the accountability and with data flow. And at a minimum, one of the data flow pieces that would be necessary for hospitals would be having timely data evaluation for patients who were readmitted

specifically outside of their own hospital or system, so that they actually can get cognizance into what the mechanisms of failure are in terms of a patient potentially requiring care that might have been obviated had certain processes been buttoned down. So thanks.

DR. CROSSON: David.

DR. GRABOWSKI: Great. I also want to thank you for this work. I'm glad you stayed at it.

I just wanted to pick up on one sort of part of this. You've been on this point, Jeff, for a long time, that readmissions aren't the only kind of thing falling here. You know, the index admissions are falling as well. And you could have used that as support for maybe that's leading to an increase in reported severity. I guess the marginal admission that's being averted is actually kind of a less acute maybe individual.

I also, however -- and this maybe sounds like something Jon Perlin's professor would have said -- you can't be readmitted if you're not originally admitted. You know, we can't perfectly predict who's going to have a readmission, and there's a lot of variability there. It's interesting. Some of my colleagues have a manuscript

that's coming out in Health Affairs where they did something I think really clever. They just simulated, by, you know, taking out admissions, kind of randomly from the distribution and it turns out they can simulate the same decline we're seeing in readmissions by doing that. And it suggests there's just a lot of noise here as to who's being readmitted to the hospital.

And so I think we just want to be a little bit more careful in interpreting what's going on with admissions there. It's not just kind of the severity that's changing. It's also potentially changing the opportunity to readmit. I think that's something we'd want to think about here.

DR. CROSSON: Thank you.

Marge and then Amol.

MS. MARJORIE GINSBURG: So I take, David, from your comment and from the other comments that we may want to be more circumspect on how we summarize the results here, because on page 7, it says, "The HRRP has been successful in reducing the emissions without an adverse effect on beneficiary mortality."

So I guess the question is, Do we need to kind of

modify our summary, our conclusions about this? We're not sorry this is in place, but there may be other events that impact reduction and just have a fair representation of those other issues rather than give unqualified -- make this an unqualified success. Is that kind of what you're saying?

DR. GRABOWSKI: Yeah. I think Jeff has been very careful in how he's framed this, and so I think continuing to be cautious here. I agree with the finding that we haven't seen an increase in mortality. I don't believe the HRRP kills papers. I don't think that's going on. I want us to be really careful about how we kind of interpret the size of the decrease in hospitalizations if it's, indeed, there.

But I think Jeff has been really good about balancing this, and I think admissions is another area just to add to that list.

DR. CROSSON: Amol.

DR. NAVATHE: So I think I just wanted to sort of give an analogous point to Jon about measurement when it comes to designing programs and evaluating them, not with respect to your workbench, in some sense, the implications

or the commission's role maybe in making a comment on how HRRP has played out.

So I think if we look at the literature, broadly speaking, it looks like there's a variety of different results, depending on the variety of different methods that have been tried, and we actually have a study that's currently under review, where we tried basically 15 or 20 different specifications for HRRP. We showed that if you pick a few, you can get an answer. If you pick another few, you get a different answer. So it's a little bit dangerous to over-interpret any particular study is where I've landed on this.

So that doesn't nullify, I think, as David said, the way that you have worded things here, but I think it perhaps give a caution around the idea of mandating national programs without some sort of testing period or demonstration project or at least following some of the methods that CMMI has been using, something like that.

I think to the extent that if we actually take a look at the evidence and the methods that have been used, I think probably most researchers would agree that there's no perfect evaluation strategy for HRRP because of the way

that it was implemented. So we're not really setting ourselves up to do a very good job of understanding what the effects are and importantly whether there are unintended effects. So I think that's probably a sort of suggested recommendation that comes out of the work on HRRP would be my thought, something that we can add into the recommendations.

DR. CROSSON: Bruce.

MR. PYENSON: I am very supportive of the conclusion and the work that was done, with one exception. I'm not sure that we're ready yet to say that the reductions in readmissions have leveled off.

I think one of the principles in setting quality improvement is to look for best practice benchmarks. We've been looking at averages, and the averages, in my mind, show that the program has been a terrific success. But if we were to look at the 10th percentile, we might find a much lower readmission rate in certain areas, in certain systems, certain parts of the country.

So I'm not ready to say that things have leveled off and we've gotten as good as we can get. I think there could be a lot more that would be done with respect to

readmissions, and that's not to say we should delay moving to the value-based purchasing program. But I'm not satisfied looking at the national average and say we've gotten as good as it can get.

DR. CROSSON: Thank you, Bruce.

Paul.

DR. PAUL GINSBURG: Yeah. I'm very glad that Jeff included the last slide because this HRRP was to me a first-generation program in trying to provide incentives for quality for hospitals. It was crude. It only focused on three conditions. It focused all its incentives on poor-performing hospitals, left good-performing hospitals along, so they had no incentive.

So the fact that it seemed to have done fairly well under those conditions to me is very encouraging and the implications that the HVIP could do a much better job at this type of program.

Amol brought up something about that this was one of the few programs to pursue quality or pursue cost that was just launched without a demonstration, nationally rolled out, and of course, it makes it harder to evaluate it.

But given the profusion of research that we've seen and all the attention on the program, I'm not so worried about putting the policy in place, and if it works really badly, we'll know it, even without the best designed evaluation.

And that the potential for progress, getting back to the challenge in our context chapter, I wouldn't want to give it up so that we couldn't do anything without spending five years first for an evaluation.

I think part of the time series that you and others attract is a period where a lot of different things are happening. Your typical evaluation would miss some of those things, and it would always be an issue of "Well, things have changed. Is the research really relevant anymore?" So, in a sense, I think there is an argument for not being too cautious in pursuing policies.

DR. CROSSON: Okay. Larry.

DR. CASALINO: Jeff, I probably should know the answer to these two questions, but I don't.

One is, Did you guys or has anyone else with reasonable analysis looked at effects on subgroups; for example, poor patients or racial or ethnic minorities? So

has this kind of work been done for them? That's the first question.

The second, kind of a twist on what Bruce was saying, if you take the 10 or 20 percent of hospitals that reduce readmissions the most, what's the relationship between readmission reductions and mortality in the hospitals that reduced it the most?

DR. STENSLAND: Second one first. Generally, when we looked at it last time, we saw, on average, those that reduced their readmissions more had a little bit better mortality changes. So that was a positive.

Harlan Krumholz did something similar, and he found the same thing.

Now, Professor Gupta's article, one of the things he did was he said, "Well, let's look at the hospitals that are going to be most affected by this, and one of my instruments for indicating that is the share of their patients that are minorities." In that case, he didn't find any ill effects of the program on mortality.

There's also been some studies that have looked at different hospitals based on whether they're treating lots of poor folks or not as many poor folks, and those

ones that were treating more poor folks actually seemed to have a little greater improvement in their readmissions rates.

Then there was a study, RAND that did a study, and they looked at changes in mortality, and I should remember. But I can't remember if it was poor individuals or individuals from minority groups, but those were individuals that were expected to have higher readmission rates and to see if they were adversely affected by this over time. And that answer was no for that group.

The other, the effect actually was bigger for the disadvantaged group. The disadvantaged group looked like they may have had some -- the advantaged group may have looked like they had some increase in mortality, not the disadvantaged group, which wasn't consistent with the hypothesis.

So there has been a fair amount of research in those areas, and in general, I think that research has been fairly reassuring.

That is the effect of this policy on outcomes on the individual, but we also want to say there's been lots of research that has shown hospitals that serve poor

individuals tend to get a bigger readmission penalty. And that's why we had pushed for categorizing hospitals based on the share of their beneficiaries on SSI or the way that the administration did it based on the share of dual beneficiaries. So you don't have the Mayo Clinic competing against Cook County. Cook County is competing against Grady Memorial when they're evaluating whether they're going to be penalized, and they made that change in law. And I think there's been some very positive response to that of taking into account socioeconomic status when you're evaluating how much penalty somebody should receive.

DR. CROSSON: Bruce.

MR. PYENSON: I just realized I misspoke when I said I wanted to proceed with the VBP. I meant let's go with the HVIP.

DR. CROSSON: We figured that out.

[Laughter.]

DR. CROSSON: Don't be bothered because you may have -- particularly, our new commissioners may have noticed that we have a lot of acronyms and a tendency towards acronym creep, and a lot of the acronyms sound like each other. So you're not alone in that regard, and I'm

still trying to figure out how to pronounce that "DMEPOS."

[Laughter.]

DR. CROSSON: Okay. Well, this has been a very good discussion. Thank you very much, Jeff, again, and have a good night's sleep. We'll see you in the morning.

[Laughter.]

DR. CROSSON: We now have time for Public Comment session. If there are any members or any of our guests who wish to make a comment on the work that's been before us this afternoon, come to the microphone.

Hang on for a minute. I'll give you some instructions. I'd like you to identify yourself and any organization or institution you're affiliated with, and please limit your comments to two minutes. When this light comes back on, the two minutes will have expired.

MR. McTERNAN: Good afternoon. My name is Joe McTernan. I am with the American Orthotic and Prosthetic Association. I am on staff with that organization.

Two very brief comments. First, I would just like to make a comment regarding the discussion earlier on the potential to give CMS broad authority to expand competitive bidding in the DMEPOS environment. Obviously,

my organization has an interest specifically in orthotics and prosthetics.

Just something to consider, I would agree with some of the commissioners' comments about making sure that competitive bidding be applied where it really should be applied, and that is within commodity items. So when you're talking about custom prosthetics especially and, to an equal degree, custom orthotics, custom orthoses, you're dealing with more than just commodity items. You're dealing with items that are custom-fabricated to the specific needs of a particular patient; in this case, a Medicare beneficiary.

There is a very significant clinical aspect of care that is part of that overall process, and to just open that up, open those non-commodity items up, even though they are part of the DMEPOS universe by acronym, I would just like the commission to consider the potential consequences of that, if making a recommendation that CMS have well-expanded authority to increase competitive bidding beyond the true commodity-type items. So that's comment one.

Comment two, I think I will ask for the

commission's continued support in their report to Congress back in June of 2018. They were very specific when they talked about off-the-shelf orthoses, and trust me, AOPA was at the forefront of criticizing the folks that were creating call centers and shipping out knee and back braces to anybody who they could convince over the telephone they need it.

So we are very much of the vein that orthoses and prostheses are required to have at least some level of clinical care, whether it's off the shelf, whether it's custom fit, whether it's custom-fabricated, but in the report, in your report to Congress from June of 2018 --

DR. CROSSON: Please conclude your remarks.

MR. McTERNAN: Will do.

That the commission recommended that providers such as orthotists and prosthetists who provide a significantly low volume of off-the-shelf orthoses, 16 to 18 percent on average have a consideration of an exemption from competitive bidding. It would not reduce -- it would not cause impact to the Medicare program because they would be reimbursed at the single pricing amount. It would just allow access to qualified, properly educated, properly

trained providers to continue to provide the limited number of off-the-shelf services that they are currently providing.

So thank you for your time. Appreciate it.

DR. CROSSON: Thank you.

Seeing no one else at the microphone, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 4:16 p.m., the Commission meeting was recessed, to reconvene at 8:30 a.m. on Friday, September 6, 2019.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 6, 2019
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Okay. Good morning, everybody. Welcome back. We're going to have a good morning this morning talking about a couple of very important issues.

Jon Perlin has an unavoidable conflict that has required him to not be here this morning.

The first presentation is on the value incentive program for post-acute care. We've got Ledia and Carol here, and Carol is starting.

DR. CARTER: Good morning, everyone.

The Commission's work on a uniform value incentive program for post-acute care began in 2016. The Commission recommended adopting a value incentive program for all post-acute-care providers at the same time that a unified payment system is implemented. At that point, we undertook work to develop a common set of outcome measures across PAC providers.

In 2018, the Commission laid out a set of principles for designing quality payment programs and used these principles to design a Hospital Value Incentive Program, or HVIP.

This year, Ledia and I plan to apply these principles and design features to a value incentive program for post-acute care.

Today I will outline a proposed illustrative design, and Ledia will provide many of the details, and these are consistent with the HVIP. At the end, we'd like to get your input on a few design decisions.

The Commission and CMS have stated that Medicare needs to tie its payments to the quality of care furnished to beneficiaries. In its 2016 report to the Congress on a unified payment system for post-acute care, the Commission noted that a value incentive program should be implemented concurrently as a way to counter the incentives inherent in fee-for-service to furnish unnecessary volume and to lower quality if that would lower a provider's costs.

When a unified payment system is implemented, distinctions between providers would narrow. A single program that uses the same metrics and approach should be used to evaluate PAC provider performance. Moreover, given the overlap of the types of beneficiaries treated in different PAC settings, a common set of metrics and way of translating performance into payments will be key to

putting all PAC providers on a level playing field.

Currently, there are two value-based payment programs in place for PAC providers: the home health agency demonstration and the skilled nursing facility program.

Neither program meets the Commission's principles for tying payment to outcomes. The Commission recommends using a small set of outcome measures to gauge provider performance: The home health demonstration includes 20 measures, including some process measures, but does not include a measure of resource use. The SNF program includes only one measure -- readmissions -- with no resource use or patient experience measures.

The hone health program does not prospectively set the performance targets so agencies do not know the targets they should try to meet or exceed. Both programs include cliffs in their incentive payments, and neither considers social risk factors in translating performance into payments. And there is no program for IRFs or LTCHs.

With the HVIP as a model, we plan to illustrate a design for post-acute care that uses a small number of risk-adjusted, claims-based outcomes and resource use measures. These include hospitalization rates, successful

discharge home, and Medicare spending per beneficiary. While the measures are consistent with those developed by CMS, our measures use uniform definitions and risk adjustment across the four settings. Ledia will discuss each measure in detail in a minute.

The quality measures will help counter the fee-for-service incentives to lower the quality of care when that lowers the providers' costs while the resource use measure will create incentives for efficient care. This is not intended as an exhaustive list of measures. Additional measures could be added in the future. For example, the paper discusses the absence of a measure of patient experience for all PAC providers that we hope could be added at some point.

You'll also note that we've avoided measures based on patient assessments since our work earlier this year raised questions about the consistency of the recording of the function items included in patient assessments.

We plan to pool an individual provider's performance data over multiple years because there are so many small PAC providers. This will help increase the reliability of the measures and increase the number of providers that can

be included in the example program.

Performance would be scored using absolute, national prospectively set targets. We do not plan to pool performances of providers that are parts of chains. That way, each provider will know its own experience and performance. To account for social risk factors, providers with similar shares of dual-eligible beneficiaries will be compared in determining a provider's reward or penalty.

We plan to model a 5 percent withhold to fund the incentive payments. Because Medicare margins for many PAC providers are relatively high, a sizable withhold may be needed to influence provider behavior. We'd like to get your input on the size of the withhold.

As context, the recommended HVIP proposed a 2 percent withhold that could increase over time. The withhold for the home health program started at 3 percent and will increase to 8 percent by 2022. The SNF program withholds 2 percent of payments, but some observers have questioned whether this is large enough to change behavior.

Now Ledia will talk about the measures in more detail and the scoring methodology.

MS. TABOR: The first measure we propose to score in

the PAC-VIP is a measure of all-condition hospitalizations within the PAC stay, meaning admissions, readmissions, and observation stays. Hospitalizations are a major source of patient and family stress and may contribute substantially to loss of functional ability, particularly in older patients.

We want to score a claims-calculated outcome measure that would hold PAC providers accountable for their patient outcomes and care they provide during the stay. Unlike a measure developed by CMS, the within-stay hospitalization measure we developed uses identical definitions and a risk-adjustment model that is uniform across all four PAC settings.

We calculated provider-level results using multiple years of data. The mean hospitalization rate was 17 percent, and a lower rate is better.

We also found that the risk-adjusted within-stay hospitalization rates varied across all PAC providers, with providers in the 90th percentile of hospitalization rates having a rate that was more than three times the providers in the 10th percentile.

The relatively high mean rate and variation signals

opportunities to improve the quality of care and the potential to use the measure to compare quality across all PAC providers.

The second measure we propose to score in the PAC-VIP is a successful discharge to the community measure. Discharge to a community setting is an important health care outcome for many patients for whom the overall goal of post-acute care includes safely returning home. However, PAC providers should not discharge patients who are not medically ready to return to the community because this may result in hospital events. Unlike the hospitalizations within-stay measure, successful discharge to community captures a patient's outcomes after discharge from the PAC provider.

The measure defines successful discharge to the community from a PAC setting as having been discharged to the community and having no unplanned hospitalizations and are still alive after the next 30 days.

We used CMS' measure specifications as the basis of a successful discharge to the community but with uniform definitions and risk-adjustment variables that were the same across settings.

We calculated provider-level results using multiple years of data. The mean hospitalization rate was 57 percent. A higher rate is better.

We also found that the risk-adjusted successful discharge to community rates varied across PAC providers, with providers in the 90th percentile of rates having a rate that was more than two times the providers in the 10th percentile.

Again, this relatively low mean rate and variation signals opportunities to improve the quality of care and the potential to use this measure to compare quality.

The first two PAC-VIP measures are outcome measures, but consistent with the Commission's principles, the PAC-VIP should also include a measure of resource use. So the third measure we propose to score in the PAC-VIP is a measure of Medicare spending per beneficiary, or MSPB. This measure incentivizes providers to furnish efficient care and discharge patients to high-quality PAC providers with low hospitalization rates.

Similar to the hospital MSPB measure, the MSPB PAC measure holds a provider responsible for Parts A and B spending during the PAC stay and the following 30 days. We

used a CMS measure as the basis for our measure but, again, used uniform definitions and risk adjustment. Carol presented this measure development work to the Commission in April of 2018.

We found that the MSPB rates varied across PAC providers, with providers in the 90th percentile of rates having a rate that was almost two times the providers in the 10th percentile.

As with the other two measures, the variation signals opportunities to improve the quality of care and the potential to use this measure to compare quality.

We found that there was considerable variation in performance on the three measures not just within but also across PAC settings. For example, the mean hospitalizations within-stay rates for IRFs was 8 percent while the mean rates for home health was 21 percent.

This variation is likely due to three factors.

First, PAC stays vary considerably in length. For example, IRF stays are, on average, the shortest at about 13 days and home health stays are the longest at about 45 days. Because we would expect hospitalization rates to be higher, on average, for longer stays, this contributes to

the variation in this measure across settings.

Second, each setting has its own conditions of participation. IRFs and LTCHs have the same conditions of participation as acute-care hospitals, so they are more likely to be able to manage acute episodes in their facilities while a SNF or home health patient with a similar condition might need to be admitted for hospital-level care.

Third, across the PAC settings, the utilization attributable to beneficiaries who qualify for both Medicare and Medicaid differs across settings, ranging from 19 percent of IRF stays to 40 percent of LTCH stays.

Because utilization and spending trends reflect the design and underlying incentives of the current PPSs, we propose to score providers on setting-specific targets and peer groups.

In the future, under a unified PAC PPS, we would expect differences in service use patterns to narrow as distinctions between "settings" becomes less meaningful, so we could move to using the same standards across providers.

Consistent with the Commission's principles, the PAC-VIP would reward or penalize a PAC provider based on its

performance relative to prospectively set targets for each measure.

Like the HVIP, we propose to model the PAC-VIP using a continuous performance to points scale set along a broad distribution of national historical data for each setting so that most providers have the ability to earn points.

Each provider's total PAC-VIP score is the average of the points across the three measures. In quality payment programs, the Commission contends that Medicare should take into account, as necessary, differences in providers' populations, including social risk factors.

However, adjusting measure results for social risk factors can mask disparities in clinical performance. So Medicare should adjust performance payments through peer grouping so that, for purposes of rewards and penalties, each provider's performance is compared with that of its "peers" -- defined as providers that treat a similar mix of beneficiaries with social risk factors.

Again, like the HVIP, to define peer groups, the PAC-VIP would use eligibility for full Medicaid benefits as a proxy for a PAC provider's patients' social risk factors.

Because of the variation across settings, we would

convert PAC-VIP points to payment adjustments within setting-specific peer groups.

Each peer group will have about the same number of providers, and those providers have about the same share of Medicare patients that are fully dual-eligible beneficiaries. We plan to explore the appropriate number of peer groups to use in the PAC-VIP.

Each peer group has its own pool of dollars that is redistributed based on the group's PAC-VIP points. Each peer group has its own "percentage adjustment to payment per PAC-VIP point" based on the group's pool of dollars and their PAC-VIP points. Like the performance-to-points scale from the previous slide, each peer group's percentage adjustment to payment per point is prospectively set and known by providers.

In summary, a PAC-VIP is essential to incentivize provider improvement. This year we intend to model the effects of the proposed PAC-VIP and present our results in the spring.

For the modeling, we would like your feedback on the proposals we have presented, including the measure set, the scoring methodology, and modeling the PAC-VIP with a 5

percent withhold.

Thank you and we look forward to the discussion.

DR. CROSSON: Thank you, Ledia and Carol.

We'll now start questions. Jonathan, Dana, David.

DR. JAFFERY: Thanks, Jay, and thanks, that was a great presentation or report, and it's really nice to see all these programs start to come in the same direction and follow these -- you know, get consistent principles and whatnot.

One of the questions in front of us is the size of the withhold, and, Carol, you presented some information about how various programs have a variety of different withholds. And I'm just wondering, as we start to discuss and think about what we think is the right size, I'm trying to figure out what we should go on, and this is a question maybe that others can answer weighing in as well. But what do we know about what drives behavior in this setting? There's a reference to these having good margins in some settings, and so maybe it needs to be relatively large. And I don't know if that actually makes a difference or not. But it feels like the question of how big may be a little bit random to me right now or sort of a gut question, and I'm

wondering if we have evidence to support how big it should be to drive behavior.

DR. CARTER: We have a little evidence. I know in the SNF, the first year of the value-based purchasing program, there wasn't that much difference between the performers at the highest end and at the lowest end, and some of that isn't that surprising. It's a 2 percent withhold, and the program's keeping 40 percent of that as savings. So it's just not moving a whole lot of money around, and so I would suggest some -- well, really, the 2 percent ends up being 60 percent of that, so definitely something bigger than that I think would be on point.

The home health starts at 3. It is three-quarters of PAC stays, and so that is the volume that's kind of driving the whole PAC PPS and the design features and the coefficients that we've used and all of the risk adjustment. You know, we've pooled all the stays, but home health dominates that just by volume. So in some sense, that may be a bit more of a metric of sort of where is the home health design, and it started at 3, it's going up to 8. So those are maybe a couple of benchmarks.

We could also model a couple -- you know, something on

the small end and something on the big end. I mean, once you've done the programming, it's not a big deal to have a different size withhold just to sort of see how much difference we expect the withholds to affect providers. So that would be another option, to pick something on the smaller end and something on the larger end and sort of see.

It wouldn't surprise me if, you know, in the end the home health is transitioning from small to big, and that's always a good idea to start something more on the conservative side and have it grow over time. We plan to only model one year, so at least as a one-time snapshot, that wouldn't be an option.

DR. JAFFERY: I guess we don't know of a lot of evidence and literature that suggests how big something needs to be before it drives that -- you can model the different amounts, and we can figure out how much the financial impact is. But it's not clear.

DR. CARTER: I personally don't know that.

MS. TABOR: You know, I don't know the literature as well, but I would say just consistently across the settings -- because home health is one example that it's going from

3 to 8, and home health agencies are starting to pay more attention to it, and I think we're hearing the same thing with physicians or clinicians as opposed -- regarding MIPS, because it started out at 2 percent, and that's going up to 9 percent. And as the incentive is getting bigger, they're paying attention more to meeting the requirements and getting good performance. So it's really just kind of qualitative.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks. Excellent chapter, and as Jonathan said, it's exciting to see the convergence of, you know, applying the principles around measurement and the basic approaches across programs. So really great work, and I really like a lot of what you're structuring in terms of the thoughtfulness about different settings and different populations.

The questions I have are mostly methodological ones and may be ones you can't answer until you go through this period of testing. But maybe they'll inform the testing.

So the first one is: What do we know so far about the sample size needed to get stable, reliable measures of the three measures you're proposing in these different

settings? Do we have that information yet? Because I'm concerned that the "n" may be too small to do a lot of what we're aiming to do here.

MS. TABOR: I'll start off. So we have looked at this already, and that was a big part of the measure development work that we did with the contractors. And we've also had a lot of internal discussion about this.

So we know with PAC providers -- we're dealing with a lot of small providers -- they have a small number of patients they're treating. So we went in with it knowing that we're going to have to use multiple years of data to get more reliable measures, and that's one thing we've done, and that has improved the reliability.

We also wanted to use a really strict measure of what is reliable, so we did a 0.7 reliability, which is different than CMS, who uses a 0.4. But, again, we just wanted to have like really accurate measures, and we thought also because we're using multiple years of data, we could kind of get up to that 0.7.

So that basically translated into a minimum denominator of 60, so a provider would have to treat 60 beneficiaries over the three years that we measured to get

that 0.7.

That still leaves out a good chunk of providers. It's about 10 percent of SNFs, about 20 percent of home health, and like 2 to 4 percent of LTCHs and IRFs. And we were kind of like, oh, we don't want to leave out that many providers, especially for SNF and home health. But then we thought, you know, if you're not treating at least 60 beneficiaries over three years, like moving money around is not going to do much. So we kind of settled on we're having good reliability at 0.7, we're going to leave out some small providers, but that's probably okay.

DR. SAFRAN: Okay.

MS. TABOR: And, I mean, that's open for the Commission's discussion.

DR. SAFRAN: Yeah, I'll come back around to that in the commentary section.

MS. TABOR: Yeah.

DR. SAFRAN: So thanks for that. And does that same sample size requirement apply on the resource use measure? Because that usually has a lot more variability, so you --

DR. CARTER: It's -- yes, it does work for that.

DR. SAFRAN: Really?

DR. CARTER: Yeah, yeah.

DR. SAFRAN: Okay.

DR. CARTER: We've checked that, because based on the work that I had done a year ago, we looked at how much variation there was in that measure, and so we were particularly concerned about that measures. So 60 does work.

DR. SAFRAN: Great. Then two other small questions. One, is stratification based on duals for the social risk, is that -- remind me whether that's what we're doing on the hospital side, too. That seems like it could be a pretty thin risk adjuster or stratification factor.

MS. TABOR: It is. We used share of fully dual-eligible beneficiaries treated, and we do acknowledge that kind of the literature is growing about what's the best kind of measure to use to kind of note as a proxy of social risk factors, and we're tracking that. ASPE is still doing a lot of work on area deprivation indices --

DR. SAFRAN: Yeah.

MS. TABOR: -- but I don't think it's there yet for us to use in our modeling. So I think kind of the best thing we have as far as data is concerned is the share of fully

dual-eligible beneficiaries.

DR. SAFRAN: Okay. And then the last question is: You referenced -- and I remember it, but I don't remember the specifics -- the problems with functional status assessment. But that seems like a really glaring miss from a measure set in this setting. So I just wonder whether you have any thoughts about how the program could begin to build toward better measures, you know, paying for participation in terms of measurement that we can count on, or, you know, what you're thinking about that area of functional status, because it seems to leave that out in this area of care is kind of ignoring the main point.

MS. TABOR: Well, where we started, I mean, so where we kind of landed in the June 2019 report was we don't want to kind of give up on the function for quality measurement, but we kind of identified three strategies that could be used and encouraged CMS to use those strategies to improve the function data.

One of those was monitoring and auditing. A second one was perhaps using hospital discharge information to kind of monitor an audit as well as even just kind of another source of function data, and third was explore the

use of potential patient-reported outcomes.

We didn't kind of feel like we're there yet but don't want to kind of give up on it.

DR. CROSSON: Thank you, Dana.

David.

DR. GRABOWSKI: Let me echo others in saying what a great chapter and presentation.

I wanted to ask about Slide 10 and just the variation across sectors. You showed some rates in the reading materials that were really stark, and I think all the explanations you have up there are true.

I worried about how well the risk adjustment works across sectors. I don't know if you could speak to that.

Did you try any kind of conditioning by stroke or lower extremity joint replacement, heart failure? Is there any opportunity to see kind of conditioning on a particular diagnosis? What do these rates look like across sectors? I'm just curious how much of this is the risk adjustment not doing enough work here and how much are these other explanations like length of stay or just some of the different patients that we're seeing.

DR. CARTER: Yeah. So when CMS developed its

measures, it used setting-specific models that were, more or less, similar, more or less, and we decided we didn't want to do that because we want uniform measures.

But I am sure that having setting-specific coefficients would improve these models. But it kind of violates one of our principles of trying to have a uniform design. You're trading off accuracy for having something that's uniform, and that's the tradeoff.

We haven't looked at sort of how these models do by condition. It's something we could do to see, just sort of seeing how those rates varied, but we haven't done that work yet.

DR. GRABOWSKI: I'm not advocating that I like the global measure.

DR. CARTER: Yeah.

DR. GRABOWSKI: But just as a way to sort of check the model and see what's kind of going on underneath, it's one way to sort of maybe better compare apples to apples across settings.

DR. CARTER: Yeah. I see what you're saying. Yeah. That's a good idea.

DR. CROSSON: On this point, Kathy?

MS. BUTO: Yes.

Carol and Ledia, I had a similar question to David's, which is I think one of the things we envision is that these providers might evolve to be more specialized under a unified PAC, that they'd really focus on things they do well, say, stroke treatment for rehab facilities, in which case I worried about risk adjustment really being able to account for that evolution, if you will. Maybe there's plenty of time to get to that specificity and precision, but I think if we imagine what these might evolve to that we -- and I support a uniform set of standards, but I'm just wondering how that's going to work as these evolve. So it's really more of a comment than a question.

DR. CROSSON: Sue.

MS. THOMPSON: Thank you, Jay.

Thank you, Carol and Ledia. You're back.

I should probably remember this, Carol, but I'm going to ask again. You referenced the number of home care visits that are predominant in this dataset. A good number of admissions to home care come from the community versus the acute setting. Do we think about those different? Are they all post-acute, even though a good portion of them

really have not been in an acute setting? Remind me of that.

DR. CARTER: So you're right. Home health is about three-quarters of the PAC stays, and about two-thirds of home health is community-admitted.

We did not include adjustors for a community admit in the models, but all the stays are in because we would expect the PAC PPS to cover all stays.

Next month, we'll be talking about aligning coverage and cost sharing, and that would be something to think about because the coverage rules differ by setting. But at least for now, we were trying -- you know, our mandate back in '16 was to move the current PPS's to a unified payment system and the current PPS's pay for community admissions.

MS. THOMPSON: I have one more question. Remind me again. As we begin and have worked through this, have we taken a look at the relationship of any of these post-acute care organizations to ACOs? In other words, do we have any data on the impact, being part of an ACO network, might have on this work, on these scores, on their quality, on additional resources to small number, low sample size, SNF units?

DR. CARTER: We haven't looked at that. I don't know that the --

MS. THOMPSON: I didn't remember that we had.

DR. CARTER: Yeah, yeah.

MS. THOMPSON: Thank you.

DR. PAUL GINSBURG: I've got a follow-up too.

I would imagine that a well-functioning ACO, which is reducing post-acute care, would mean that those that do go to post-acute care have greater needs.

MS. THOMPSON: Could you repeat that, Paul?

DR. PAUL GINSBURG: Yeah. If an ACO is reducing post-acute care use, not referring as much, presumably those it does refer to post-acute care have greater needs.

DR. CROSSON: Larry.

DR. CASALINO: Yeah, a few questions. Again, I thought this was to me very interesting and very clearly presented.

In terms of the size of the peer groups, which you mentioned could be 60 -- I'm sorry -- the sample you need to get a reliable measurement, you gave some pretty low figures for how many post-acute care providers that would exclude needing to get to 60 over three years, I guess.

But how about when you separate them into peer groups? Would that have any impact? I guess the 60 is all patients, not just the duals hat wind up in a peer group.

MS. TABOR: Right. It would just be the 60 we'd apply kind of firsthand before we even put them into peer groups.

DR. CASALINO: Okay.

MS. TABOR: So to make it into a peer group, you'd have to have the minimum sample of 60.

DR. CASALINO: Okay. The peer group doesn't really impact the number you can get with the minimum sample.

In terms of the length of stay, I'm sure you've thought of this, and maybe it was in the manuscript. But if it was, I missed it. It would be easy to adjust for admission rates for length of stay if one wanted to compare across settings. Is that right?

DR. CARTER: Yes, it would.

We also developed another measure, which was looking at readmission rates for the first 14 days, sort of controlling for length of stay across the settings, so we looked at those at hospitalization rates.

But we didn't go with that, and that's because the commission has long held that providers should be

accountable for patients throughout the entire stay. When the patients are under their control, we want measures that reflect the quality of care throughout the stay. So we decided not to go with that, that measure.

DR. CASALINO: Is there a downside or a reason to just not adjust length of stay, not adjust admission rate, readmission rate for length of stay?

DR. CARTER: We could think about that.

DR. CASALINO: Okay.

Then I think David and Kathy and Sue were all bringing up this concern in different ways, but several places in the manuscript, there are assertions that the patients are the same across settings, and therefore, it's okay to compare everybody, eventually to compare everybody to everybody. And maybe this discussion happened before I joined the commission.

How can I say this? As a physician who has taken care of people who were in different settings, that assertion, face value, I was surprised at that assertion. So is there evidence for that, or is it driven mostly just by the strong principle of wanting to compare across all four settings using the same measures?

DR. CARTER: We've done a fair amount of work on this, and also the PAC demonstration that CMS did several years ago looked at how much overlap there was in the patients across the four settings. And they looked at a variety of measures, including function, for example.

When we looked at, say, the over -- we did quite a deep dive, and the patients -- this is before the unified PAC PPS. We looked at site-neutral payments between SNFs and IRs and compared the overlap in those patients and found a fair amount of overlap.

If you look at all of the -- we've looked at a number, something like 40 different clinical groups, and you do see a distribution across the four settings. Invasive event patients may be the most concentrated in sort of one setting. That's not a bad marker for LTCH, if you will, a clinical condition that actually is very highly concentrated in LTCHs, but there SNFs that take care -- there are some SNFs that take care of those patients.

So I would say that -- and I hope that the text is careful to say we see overlaps in many patients or many clinical conditions because, obviously, patients who are in LTCHs can't be in home health, and there are many SNFs that

are not capable of taking care of many LTCH patients.

So there is not a complete overlap, and we would never say that. But I think there's enough overlap, particularly in certain patient conditions, that I think that that should be a qualified statement. And I think we could stand behind it.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, thank you on a fantastic chapter. It was exciting to see PAC PPS meets HVIP.

So before I ask any questions, I just want to be wildly complimentary to this because I'm actually nervous about asking questions, thinking it's going to detract.

I do want to build no the comment David made about those conditions specific and then the question Kathy asked about the provider specializing, and this is truly just to clarify.

Your risk adjustment model does account for reason for treatment and comorbidities. Would that account for -- let's say Kathy's scenario plays out and you do get specialization of these providers. Is it reasonable to think that the risk adjustment model is going to absorb that?

DR. CARTER: I would say with a uniform set of relative weights and the coefficients, I think that might not be true.

So let's say you have an indicator in the model for whether the patient is on an invasive event, but the weight of that coefficient is going to be reflecting the entire pool of patients. So it may not sway the payments enough for a concentrated -- a provider who concentrates in that type of patient.

DR. DeBUSK: Okay. Let me see if I get it correctly the other way.

For example, let's say that one PAC provider got really, really good at stroke. All they did was PAC strokes. Presumably, they, through specialization, had better outcomes.

In theory, in the risk adjustment model, there could be arbitrage there, because they would always look like they're beating the expected outcome, but they really would be because they're good at it. Is that a bug, or is that a feature?

DR. CARTER: Well, I guess the other thing to think about, because what you just said made me think about the

Value Incentive Program, if you're concentrating in a particular type of case and doing really well on the outcome and resource use, then depending on the withhold, you may always actually beat your peers. So even though you're being -- so you may be made whole through the incentive program. I'm not sure.

DR. DeBUSK: Okay. I was just thinking it may be a way to beat the system --

DR. CARTER: Yeah.

DR. DeBUSK: -- but beat it in a way that benefits beneficiaries.

Okay. Those two got me thinking when they asked those questions because, Kathy, I knew exactly where you were going.

The second question, I like the measures you chose, the three measures, but is there an element of triple jeopardy here? Let's say you do have a hospitalization during a PAC stay. So I'm going to flunk the hospitalization measure, but then I'm also going to flunk the discharge to community measure, because clearly you're not going home or at least immediately, and then I'm also going to flunk the MSPB measure. It's almost like --

MS. TABOR: There's an element of double jeopardy. I'm not sure both because the first measure is looking really just at within stay. So if you have a hospitalization within stay, that will count once.

Once the patient leaves the PAC provider, if there's a hospitalization within 30 days, they'll get dinged on the successful discharge-to-community measure, and they'll also get dinged on the MSPB measure.

DR. DeBUSK: Okay. So a hospitalization or a readmission within 30 days of discharge doesn't count against the first measure.

MS. TABOR: Exactly.

DR. DeBUSK: Okay.

MS. TABOR: That's only within stay.

DR. DeBUSK: Okay. That's one thing just to keep your eye on.

MS. TABOR: Yeah.

DR. DeBUSK: I had some questions about that in the reading, because I really like your measures. It's just an aggregate. It looked like if I flunk one, I flunk them all.

MS. TABOR: Yeah. We kind of dealt with this also in

the HVIP too, like readmissions and MSPB or kind of also double counting, but I think we've kind of landed on it's okay to double count these things because they're bad.

DR. DeBUSK: No, that was my other question. Maybe an element of double or triple jeopardy makes sense.

MS. TABOR: Yeah.

DR. DeBUSK: The final thing I was going to ask, in the reading, you mentioned that there isn't a uniform patient experience. Some of these areas, you don't even have the CAHPS for some of these. Could you speak to your impression of having, say a unified CAHPS-type instrument, versus say something like a net provider or net promoter score? I only know a little bit on the fringes of that, but if there isn't a CAHPS already in place, is this a chance to cross over to something that's perceived as more contemporary?

MS. TABOR: I think there is an opportunity, and I will say the AHCA, which has developed what's more similar, it's lighter than the CAHPS survey. It's about three measures. So it's a little bit more than net promoter score, but it is kind of getting that idea. We do understand that SNFs kind of do use this tool, and I think

CMS has also considered using it. They proposed it in, I think, two years ago in proposed rulemaking, but then we have not heard of it since then.

So I think there are things out there like a net promoter score, like this AHCA tool, that could be used, but it's just currently not being used systematically across the settings.

DR. CROSSON: Thank you, Brian.

Pat.

MS. WANG: Good morning.

I was wondering. I wanted to ask you a little bit more about home health. I understand the principle of uniformity of measures across settings, et cetera. I think the fact that these are really different settings and home health being the only non-institutional setting, that you've tried to control for that by saying we'll do within setting comparisons at least to start.

But I guess I just wanted to ask you whether for home health in particular, the particular measures are the most appropriate. Whether you had thought about that particularly within stay admission as well as the readmission, I mean, given the nature of home health, the

value of uniformity is important but not if it obscures the most appropriate measure of quality for that setting. I just wondered whether you thought that you had thought about that, because some of the -- even the spending per beneficiary, there's sort of verbiage in the chapter about giving incentives to PAC providers to make recommendations for the highest quality providers, et cetera, et cetera.

Could you say more about what you're feeling about home health agencies, the reality of they are really doing that, given the nature of what they're doing?

Usually, when we think about home health contributing to avoiding admissions and readmissions, it's been in the context of working with organized delivery systems. Since this is going to apply to the agency that's freestanding, whether they're part of an ACO or not, I wondered if you had thought about that or struggled with it a little bit in your mind about one of these things is not like the other in terms of uniformity of the quality measures or not. I don't know.

DR. CARTER: So we haven't really thought about a measure that would be a better fit for home health. These seemed like good measures for post-acute care, more

generally, and so then your question is maybe they're not great fits for home health.

It is a reason why in the hospitalization measure, we were very keen to include hospitalizations and not just readmissions, since so much of home health care is not preceded by a prior hospital stay. So we were trying to accommodate a feature of home health in the design of that measure.

The MSPB measure, because the spending for home health is one-sixth of institutional stays, that measure is always going to have to have some kind of adjustor for looking, even when you get to being able to compare across settings. You're going to have to have a home health adjustor because the spending for home health just starts from a lower place, and so that would be another accommodation for the realities of the PAC landscape, even under a unified payment system and the breaking down of the laws between the settings.

I guess the one place where I'm not sure, the successful discharge home, home health patients are already home, and so then the question is once your home health care ends, is that a fit for home health care that's really

a good measure compared to other settings? Probably. There's a lot of home health care that's back to back, back to back. So trying to think about when it's really appropriate, home health care, I think, is a reasonable measure for successful discharge home.

But we haven't thought about a measure that's a good fit for home health and then thought, oh, could this apply to other settings. We didn't start there.

DR. CROSSON: Okay. Warner.

MR. THOMAS: A couple of questions.

DR. CROSSON: On this? Sorry. Sorry. Are we on this point?

MS. BUTO: I was on Pat's point.

DR. CROSSON: Go ahead.

MS. BUTO: Actually, when I was looking at this I thought of the successful discharge to community as being more appropriate to home health, because they're already home, than, say, an LTCH patient or many SNF patients. So I actually thought that was the one indicator or standard that would be more likely to fit home health.

DR. CARTER: Yeah, and we did, and this doesn't get at your question, but thinking about the appropriateness of

the settings for patients who are discharged home but are really going to nursing homes, because that's really their home now, we did include those patients. And I know some of CMS' measures do not consider that as discharge to community. But for those patients, that's where they're living. So we were trying to tailor the measure to the realities of nursing home residents.

DR. CROSSON: Okay. Thank you. Warner.

MR. THOMAS: Just a couple of questions. First of all, did you look at the types of hospitalizations? I mean, is it -- and should that be considered in this whole process? You know, because obviously there could be some that are totally unrelated. I don't know if that plays out in this situation at all.

MS. TABOR: Well, so we looked at -- when we looked at -- we looked at admissions, observation stays, and readmissions, and we were very thoughtful to include the observations stays, because in Commission discussions that even came up yesterday about how there's this move towards observation stays. And from a patient perspective those are just like an admission.

We didn't look, like, specifically at reasons for

admissions. I mean, we could look at that. But we just did include all admissions plus observation stays.

MR. THOMAS: Okay.

DR. CARTER: But in the risk adjustment, for some of the measures, the principal reason for the hospitalization is the primary reason to treat. And if you were a patient who was community admitted, we ran your PAC claim through the DRG group to get a DRG assigned to you so that we could put you in a primary reason to treat, just like the other patients. So the reason for your hospitalization is captured in the risk adjustment.

MR. THOMAS: Okay. On the -- you had the question about the percentage of payment that should be at risk and whatnot. What is the current percentage today on post-acute payments that are at risk?

DR. CARTER: Doing math in my head in front of a crowd is always a bad idea. So home health is three-quarters of stays but it's about, what, 40 percent of PAC payments? I'm not sure.

MR. THOMAS: But, I mean, my point is what percentage of their -- like what percentage of their payments would be at risk today, based upon quality? So it says, you know,

in Slide 4, basically there's no value-based payments inn IRFs and LTCHs, so for home health and SNF what percentage of payment is it? Is it a percent? Is it 5 percent? Is it 2 percent?

MS. TABOR: Well, so for home health I think it's -- is it 4 now?

DR. CARTER: Yeah, it is, yeah.

MS. TABOR: It's 4, and in SNF it's 2, and those are the lion's share of the PAC stays.

MR. THOMAS: And have we seen any change in outcomes based upon the implementation of those programs and those -- you know, those withholds or those value-based programs?

DR. CARTER: I would say there's been not as much change in the SNF as you might have thought. I think one reason is there just isn't really that much money at stake. In the home health you see the patient-reported outcomes have improved -- I mean, not the patient. The provider-reported outcomes have improved and the claims-based measures really haven't improved.

MR. THOMAS: Okay.

MS. TABOR: The process measures, most have improved. So home health agencies are paying attention.

MR. THOMAS: Okay. And then last question. Did you look at any of this information based on volume of the provider? So is there any variation based on low volume versus high volume providers? Should that be something that is thought about as a potential measure?

MS. TABOR: We didn't look at large versus small providers, so that's something that we could do. I would say that we do capture some of this in the fact that we do have a minimum sample size. So you've got to have 60 beneficiaries that you treat over three years to even make it into the process.

MR. THOMAS: Okay. And then the last question -- and I know you've looked at this some -- as far as the types of patients that actually get accepted by post-acute providers, and when it comes to the risk of hospitalization. This idea of cherry-picking or not taking certain patients, I mean, is there any concern about that, or have you -- do you see any trends of that for post-acute to have quality measures in there today?

DR. CARTER: I think in the SNFs basically you do see some cherry-picking. We haven't looked at it but just looking at the design of the payment system you would think

that there is some. Since it's a payment system that currently really rewards therapy and doesn't pay adequately for medically complex patients, I would think that there is some selection. The IRF and the LTCH have admission criteria --

MR. THOMAS: Right.

DR. CARTER: -- kind of that are screening at the door who is admitted.

We've also heard, anecdotally -- not me, but Stephanie, on her site visits -- that LTCHs are careful about who they take, and so there's a little bit there.

I will say, then, under the PAC PPS where we're hoping to redistribute money, based on patient complexity and clinical characteristics, you will see less of that. And with the redesign of the home health and the SNF PPSs that are starting, well, next month for SNF and then in January for home health, that's going to move money around. Those are really redistributing payments based on clinical characteristics as opposed to therapy. So some of the cherry-picking that may be going on I think will diminish with just the advent of these redesigns.

MR. THOMAS: Thank you.

DR. CROSSON: Okay. Thank you. And let's move on to the discussion. Could we have the last slide? I'd like to focus your attention on the last bullet point in the sub-bullets. Carol and Ledia would like some input. We've already had some snuck into the questions. But specifically on the measure set -- does everybody like it or would you like to have some more things added to that, the arguments for that -- the scoring methodology -- would people like to continue a scale, peer grouping, other suggestions there -- and then the size of the withhold, which is proposed to be 5 percent. There are arguments -- I think we'll hear arguments that it's too large, and I think there's maybe a case to be made that it should be even larger than that. So try to focus your comments on those issues if you would.

I'm sorry. David, you're going to start.

DR. GRABOWSKI: Yes. Thanks. And once again I'm really excited that you're doing this work. As Brian said, it's really kind of a marriage of all of the unified payment work we've been doing with the HVIP and quality measurement. I said to you yesterday it's like a MedPAC greatest hits chapter, you know, and we're touching on a

lot of the issues we've been discussing for quite some time.

You can't have unified payment in post-acute care without some sort of PAC value incentive program. It doesn't work. And one of the criticisms I've heard of this whole effort is are home health agencies, for example, going to take patients that aren't appropriate for that setting, and a quality program helps guard against that sort of activity and really helps encourage each of the settings to admit patients that are appropriate for that setting. So I'm really happy we're doing this.

There's not a program -- and I think you did a really nice job of reviewing what's out there in the post-acute care space. There's really not a program we can take off the shelf. Home health, it's a big program with 20 measures and really doesn't fit well here. The SNF, value-based purchasing program is very narrow with just the readmissions measure. So I like that we're building something that fits across all four sectors.

To the questions up here, do we have the right measures, I like the three measures that are currently proposed. I want to sort of make two points, and I know

maybe we're not there on either of them yet, but I really think patient experience needs to be in here. And I know the data aren't there yet with the CAHPS. Other Commissioners may have ideas of other places we could go for better patient experience data, but I think we want to continue to say that in the chapter, continue to push CMS that we want a uniform patient experience measure that we can use in this model, because I think that's really the missing measure relative to the HVIP and some of the other programs that we've discussed.

Dana raised my other point here and that's functional status, and that's really what post-acute care is supposed to do is get individuals back to full functioning and get them successfully discharged to the community. I appreciate we have this community discharge measure already in the kind of measure set. I really think some sort of functional status -- once again, that's provider-reported right now. It's not ready for prime time. But I think, once again, we have to stay on CMS to -- if it's auditing, if it's trying to use something from the hospitals, that's a measure that belongs in this program, and currently the data aren't up to snuff. But I hope we can continue to

encourage CMS to push on that front.

Towards the scoring methodology I wanted to make two points there. I think I already pushed you a little bit on the risk adjustment, and Kathy and others had good ideas here as well. I really worry when I look at those kinds of rates that you presented in the chapter across sectors, that we're not comparing apples to apples here. And how can I look at, for example, a hospitalization rate for a home health patient and compare that to an LTCH patient and think, how much of that difference is really quality versus just these are totally different patients, even after we apply our risk adjustment?

So I think two parts to this. The first is that I really like that you're initially going to score within settings, and I think that's really important. Downstream, as you begin to implement this payment system, I do think this will level out, because once you start paying a unified rate you actually then can look at apples to apples. And so I think over time we will be able to go to using similar standards across settings, but initially these differences are too big to sort of be believable, that this is true quality. It's really there's something

else going on here.

The other point I was going to make, I like your peer groupings. I think that's also essential. There was a Health Affairs paper a couple of months back that just showed, in the SNF VBP, which doesn't adjust for social risk factors, that just proportionately those facilities that were being punished were caring for more dual-eligibles. You know, the current programs aren't working very well around this issue, so I think the peer grouping is really an important element.

Finally, on the size of the withhold, I like 5 percent. Jonathan, you kind of challenged us. What is the right rate here? I think 5 percent sounds reasonable. I wouldn't be opposed to going even slightly larger. I do think, however, there has to be an on ramp, so maybe starting in year one, 2 or 3 percent, and then sort of getting up to those rates to allow providers to get familiar with the program.

I'll stop there, other than to say again that I'm really excited we're doing this. This is great work and I think it's essential that we marry the unified payment system with a PAC-VIP, so thanks.

DR. CROSSON: Thank you, David. I've got Brian.

DR. DeBUSK: First of all, thank you again for a great chapter. I echo David's basic comments. I'm a huge fan of sort of both the pieces of work that have merged to make this work.

I do like your measures, and to David's point I would like to see a patient experience measure in there. And in the absence of having this CAHPS, I do think there is an opportunity for us to explore some more contemporary measures, something that's maybe a little bit lighter weight that we could use. I mean, I think we should take advantage of the vacuum, basically, is what I'm saying.

I also like the pragmatism of being able to go by setting and peer group. I thought that was nice to see in the article because so much of what you guys are doing is very theoretically pure and very theoretically satisfying. It's nice to see us depart, when the data just doesn't support it, to depart to a more pragmatic theme, like peer grouping by setting. I did like the fact that you did speculate that as the PPS side drives realignment of the industry that maybe we go back and revisit that, because with realignment and the risk adjustment model you may be

able, ultimately, to do one peer group. So I guess I like the pragmatism now but I like the way that you were also looking forward to the future and saying we may be able, ultimately, to reconsolidate that.

The final comment that I want to make was something that came up -- well, two things -- in round one. I would keep my eye on the specialization thing. I think the risk adjustment model, being able to accommodate that, watching these providers specialize might be a really, really good thing. And if we see it in the data, in the outcomes data, maybe it's okay to have some arbitrage there where they're always going to come out one or two or three points ahead on the withhold, just because they're really good at specifically what they do. So I wouldn't necessarily see that as a problem. I would see that as a potential feature to reward providers who decide to specialize or focus on a particular condition.

And then, finally -- and again, David, I echo you, actually in the same order -- but I would consider making the withhold larger. I mean, I think you're in a space, particularly with, say, SNFs and home health, where there is some overpayment here, and I think you could take

advantage of that, to maybe a 6, 7, 8 percent holdback that's ramped up over time.

Thanks.

DR. CROSSON: Okay. Amol, on this point.

DR. NAVATHE: On the point of specialization, because I think it's an important one, I totally agree with Brian that it's something to keep our eye on. I would probably characterize it, or at least the reason to keep an eye on it I think actually also has the other side, which is, you know, potentially while our risk adjustment models hopefully will get better and better over time, there's the type of care that's actually being provided.

And I think, Carol, you alluded to that in the Q&A session in one of your responses, which is if they're providing more intensive services that require any additional technology, additional capital investment, additional other stuff, variable costs, that that actually may not end up being factored in. And that more severe population, who requires that more intensive care, even given the same reason for admission, those would be unobservably essentially to our model, sicker people. And maybe what we want is to spur that type of specialization,

but this kind of model could potentially penalize that type of specialization, which would be not in the best interest of the beneficiary.

So I think no model is ever going to be perfect, but I think it's important to keep both the good sides of specialization and potentially, or the benefit specialization as well as the potential harms of specialization in view here as we go forward.

DR. CROSSON: Larry.

DR. CASALINO: Yeah. I would pretty much second everything that's just been said, but a question and then a comment.

The question is, so in terms of the risk adjustment, with the claims data that would be available, will that be able to differentiate between someone who has a stroke that produces just mild, pretty temporary, you know, improving relatively rapidly, weakness in your left arm, for example, as opposed to someone who's got permanent hemiplegia and an inability to speak, because those are very different. One could go to home health. The other is going to spend, you know, a long time in a facility probably. Will claims data nowadays allow differentiation between those two things?

DR. CARTER: I don't know. I can look at that. That is a condition, when we were doing the SNF/IRF comparison many years ago, but that was using ICD 9 data. That was one of the concerns we had, is that a stroke is not a stroke, and we're very aware of that. But let me -- I can get back to you on that, because it is a real concern.

DR. CASALINO: A stroke is not a stroke is, in a way, true of almost any diagnosis, but with stroke it's really important, and particularly in the subject we're discussing now. In fact, it could sink the whole thing, honestly. And particularly if the idea is to compare across all four settings.

So then my comment was -- and there's a lot of attention being given to this, I think, by the Commissioners -- the idea of comparing home health to the other settings. So I understand, conceptually, and, you know, it's kind of beautiful to read it conceptually, let's compare across all four settings. But I'm trying to think concretely, what would be the purpose. And to the extent the purpose is to aid decision-makers about where is a patient going to go -- so if I'm a physician who has a patient with whatever, or even a family member that is

trying to decide, as a physician am I going to believe admission rates, say, between home health and any of the institutional settings? And the truth is I suspect it would be very hard to convince physicians that those are comparable numbers.

So if there's not a decision-maker going to be making decisions based on the comparison of home health to the institutional settings, one could ask a little bit, well, what's the purpose of it or what's the good of it? If it's not good enough for a physician to make a decision then maybe it's not something that should be used to compare -- you know, maybe there shouldn't be comparison across all four settings for rewards.

DR. CROSSON: Yeah. Did you want to answer first, Carol, or not?

DR. CARTER: I guess the only thing I would say is part of what we're trying to do is get Medicare to tie its payments to performance. And so if you have a provider that looks more like a SNF, or another that looks more like an IRF but they're actually treating very similar mixes of patients, eventually you would want to be able to directly compare their performance. I understand we need to go

through a transition, and I think it's really important, but at some point those distinctions are going to certainly blur more than they do now.

DR. CASALINO: I guess what I'm concerned about, and maybe some of the other Commissioners as well, are home health agencies ever going to really treat patients who are very similar to patients who are institutionalized? I mean, I think that's a really key question in this otherwise very tight structure.

DR. CROSSON: Karen, on this point.

DR. DeSALVO: I have a similar clinical intuition about this that I think I've raised before, that not all home health is the same. And maybe one way to look at this is to pull out those that are community referrals, because there's an evolution perhaps where home health is becoming a substitute for ambulatory care rather than a pure post-acute-care option. And the post-acute care probably relates more to these -- is more similar clinically and socially to the other patients versus those that are community referred. It may just give you some view on differences and whether those are apples-to-oranges comparisons.

DR. CARTER: I'm wondering whether -- and we haven't talked about this, but in the PAC PPS work, we had about 40 different patient groupings and provider groupings that helped us test sort of how good is this model and are we aligning payments with costs. And this is giving me the idea that when we get to doing our PAC VIP, we should do more than provider characteristics but starting to look at characteristics of, like, social risk factors or community versus prior hospitalization. So doing a little more analysis, not just by provider -- our usual provider categories would maybe help there.

DR. CROSSON: We'll have you next, on this point and you're still in line?

DR. NAVATHE: Yes, I'm still in line, separate point.

DR. CROSSON: Okay.

DR. NAVATHE: Okay, so on this point first and then the next point.

So on this point, I think I'm a little worried that we're kind of mixing two different objectives and then how we sort of converge those objectives to get to the final path. So I think there are two objectives as I see them. One objective is we want to do value-based purchasing for

post-acute care, right? So we want to link it to quality and have payments tied to quality. That makes perfectly good sense to me. I think in the context of the first phase of this where we do it within setting, that seems -- you know, other issues notwithstanding -- sort of not problematic.

The other piece that we start moving to a PAC PPS, it seems like we're also embedding within that is appropriate setting of care choice, right? And so we want to match patients to the right setting of care, and we're presumably using PAC PPS as a way to drive that as well as link to the value-based purchasing piece of this.

And I echo sort of Larry and Karen's comments because if we think about this from an end-state situation, you know, we may actually want the types of patients that live in IRFs and the types of patients that live in LTCHs to be very different from the patients that are living in home health agencies. And if that's indeed true and there's perfect separation of that from a clinical perspective and from what we observe in the data, and probably a lot of what we don't observe in the data, from a risk adjustment perspective we could get this -- we could kind of create

the wrong incentives here to underprovide intensity in a way that actually could end up harming beneficiaries in the long run.

And so the two objectives to me I think are crystal clear in terms of what we're trying to get to. I'm a little worried about the idea of eventually converging them and how that works unless we're really confident in our risk adjustment model. And I realize that you just mentioned, Carol, that there's data there that you could bring, and I think as part of -- as we continue this conversation, perhaps that should reemerge, as you point out. I would agree with that suggestion.

The other thing that I think it calls upon us to think about is, you know, other models that we've been talking about here in terms of ACOs and bundled payments. They have an incentive and have -- you know, particularly bundled payments have largely worked on this idea of reallocating people who go to a SNF who would otherwise be just as well served by going to home health. And so is PAC PPS necessarily the right mechanism to drive that piece of the sort of appropriateness infrastructure or appropriateness piece? I'm not sure about that yet. I

don't know that we know definitively, but I would call that into question as something that we should be worrying about going forward and whether, again, these two objectives belong together or whether we should actually think about them separately.

DR. CROSSON: Okay. Kathy, on this point or --

MS. BUTO: Yeah, I just wanted to clarify. I'm not sure I totally followed what your concern is, but let me see if I can articulate where I think we're coming from generally, which is, as I understand it, we are trying to unify post-acute-care payment particularly for patients with similar clinical conditions, so the overlap groups. Where patients are quite different, we are looking to make sure that the payments for those patients' care is appropriate, and we are thinking also that there are certain settings that just by virtue of having specialized already in treating some of those patients more severely or more acutely in need, that those institutions might gravitate toward those patients.

But I think at least where I've always thought we were going with the unified PAC was to really deal with the fact that these settings pay for or reimburse for care for

similar patients very differently, and that's what we're really trying to address, not necessarily in the main because we want to make sure that care is appropriately paid for, but it's okay with us if there's some specialization as long as, where patients are similar, there are not distorted incentives just based on reimbursement to go to one setting versus another.

So I think that's where we were coming from, and I don't know if that's what you're getting at.

DR. NAVATHE: Yeah, I don't disagree. I think, you know, the first point of the sort of value-based purchasing piece is sort of we want home health to be the best that it can be, right? And we want -- the better the home health you are, services you provide, the more you get paid because you're providing that value. That's kind of objective number one. That's where we are right now.

And then I think the other objective is the point, Kathy, you were just making, which is to the extent that there's a patient who right now could end up at SNF or could end up in home health or could end up at SNF and could end up at IRF and right now we pay them differently even though essentially they require the same thing and

they're getting the same thing and they're getting the same care, that's a matching piece. We need to get appropriateness. We need to get the person who can go to home health should go to home health, and the person who needs to go to SNF should go to SNF.

And because of the overlap in that setting, I don't disagree with the intent of saying that PAC PPS could help get there. I think what I'm wondering is kind of like with the patient experience or the patient-reported outcomes. Is the data there yet for us to be able to actually provide rational payments that don't end up creating a perverse incentive? That's what I'm worried about. I agree with the intent. I'm just worried if our data infrastructure and other pieces will have caught up at the time that we want to make that shift, and I think we should just be mindful that we keep that in focus. Otherwise, we could end up creating the wrong incentives here.

DR. CROSSON: Thank you both. That was a good point/counterpoint and I think important.

DR. NAVATHE: So can I make my separate point?

DR. CROSSON: Oh, you --

[Laughter.]

DR. NAVATHE: That was just on that topic.

DR. CROSSON: Okay.

DR. NAVATHE: My second point is hopefully a shorter one.

So Dana was sort of pushing on the number of patients required to have a stable measure of 60-plus, and as I understand it, if you're -- by pooling to three years, then we have more low-volume providers. But the pooling to three years is going to happen regardless whether you're a low-volume provider or a high-volume provider. And so instead of 60 per year -- I'm just going to make a number up -- if you're at 6,000 per year, then effectively your sample size becomes 18,000 over three years. And my concern about that is if -- we're creating perhaps an imbalance in the ability to actually move measures. So if I am that 18,000 volume provider over three years and in the next year I do really well on my next 6,000, I am still held to 12,000 of the previous ones, which may not have done as well; whereas, if I'm that smaller-volume provider and I have 100 per year, then that next 100 proportionately is a lot bigger in some sense where I'm able to move that measure more.

And so I think that's important for us to think through because, otherwise, we might actually harm the providers who are improving who are actually high volume to the extent that we know there's some volume-outcome relationship that exists across health care. That, again, may be something that we should be thinking about. A potential way to think about this would be to have a minimum threshold and then have a cap or something like that and say we'll take the most recent X thousand patients or, whatever, X hundred patients, whatever it is, so that way that measure still becomes movable, but we retain some of minimum threshold. So just something to think about.

MS. TABOR: I will say this did come up with the HVIP, and so I believe it was Jon Perlin who had the idea of maybe we weight the last year more than the other two years to kind of get at this, and we kind of talk about that as something policymakers could consider. We haven't actually implemented it in our modeling, but we could talk more about that.

DR. CROSSON: Dana, do you want to make a comment on this?

DR. SAFRAN: I have [off microphone] earlier.

DR. CROSSON: You are in line. Do you want to jump the line?

DR. SAFRAN: No.

[Laughter.]

DR. CROSSON: Larry wants to make --

DR. CASALINO: Just very briefly. I think the weighting idea that was in the managed care is a good idea, and based on what Amol was just saying -- and this is off the top of my head, but maybe give some thought to the idea that there could be weighting across the three years with the most recent year weighted mostly highly, but that maybe could differ by volume somewhat. Not to make this too complicated, but if you were really high volume, you know, maybe you don't weight the previous two years very highly; whereas, with a lower-volume provider, you could weight them more equally, whatever.

DR. NAVATHE: Agree, yeah.

DR. CROSSON: Pat is next.

MS. WANG: So I just want to say I agree with many of the comments that were made by the Commissioners, you know, David's comments around the importance of risk adjustment and being careful there.

I want to really talk a little bit more about social determinants and the adjustment there, because as the Commission, you know, advances, these more sophisticated, more uniform quality measurement systems, I really would like to see us be more proactive in finding better and more predictive assessments of the impact of socioeconomic status, particularly, you know, in the hospital. So dual status is definitely better than nothing, okay? But as you noted, Ledia, there is a lot of work going on. I'd prefer as we kind of take on our front foot with the development of these more advanced measures, that we not wait for those things to develop, because I think the importance of introducing more refined social determinants adjustments is critical, particularly when you're talking about things, measures of discharge to community. So just for example, a full dual can be somebody who has been poor or on and off of Medicaid during their life, has enough work quarters and is aging into Medicare, but lives in a very, very low-income, crime-ridden, food-desert community versus somebody who has spent down to dual status, has worked during their life, has had consistent health insurance coverage and health care, and really actually lives in a more middle-

class, stable environment. For a measure like that, full dual status is not sufficient, I think, to really get at an accurate measure of who's doing a better job, for example, discharging to community.

So there is definitely a lot of work that's out there. States like Massachusetts have introduced -- it seems like people are really going towards where you live as being more predictive of your burden from social determinants, whether it's nine-digit ZIP code level or what have you. And I think that Massachusetts has actually introduced much more granular determinations even into stratifying their Medicaid population.

So, you know, again, it's my request, it's my urging that the Commission, as we are very proactive in developing these newer approaches towards measuring quality, that we not leave the social determinants thing, you know, for somebody else to figure out. I'd really like us to be more proactive. We have the ability to do that, and I think we could make a big contribution to the field.

DR. DeBUSK: First of all, I totally agree, Pat, with what you're saying on the social determinants side. Along those lines, specifically discharge to community, I know

right now we do the risk adjustment first -- and we've had this conversation before. We do the risk adjustment first. Then we do the peer grouping.

Just a request. Throughout the analysis periodically do a check there, because, I mean, Pat -- and I think is where you might be going -- finding a better way to get at some of those social determinants, for example, discharge to community -- and this is just me speculating on that. I would think a very affluent person, probably their age doesn't affect their discharge to community rate nearly as much, say an affluent person, because they're going to have more options like nursing at home, they're going to have better surroundings than, say, someone of low socioeconomic status, they're probably going to be a lot more sensitive to age and how it affects their ability to be discharged to community.

So I would just -- as you do the analysis, we're always looking for something better than dual status, obviously, to do the stratification with, but I would also periodically go back and look at those variables, because what would happen if you compared the top 10 percent to the bottom 10 percent in SES and got dramatically different

coefficients relating to, say, age as a function of discharge to community? Because, intuitively, I think there will be cases where things like that are going to pop up.

DR. CROSSON: Thank you. Jaewon, I had you -- you passed. Okay. Bruce.

MR. PYENSON: I want to compliment the work, and my comments are on a framework for thinking about the size of the withhold. I think my comments are hopefully generalizable. We struggle or we have that question about just about every area that we look at on payment policy, how to set an appropriate withhold, whether it's hospitals or hospices or others. And I know it's -- some of the approaches Jonathan and Dana and David had talked about it earlier, and one of the approaches is kind of behavioral, to say, well, how much is enough that it matters to get someone to pay attention, and that's one way, and what's the evidence for that?

I'd like to suggest a different, an additional approach, which gets at the underlying financial risk, and a withhold can be thought of as a financial risk. It could be gained or lost, and the outcome is uncertain until the

end of a period. And at what point does that withhold actually threaten the solvency or the financial viability of the organization?

So, for example, if there was a 100 percent withhold -- of course, it's absurd, but an organization would have to borrow money to meet payroll and supplies and things like that, which conceivably some organizations might be creditworthy enough to do that, but many may not be.

I think the approach that is established for those sorts of issues, one of the approaches is to think about -- is used for risk-based capital for insurance organizations to look at the underlying fluctuations in financial outcomes that happen historically with organizations. So within SNFs or home health agencies or others, the cost reports might give us insight into the year-to-year fluctuations that happen anyway because a business is risky and things happen, either business or management or environment or other things that happen, and gains and losses fluctuate from time to time. And adding looking at the portion of businesses that go out of business is another way to do that. Some of that data I think is available. For sure we'll see that the size of the

organization, the enterprise, has a lot to do with its financial fluctuation.

So I think that's a useful framework not just for PAC but for other kinds of enterprises, including physician organizations, and it's a way to also think about capital and access to capital.

So if we do that, I suspect we'll think about whether the withhold should vary with the size of the enterprise. And while I think it's very appropriate that the quality metrics are presented at the individual enterprise level, the individual site level, as opposed to the organization, collective organization, I think the withhold and the financial risk is probably more at an enterprise level, so that a nursing home network or nursing home company with multiple sites can withstand more fluctuation than an individual site organization could. And, in fact, that could be part of their business strategy, the expectation that some sites will make more or less over time.

So I think having that kind of framework could -- an analysis could actually create a boundary on how big the withhold could be or how big it shouldn't be. And that's one end of looking at this. Of course, the behavioral

aspect is another approach to that.

Thank you.

DR. CROSSON: Okay. Paul, on this point?

DR. PAUL GINSBURG: I'm really glad that you brought up this analysis, Bruce, and I agree that that's the way to go.

Ironically, I was on a call last night as a board member and member of the investment committee of a nonprofit organization, and one of the topics was how much should they carry in cash to protect themselves for unplanned reverses.

When I think of this, a large withhold really increases the amount of capital needed to enter this business as viable, and I think it really requires some simulations of who could be affected and not just focusing on averages, because we know that the averages, average returns and post-acute care, cover up a lot of variation, particularly nonprofits versus for-profits. So I think you really opened up a rich part of our inquiry, Bruce, and I'm glad you did it.

DR. CROSSON: On that point?

DR. JAFFERY: Yes. I would echo that. I really glad

you brought those points up, Bruce.

I guess the other thing, I had mentioned this, I think, in some other conversations related to shared savings model. I'm just thinking also about we do these things with annual payments, often with a very lengthy delay, so that the payment comes back two years after the payment period or the evaluation period. I wonder if we can get to things where we're having this in a little bit more real time and thinking about organizations, particularly ones that may be pretty small and thinking about their cash flow concerns that may make the requirements to keep cash on hand a little bit less if they're getting these things back in more real time. I think it just may help organizations think about how they transform their models, if it's more tied to sort of an ongoing revenue cycle, if you will.

DR. DeBUSK: On the point Bruce had made and Paul made as well, I think that it's really novel, the idea of scaling the withhold based on the size of the institution.

The one thought that popped into my head is what would keep me, say, as an operator, the hospital, and I've got a SNF, what keeps me from just spinning that out and setting

that off to the side, and all of a sudden, instead of being exposed to a 6 percent withhold, because I'm part of a major system, now all of a sudden, I look a lot like a standalone little guy. Now I'm back to a 2 percent withhold.

I love the idea, and it's novel. I just think we have to think about how to operationalize it.

DR. CROSSON: Okay. Dana? I'm sorry. Bruce, did you want to answer?

MR. PYENSON: Just on that point, I think that that's already -- more sophisticated organizations think about that with their other risks as well, diversification and so forth. So this would just be another layer of what's the value of diversification.

DR. CROSSON: Dana, you have the floor, and you have the last discussion.

DR. SAFRAN: Okay, great. I'll be brief.

I had four points, and most of them have been mentioned, but I'll just add a little bit.

On sample size, my main concern was the same one that Amol mentioned and that Jonathan referenced yesterday, which is carrying your performance from three years ago is

really a burden and a de-motivator for improvement, and this is trying to be a program that's motivating improvement.

So I'd like us to do everything we can to avoid having to have three years of data. I thought Amol's idea of like if you don't need it to have adequate sample size, then maybe you only use this year's performance.

The other thought I had was, Do we have access to all-payer claims data, and could we actually base performance for smaller organization on all-payer data rather than having to go back several years? There's tradeoffs either way, but that seemed like something to consider.

I would even consider sacrificing a little on the 0.7, reliability. I was stunned to hear you say CMS had 0.4. I mean, worse than a coin toss? That doesn't seem like a good idea, but we could maybe justify 0.6. But it would have to tie to the issue of how high the withhold is. The less certain we are of our information, the less consequential it has to be.

But I wouldn't tie ourselves to 0.7 necessarily, though I do like a program that is at 0.7 or higher, just for what it's worth.

On the duals, I was going to make a point similar to Pat's and others that have been made. I heard you say that you are going to keep testing and try to improve on the methodology. I just wonder if we have the data available during this period of testing you're going to be doing, to include nine-digit ZIP, we know that that adds so much richness. If you have it, you can go out and get the Census block-group-level variables, but maybe you don't need to. Maybe you just use nine-digit ZIP as a dummy variable, and that really enriches the model a lot. I think that's worth looking at.

Functional status. As I intimated my question around, I just think that we have to find a way to begin to include that, even if it's in the initial round, paying for adoption and much more valid measurement than we've seen to date. But we have to find a way that functional status measurement and outcomes becomes part of this and similarly for patient experience.

Then the last comment was just to offer feedback on the 5 percent level. I like it as a starting point and agreed with -- I think it was David suggested that maybe it's a starting point and it ramps up from there, but based

on the dialogue that was had there this morning, I feel pretty assured that 5 percent is meaningful enough to particularly the SNFs who are coming from 2. But from what you said, Ledia, about home health and 4 and that that seems to really be getting folks' attention, then 5 certainly would too. So I think 5 sounds like a good starting point, and that you could ramp up from there was you get more certain and really starting of our risk adjustment, realizing certain of our social stratification, et cetera.

Thanks.

DR. CROSSON: Thank you. Thank you, Dana.

Thank you, Ledia and Carol.

I say this often. This was an excellent presentation, an excellent formulation, but also the discussion, I think, was one of the richest I've seen in a while. The points that were brought up here, I hope you find those useful because I think they're going to turn out to be very valuable to all of us.

So thanks again. We'll move on to the last presentation.

[Pause.]

DR. CROSSON: Okay. I think we can begin here.

The commission has had an interest in the payment from the Medicare program to institutions for graduate medical education now for almost 10 years. We spent some time in 2009, ultimately, and 2010, made a series of recommendations at that time.

When the expenditure level was about $9 billion, as I remember, now I think we're looking at something like $13 billion.

So we're going to take another cut at this. I think one that will enrich the physicians that we've had historically, but I also think that as we think this through, the whole issue of what the Medicare program is, in fact, getting for this substantial investment is a critical issue for the commission.

Alison and Jeff are here, and who's going to begin? Alison? Terrific.

MS. BINKOWSKI: Good morning. In this last session of the commission's September meeting, we will be discussing indirect medical education payments to acute care teaching hospitals. We would like to thank Stephanie Cameron for her assistance.

This presentation will cover three IME topics. The first topic is IME background, including the history of IME, how IME payments are calculated, and how IME payments are distributed across settings and hospitals.

Medicare makes two types of supplemental payments to acute care teaching hospitals for the provision of graduate medical education. The first type--and focus of this presentation--is indirect medical education payments, which totaled $9.3 billion in fiscal year 2017.

These payments support teaching hospitals' higher costs of patient care that are not otherwise accounted for in the inpatient prospective payment system, such as additional tests and procedures ordered by residents and specialized services provided by teaching hospitals. IME payments are made as an adjustment to IPPS payments.

The second type is direct graduate medical education payments, which totaled $3.7 billion in fiscal year 2017. These payments support teaching hospitals' direct costs of sponsoring residency programs, such as resident stipends and physician salaries, and are made outside of the inpatient prospective payment system.

The treatment of acute care teaching hospitals'

indirect costs of medical education varies across the two hospital inpatient prospective payment systems.

When Congress implemented the inpatient operating PPS in 1983, it explicitly specified the formula and level of an IME adjustment, which it described as a proxy for a number of factors which may increase costs in teaching institutions that were not fully accounted for in the new PPS.

In response to concerns that the new PPS would adversely affect teaching hospitals, the IME adjustment was originally set at twice the empirically justified level estimated by the Secretary. The level has been gradually reduced but remains significantly above MedPAC's estimate of the empirically justified level.

In contrast, when Congress established the inpatient capital PPS in 1991, it did not specify if an IME adjustment should be included. The Secretary chose to implement an IME adjustment, using a different formula. The level has not changed since its enactment.

Congress also left discretion to the Secretary when it established the outpatient PPS in 2000. The Secretary stated that Medicare determined an IME adjustment to the

outpatient PPS was not necessary to ensure equitable payments to teaching hospitals.

Teaching hospitals receive an IME payment for each inpatient stay by a Medicare beneficiary. I will provide more details on how this process differs across the inpatient operating and inpatient capital PPS's on the next slide, but at a high level, teaching intensity is measured as the hospital's residents relative to its inpatient size. Teaching intensity is converted to an IME percentage add-on through formulas specified in law or regulations. This IME percentage add-on is multiplied by the base DRG payment rate for a Medicare beneficiary's inpatient stay, and the result is Medicare's IME payment to the acute care teaching hospital for that stay.

While IME policy under the inpatient operating and inpatient capital PPS's have the same broad components described on the prior slide, they differ in several respects.

In particular, the PPS's differ in how teaching intensity is measured. For example, while both PPS's use the same count of residents, the inpatient operating PPS measures teaching intensity as residents per available

inpatient beds, while the inpatient capital PPS measures teaching intensity as residents per average daily inpatient census.

The Secretary chose this latter measure and stated it was more appropriate as costs were more closely to a hospital's ratio of residents to patients than a ratio of residents to available, but potentially unoccupied, inpatient beds.

The IME adjustment to the PPS's also differ in other respects, such as the formulas to calculate the percentage add-on and the treatment of fee-for-service and MA beneficiaries, which we would be happy to discuss during the discussion period, as helpful.

The formulas presented on the prior slide result in IME percentage add-ons that vary substantially across teaching hospitals, as a result of the wide variation in teaching intensity.

In fiscal year 2017, the median IME percentage add-on to inpatient operating rates, as indicated by the middle line in the box, was 6 percent, corresponding to a resident-to-bed ratio of 0.11, or one resident per nine

inpatient beds. However, the IME percentage add-on varied substantially across teaching hospitals, as indicated by whiskers, ranging from less than 1 percent to 78 percent, corresponding to a resident-to-bed ratio of less than 0.001 to greater than 2.

Despite the different measure of teaching intensity and formula specification, the median and range of the IME percentage add-on to inpatient capital rates was similar, though subject to an absolute maximum of 53 percent.

Despite similar IME percentage add-ons in the two inpatient PPS's, the IME percentage add-on to inpatient operating rates account for nearly all IME payments, as inpatient operating rates are substantially higher than inpatient capital rates.

Among inpatient operating IME payments, $6.2 billion was for the care provided to Medicare fee-for-service inpatients and $2.7 billion was for the care of Medicare Advantage inpatients, similar to the distribution of Medicare beneficiaries in fee-for-service and Medicare Advantage.

While there are approximately 1,100 acute care teaching hospitals, both residents and Medicare's IME

payments are concentrated among a small subset of teaching hospitals. For example, the 100 teaching hospitals with the largest IME payments in fiscal year 2017 accounted for 47 percent of residents. These 100 teaching hospitals also accounted for 51 percent of the $9.3 billion in IME payments.

I will now turn to summarizing concerns with Medicare's current IME policy and potential revisions the commission could consider.

The Commission and others have raised concerns with Medicare's current IME policy, which can be grouped into four categories.

First, IME payments are only made for care provided in inpatient settings and policy has not evolved to reflect the contemporary spectrum of settings in which hospital care and resident training occurs.

Second, IME payments are not reflective of the empirically justified effect of residents on patient care costs and result in overpayment of IME for care of inpatients while making no IME payment for the care of outpatient patients.

Third, IME payments have no link to performance or

accountability for how they are used. Specifically, IME payments are not linked to whether teaching hospitals achieve desired educational goals and outcomes, and while some have argued that IME adjustments above the empirically justified effect of residents on patient care costs are appropriate in order to help fund social missions that teaching hospitals operate at a loss, there is no requirement on how hospitals use IME payments or way to track how hospitals use IME payments.

Fourth, the inpatient PPS's are also inconsistent, including in their treatment of fee-for-service and Medicare Advantage beneficiaries.

To address these concerns and other inconsistencies with current IME policy, the commission could consider several revisions. Specifically, the commission could consider moving to an IME policy that applied to care provided in both inpatient and hospital outpatient settings; updating IME payment levels to reflect the empirically justified effect of residents on patient care costs in each setting, levels that could be episodically recalculated; adding a link to performance by using any current aggregate IME payments above the new empirically

justified payments to fund a new performance-based program, consistent with the commission's June 2010 recommendation; and moving to a consistent IME policy, with Medicare making payments for the care of fee-for-service and MA beneficiaries.

Collectively, these revisions could maintain aggregate medical education payments to acute care teaching hospitals while aligning IME payments with the settings in which care is provided, removing disincentives to shift patient care to hospital outpatient settings, and adding rewards for high performance.

Moving to a revised IME policy with the features described on the prior slide would involve key implementation decisions.

One key decision is how to measure Medicare Advantage beneficiaries' hospital outpatient use. Currently, hospitals are required to submit information-only claims for MA beneficiaries' use of inpatient services but not hospital outpatient services.

As part of a revised IME policy, Medicare could require hospitals to submit information-only MA outpatient claims. This new requirement would not only support more

accurate IME payments but also provide a valuable data source to validate MA plan-submitted encounter data.

Until informational MA outpatient claims are available, Medicare could estimate MA hospital outpatient use. For example, one option would be to estimate that MA outpatient use has the same relationship to fee-for-service as it does for inpatient use.

A second key implementation issue is how to measure teaching intensity. Both current measures of teaching intensity are inpatient-centric. One option for a new inpatient plus outpatient measure of teaching intensity is residents to average daily total equivalent census, which could be calculated as average daily inpatient census, scaled up by the hospital's inpatient and outpatient revenue relative to its inpatient revenue.

A third key implementation decision would be how to maintain budget neutrality. Consistent with MedPAC's June 2010 report, aggregate payments to teaching hospitals could be maintained under a revised, empirically-justified IME policy by adding a new performance-based program that rewarded teaching hospitals meeting educational standards.

The standards could be established by the Secretary,

after consultation with stakeholders, including accrediting organizations, patients, and consumers, and the level of performance-based payment could be tied to the hospital's performance on these new standards.

This new program could support workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality.

While the effect of a revised IME policy would depend on the specific design features chosen and related implementation decisions, to give the Commission a sense of how IME and overall Medicare payments to acute care teaching hospitals might change, we modeled one illustrative policy consistent with the design features described in earlier slides.

As you will recall, this includes moving to an IME policy that applied to care provided in inpatient and outpatient hospital outpatient settings, setting payments at the empirically-justified level in each setting, adding performance-based payments, and Medicare program making IME payments for both FFS and MA beneficiaries.

Under our illustrative policy, aggregate IME plus performance-based GME payments would be maintained, but the

distribution across settings would change and performance-based payments would be added.

In particular, moving from left to right in the graph, inpatient operating IME payments for both fee-for-service and MA beneficiaries would substantially decrease, consistent with MedPAC's prior estimates of the portion of the inpatient IME payments that were empirically justified. Inpatient capital IME payments would decrease from $0.4 billion to $0, as our regressions found no empirical effect of residents on inpatient capital costs.

This lack of a significant effect of resident involvement on capital costs suggests that residents do not systematically affect hospitals' capital costs and therefore an IME adjustment to the inpatient capital PPS is not warranted. Outpatient IME payments would increase from $0 to $4.8 billion, reflective in part of our estimate that the effect of residents on costs was larger in outpatient than inpatient settings; and performance-based payments would increase from $0 to $1.1 billion, such that aggregate IME plus performance-based payments would be equal those under current law.

Under the revised IME policies, many teaching

hospitals would have material changes in their IME payments, consistent with the wide variation in hospitals' inpatient to outpatient use and the reduction in aggregate IME payments and shift to performance-based payments. More outpatient-centric teaching hospitals and those with better performance on the new standards would have the largest increases in IME payments, while more inpatient-centric and poorer performing teaching hospitals would have the largest decreases.

However, despite this substantial redistribution of IME payments, most teaching hospitals' overall Medicare payments would change by less than 2 percent. Furthermore, financial impacts resulting from these new policies could be mitigated through transition policies, such as phasing in the revisions over multiple years and adding transition corridors limiting the change in payments teaching hospitals could experience in any given year.

That concludes our presentation. In summary, current IME policy does not reflect the increasing shift towards hospital outpatient care nor the empirically-justified effect of residents on patient care costs. During the upcoming discussion session, we look forward to answering

any clarifying questions Commissioners may have.

In addition, we would like the Commission's feedback on the concerns with current IME policy and potential revisions outlined in this presentation. We would also be interested what next steps the Commission would like staff to take regarding exploring potential IME reform.

With that, I turn it back to Jay and look forward to the discussion.

DR. CROSSON: Thank you, Alison and Jeff. We will now take clarifying questions. I see Brian. I see Paul and Jaewon.

DR. DeBUSK: First of all thank you for the great chapter, but I'm going to save a lot of my comments for round two.

I did have two questions, the first one being have we looked at the economics of a residency slot? I mean, let's say that DGME is $90,000 per slot, the IME is probably $120,000, $150,000. You know, I'm just kind of giving round numbers here. But those two spots can generate dramatically different amounts of revenue, say a third-year primary care resident versus a fifth-year orthopedic surgery resident. Could we enter analysis -- or, I mean,

you may have already done this already -- looked at the economics of a residency spot? Because even though we, Medicare, pay consistently the same amount regardless of specialty, I think the revenue generated would be dramatically different. Has there been any research or have you guys done any work in this area?

MS. BINKOWSKI: It's a great question and the short answer is no, that there's not great data to use at this point to do so. In our June 2010 report we did note how there are both financial costs associated with residents as well as financial benefits, and how those can vary by specialty as well as year, and we recommended that the Secretary collect data on that and report it. It's something that we could consider trying to explore more with available data, but there are challenges. I'd be happy to discuss more later.

DR. DeBUSK: Okay. Well, it opens up an interesting avenue and I wondered if there had been any research.

The second question was, you know, you speak in the chapter and in the presentation of this performance-based concept, and again, I love the concept of performance based. But could you elaborate just a little bit? I mean,

what would be good performance versus bad performance in a residency program?

MS. BINKOWSKI: I think that's a ripe area for future Commissioner discussion.

[Laughter.]

DR. DeBUSK: Well played. Very well played.

DR. CROSSON: I'm going to jump in there, because I was going to make this point a little later. But having been here during our discussions and recommendations in 2010, we had, you know, a fairly simple concept here and that was, as I said before, that the Medicare program is making a tremendous investment on the part of its beneficiaries and the public in residency training. And it's not unreasonable to think that the program has an interest in having some level of accountability for the use of those dollars.

It's become clear, I think, to the Commission, that issues such as the balance of the physician workforce that's coming out of training, for example, the ratio between primary care and specialty care, is of interest to this Commission. It has been in a number of other discussions.

In addition, I think the readiness of residents coming out of program to deal with the reality of health care as it's delivered today is important. Issues like the understanding and readiness of physicians to participate in collective quality improvement efforts, the sensitivity of residents coming out of training to the problem of inappropriate care and overuse of services and resource stewardship.

So our proposal in 2010, which was fundamentally based on this set of physicians, was that we would request the industry to take this accountability to heart and to make recommendations to the Secretary for what that performance measurement process would be. That has not been forthcoming.

And so this proposal that we have today is a little bit stronger than that and suggests that, in fact, in the absence of the industry coming forward with its own proposal for accountability, both in terms of the nature of the specialties that are being produced -- and this is in keeping with Brian's point here that there may, in fact, be economic incentives we are not aware of, which is adding to the disparity of availability of physicians for Medicare

beneficiaries -- as well as the nature of what's taught in training programs relative to the reality of the world that physicians in training are going to face.

In the absence of that, the proposal on the table here could be that the Secretary could, in fact, with consultation, determine the nature of those performance parameters and incentives.

Sorry. Go ahead.

DR. PAUL GINSBURG: Yeah, and that's what I was going to ask, about performance. I think it would be -- I don't want to stray too much into round two, but I think the idea of looking to the industry to come up with ideas is very valuable.

This seems to be something beyond the specialty mix, which, you know, people have talked about for years. I've never seen anything getting concrete about other aspects of performance of a teaching program. And, certainly, I don't think we're set up to explore it very well, although I think that if we write a chapter on this we really should have some ideas, if only at the level of what Jay was sketching out a minute ago, as to some of the directions it could go.

But I'll hold off until round two with the rest.

DR. CROSSON: Okay. Karen.

DR. DeSALVO: I'm really excited that we're taking up this work and I hope this is the beginning of more than we can do, because there are many component parts. We've got to build a workforce ready to meet the challenges we talked about yesterday.

I had a question for you all, because I don't know the answer, which is about the context in which Medicare payments are supporting residents in training, and what the scale is, for example, compared to VA support for residency training, and I'm pretty sure that HRSA funding is quite small relative to the CMS investment.

I'm interested in whether or not that context, first of all the numbers, but also if we could start to think about how all of those various resources could be more strategically aligned to develop a workforce of the future. So as we're thinking of the opportunity here it may be helpful to start thinking about how this nests in the broader view. But I wonder if you all have looked at the VA and the way that they fund GME and what they're spending.

MS. BINKOWSKI: So partially, I'm actually going to give a shout-out to a recent GAO report that looked at GME funding across payers. Medicare is by far the largest. I don't want to cite the number offhand, but it is over 75 percent. I can get back to you on the exact statistic of funding, but yes, VA and HRSA are the two other major players and there are some smaller ones.

The short version is Medicare is the largest payer but VA and HRSA are the next two largest funders of GME. There's also Medicaid programs. The IOM, in its report, did talk about possibly trying to harmonize all of those different payers and should even move to a new entity that does GME across all. I think that's beyond the scope of MedPAC, but it's something the Commissioners could discuss.

DR. DeSALVO: Thank you. I think the Medicaid component of this may be on the edge of MedPAC's role, but given that a lot of states have been thinking about innovation for performance-based residency payments it would be so helpful to have some of that as aligned as possible, and at least be aware of what the VA is thinking. There may be some good ideas growing from their work.

I have a second question, which is about this

startling fact that 10 percent of the hospitals in the country have about half of the residents and resources, and whether that's been sort of a fixed number over time or if that's been a trend of concentration of training, and if anyone has looked at whether that is related to later geographic distribution of physicians as they go out into practice, or diversity of physicians, or even experience of them. I just wondered about if there's a sort of -- if you'll pardon me for saying it -- the rich getting richer, and as concentrating training at some geographic areas that some experiences, when, in fact, beneficiaries live all across the country.

MS. BINKOWSKI: I don't know the exact numbers. I can look into the trends over time. But it definitely has been highly concentrated from the beginning of the program. But it's something I can look into more.

DR. PAUL GINSBURG: I can comment on this. I think whatever the trends might have been, to concentrate or not, the fact that the DME payment is tied to, historically, each hospital, how many residents did you have at a certain point in time in the 1980s, probably works against movement in that distribution.

DR. CROSSON: Okay. I have Jaewon next.

DR. RYU: Yeah. I had a question around distribution as well. It seems like there's a comment on Slide 17 where you say that most teaching hospitals overall, Medicare payments will change very little. And so it just strikes me that if we're trying to redistribution, in some way, to be more accurately representative of where teaching activities take place today, whether an inpatient versus outpatient or geographically too much concentration, or maybe it's even by specialty, too much concentration in specialized areas versus primary care, as an example, I just wonder if this approach fundamentally moves enough money. And I don't know if you've done any modeling around how much money would actually move, because a lot of these organizations, they're doing inpatient but they're also doing a lot of outpatient.

And so if this is the new approach it seems like they would still get roughly the same amount and maybe this wouldn't achieve sort of the redistribution or the reallocation that we might be shooting for. So I was just wondering if you had any sense of what is that amount.

MS. BINKOWSKI: Yes, I do have some things to say on

that. Two points to make on the slide is there would be wide distribution in IME payments, which is the first bullet on this slide. It's then just putting it in the context of most hospitals are large and have many lines of business and IME is a smaller share of their overall Medicare payment.

DR. RYU: I see.

MS. BINKOWSKI: Within the IME payments itself, as I said, the distribution would be wide. To give you a flavor of that, about a fifth of teaching hospitals would have more than a 25 percent decrease, and a sixth would have more than a 25 percent increase in IME payments. When you add performance based on top of that it would obviously shift, depending on performance, and there is large variation in the degree of outpatient centricity, to coin the term.

DR. CROSSON: Yeah, on this point.

DR. CASALINO: So I think this is related. I just want to try and understand the difference between two numbers, the one that Jaewon is referring to in the next to the last slide, Slide 17, that most hospitals, their payments would change by less than 2 percent. And then on

the previous slide, Slide 16, where, if I'm understanding correctly, the estimate that there would be $1.1 billion in performance-based payments, which, if you kind of want to look at that as a withhold, in the language of our previous discussion, that would be $1.1, if I understand correctly, of the $9.3 total in IME payments, which would be more like kind of an 11 percent withhold, or 12 percent, whatever.

So if I'm understanding that correctly we have a 12 percent withhold, which is much bigger than we were talking about in the previous discussion, but yet we'd only expect the hospitals' aggregate IME payments to change by 2 percent.

MS. BINKOWSKI: So again, I think maybe to clarify, it's that they're overall Medicare payments across all lines of business, not their IME payments.

DR. CASALINO: I see. They're overall, because IME payments could change quite a lot --

MS. BINKOWSKI: Dramatically --

DR. CASALINO: -- according to this slide.

MS. BINKOWSKI: -- as well could their performance-based payments.

DR. CASALINO: Okay. Thanks.

DR. CROSSON: Okay. Larry, you're also up next.

DR. CASALINO: No. That was it.

DR. CROSSON: That was it. Okay. Warner.

MR. THOMAS: So this was a great analysis. Thanks for the information. Just a couple of questions.

Did we look at -- and I know there's questions about like MA pays, you know, some of this but doesn't pay on others. Did you look at what the impact would be if MA paid consistent with fee-for-service Medicare, because I know right now it's inconsistent.

MS. BINKOWSKI: so we haven't done any analysis on it to clarify if it's currently consistent on the inpatient operating side. Where it's inconsistent is for inpatient capital IME. We do know, anecdotally, that some MA plans do build that into their contracts.

MR. THOMAS: Okay.

MS. BINKOWSKI: But we don't have data on the extent to which that is done.

MR. THOMAS: Okay. Do you know -- and I don't know if this is even knowable. I know there are many organizations that have unfunded slots. Do we have any idea of the magnitude of that, you know, kind of nationally? Is that

something that we should have as part of our analysis and kind of know how unfunded slots kind of line up with these funding mechanisms?

MS. BINKOWSKI: So, yeah, some of that is buried in a footnote in the paper, but there are roughly 84,000 funded residents and roughly 100,000 total residents. There are several reasons for that spread. I think we defer it to the Commission on what the right sequencing is of looking at residency slots.

DR. DeSALVO: Sorry, but do you know of -- so that's about a fifth -- do you know if they are in the same markets where most residency slots are concentrated, or if they're filling the gaps across the country where there are unfunded slots?

MS. BINKOWSKI: I don't have that off the top of my head. I can look into it.

MR. THOMAS: What's that again? I didn't hear.

MS. BINKOWSKI: There are slightly different counts of residents for IME purposes and DGME purposes, and so the exact numbers that we're talking about vary, but those are rough ball parks across the two.

MR. THOMAS: And then, you know, going back, you had

mentioned that there's a pretty wide swing in the impact of payments if we're going to make these changes. Is it knowable to then know the impact on -- because I know we look at Medicare margins, you know, we kind of look at Medicare rates. Is it knowable to know the impact on Medicare margins as you relate to different groups of facilities? Or have we run any of that information?

DR. STENSLAND: We could do that once we know exactly how the performance-based payments would be distributed and somehow model that. Until you know that, you'd have to make some sort of broad assumption, assuming everybody just gets their share of it or something like this. And then, of course, since this is budget neutral, on average everybody's margins are going to be the same, because, you know, we're spending $9.3 billion now. We're still going to spend $9.3 billion. So, in aggregate, it's not going to change the margins for teaching hospitals. But who gets that money might move a little bit. But in terms of their overall Medicare margin, it really shouldn't move, as Alison said, by more than 2 percent for very many of these because this is going to be less than 2 percent of their revenue in almost all the cases.

MR. THOMAS: 2 percent of total revenue, okay.

DR. STENSLAND: Not the total all-payer but just from their Medicare --

MR. THOMAS: Total Medicare revenue.

DR. STENSLAND: Yeah.

MR. THOMAS: Okay, great. Thank you.

DR. CROSSON: Thank you, Warner. Pat -- on this point, Amol.

DR. NAVATHE: So just to get a sense of data, do you have a sense of how the distribution of payments right now relate to margin? So, in other words, those hospitals that are disproportionately getting the payments right now, are they higher margin relative to other teaching hospitals? I think that might be helpful just as a starting point to understand what the downstream impact would look like, and the equity in some sense of where the -- what the economics -- trying to tie kind of Warner and Brian's pieces together.

DR. STENSLAND: When you say margin, do you mean Medicare margin or all-payer margin?

DR. NAVATHE: I actually mean both. I think we'd be curious in Medicare margin, but also just overall operating

margin.

DR. CROSSON: Pat.

MS. WANG: I was wondering if you could say more about the origin of the capital IME adjustment. If it's not empirically justified today, was it when CMS elected to add it to capital? Has something changed? Or was there something -- does it have implications for the adequacy of the capital PPS that it's missing some things that somebody -- I'm putting it crudely -- decided to do a little bit of a plug. Teaching hospitals with the highest intensity would tend to have more elaborate capital infrastructure, and I'm just wondering if there's no empirical justification today whether that has other implications for the accuracy or adequacy of the capital PPS.

MS. BINKOWSKI: So I have not been able to look at the data that far back to test if we would have found an empirical relationship then. The Secretary did -- I would -- there have been several changes since that point, including the addition of DSH payments, which I think could have affected the relationship between costs and maybe some of it was loaded onto the IME before. But I don't know for sure.

MS. WANG: A DSH adjustment to capital? Oh, okay.

DR. STENSLAND: In the DSH adjustment to Medicare payments in general. I think the other thing that's happened over time is there's a lot better risk adjustment now than there was when the system first started. So I wouldn't be surprised if when the system first started you looked at the empirical relationship and you said, oh, it does look like these teaching hospitals have higher costs than can be explained by whatever, how we're paying them then for their inpatient DRGs. But part of that might have been that they were dealing with some of the more difficult cases. But over time we have more risk adjustment. When we started -- now we even have adjustment for CCs and major CCs get you different payments that didn't before. So to the extent that teaching hospitals historically have had more difficult cases and were better at measuring how much more difficult those are and adjusting the DRG payments accordingly, there may be even less of a need for some of the IME payments, which in the past may have served as kind of a real crude risk adjuster.

MS. WANG: But you're referring to the IPPS. What about capital? I'm really not familiar with how the

capital is reimbursed. Is that risk-adjusted, too?

MS. BINKOWSKI: There is the same DRG weight to the base capital payment.

MS. WANG: I see. Okay.

The second question I had was: Would you mind going through again how you would -- what kind of formula you would put for outpatient activity? Which I assume would include anything that is paid under OPPS? Okay. Can you go through that again?

MS. BINKOWSKI: So it would follow the same broad formula. So teaching intensity would be the same across the three settings, this measure of potentially resident to average daily total equivalent census. The IME percentage add-on would come from our setting-specific model, and it would retain the same kind of log-log relationship that is under the current model. So I could go into more details, but essentially one plus this measure of teaching intensity to a power.

MS. WANG: Okay.

MS. BINKOWSKI: And it would be multiplied by the base rate for APC. Maybe this is too easy.

MS. WANG: No, it's okay. But just, you know, forgive

me, to me "log-log" is like what you put in the fireplace.

[Laughter.]

MS. WANG: But to start, you wouldn't use a resident-to-bed ratio. You would use average daily census to --

MS. BINKOWSKI: Right. So it's saying that the measure of teaching intensity is something that the Commission could discuss, but we think we'd need to move away from an inpatient-centric measure of teaching intensity, such as residents to inpatient beds, and we proposed one, and then it would follow the same kind of broad formula as under the inpatient operating, but it would be a different exponent.

DR. STENSLAND: [off microphone].

DR. CROSSON: Jeff, mic.

DR. STENSLAND: It's roughly the volume of outpatient services you're doing measured by how much you're getting paid for those outpatient services. So, you know, if you're getting paid X for a CT scan and you're getting paid one-half of X for an office visit, then that would be kind of the magnitude of those things. And so calibrating it to the inpatient would be based also on the relative prices that you're getting for those two things. That's how that

could be done, and that's the broad general idea of how it would be computed.

Now, there's details inside there, which I think is a level for way beyond this meeting. But I don't want people to go away and think, oh, everybody's dead set on saying it's going to be all outpatient. For example, you might say we think that having residents running around can affect your costs for lots of your outpatient services, so we're going to have that adjustment for your therapy services and your visits and all this. But we're not going to make an adjustment on your Part B chemo drugs because we don't think just because you have a resident there means it's going to cost you a lot more to buy the Part B chemo drug.

So there's some details which could go into it later which I think are, you know, for a later meeting.

DR. CROSSON: Okay. Now, Jim, did you want to jump in on this?

DR. MATHEWS: No.

DR. CROSSON: No. Okay. All right. So then we've got Marge and then Bruce and Amol. Is that it?

MS. MARJORIE GINSBURG: Based on something that Jaewon

referenced about specialty had me thinking. You haven't today or the current system doesn't look at compensation based on the specialty level, I assume? A resident is a resident. It would occur to me -- and maybe this goes into the second part of the session -- that in our interest to encourage more primary care physicians, would it make sense to try to orient payment according to the specialty with regard to the need of certain specialty areas more than others? So, anyway, that may be part of the next discussion, but mainly I wanted to know whether this ever looked at the differences between the intensity of the specialty.

MS. BINKOWSKI: These analyses did not. As we noted before, there's not the great data that we would like to be able to look at the level of how costs vary by specialty, but that's something we'll continue to look into.

MS. MARJORIE GINSBURG: Certainly not -- I mean, learning what the teaching hospitals now focus on and the number of residents that focus on orthopedic surgery versus oncology, those data are there, right? They just haven't been accumulated?

MS. BINKOWSKI: There's data on the number of

residents and their distribution by specialty. Trying to tie that to their effect on costs is where it's more lacking.

DR. STENSLAND: A two-part decision to be made. The one part is: Do we think maybe we should make some adjustment, depending on what kind of resident it is? And then there's a question of where do we do that. Do we do it in this indirect medical education portion which is supposed to account for the extra costs the hospital has because the residents are running around? Or do you do it in the direct payment where you're having some direct payment for their salaries and this kind of thing? I think it's a two-part question.

MS. BINKOWSKI: Or is it part of the performance program?

DR. STENSLAND: Yes.

DR. MATHEWS: And, Marge, just to add a little bit of clarification to that, I agree with Jeff that there are two ways you could do it, but this conversation is focused purely on IME and having a direct GME conversation is going to be for another time. But if you wanted to contemplate a policy that would favor programs that produce, you know, a

certain type of resident, you know, more primary care focused, we're coming back to the pipeline issue later this cycle, so you'll have an opportunity to hear a couple of other different ways to do that.

But the second thing is that, to the extent we are going to be talking about a performance-based component to redistributing some IME dollars now, you know, a consideration of the level of production of primary care type residents might be a factor in the development of that performance-based idea.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: I've got a question on the recent news that Hahnemann Hospital's residency program is apparently being purchased by a consortium of other entities, and I don't know if this is an appropriate question for you because it's such recent news. But it's interesting that the bankruptcy of Hahnemann, apparently the residency program is one of the assets of the bankrupt institution, and a consortium of organizations has seen value and the bankruptcy court has apparently made some decision on the appropriateness of the value. I understand, just from not much more than the headlines, that CMS has some concerns

over that. That strikes me that you then surround that and maybe even the numbers might be relevant to this discussion, and I wonder if you have any thoughts or comments on that.

MS. BINKOWSKI: I don't have any comments on the specific numbers as they are, you know, a moving target and have just come out. But, yes, the cap on residents has made residency slots valuable, and one of the changes in the ACA was to allow slots of closed hospitals to be redistributed as opposed to lost, and the sale of Hahnemann's slots is a result of that change. We can talk more afterwards.

DR. CROSSON: Okay. Amol.

DR. NAVATHE: So I just had a question and then perhaps a suggestion going forward. One of the other big changes that's happened over the last several years is duty hour reform and its impact on sort of the economics of these slots may actually be something that's evolving. And so I was curious, if we haven't already looked at, perhaps we should look at how duty hour reform has impacted the economics of those slots in some sense and on the downstream financial health of hospitals. And then

secondly would be in an ongoing fashion, as duty hour reform continues or likely continues to evolve, that might be another factor for us to just keep in mind to ensure that we're not --

MS. BUTO: What kind of reform, Amol? Sorry.

DR. NAVATHE: The reform that we're talking about there is just the number of hours that residents can work, so 80 hours per week. My sense is that would disproportionately be impacting the inpatient care; therefore, the institutions that are heavily focused on inpatient care would be more impacted. The general sense is that has caused the variable cost structure of these hospitals to go up because as residents have been capped, they've been hiring PAs and other hospital physicians and whoever else to fill those hours, because obviously those hours were needed for patient care. So just another variable here that we might want to make sure we keep in this discussion.

DR. CROSSON: Okay. Thank you.

Seeing no further clarifying questions, we'll move on to the discussion period, and Paul I think is going to begin.

DR. PAUL GINSBURG: Yes. Well, first, thank you for a really good job on the presentation, and I think the issue was a very important one. You know, in context, in payment for IME, the policy was created in 1983 in conjunction with the Inpatient Prospective Payment System. It has not really been revisited much since then, and the context has changed so much because outpatient care is so much larger a portion of the activities of teaching hospitals, and that's where a lot of the teaching is done. It's not just the primary care residencies, but there are lots of specialty residencies where that specialty rarely sees an inpatient, so much of the training for those specialties does take place in teaching hospitals, but in their outpatient departments.

So one other aspect of the history is that, of course, MedPAC and its predecessor, ProPAC, has been concerned about the excess payments for IME for a long time, and that was not a failure of policy analysts in setting because HCFA and CBO came up with the right number, and Congress deliberately decided to go for a much higher IME add-on because it wanted to make sure that the AAMC supported the Inpatient Prospective Payment System. And they succeeded

at that, and then they have been stuck with it ever since.

But, you know, it was very compelling, the point you made, about how to train residents in outpatient departments is expensive, and I gather you're saying it's actually more expensive on a percentage basis than training them in inpatient settings. So the result is that, you know, we have a situation where, for not only primary care but for many specialties, you know, it becomes a losing proposition to train -- to have these residencies because they're not getting any of the IME type support. It's all going to the inpatient residencies.

So I don't know the degree to which this has been decisive in having hospitals change the mix. You know, the fact that so much of it is tied to numbers back in the 1980s with the DME probably prevents that from happening. But I think unfunded residencies have been growing, and so it could be a factor.

So, you know, I think this would make the system fairer. It certainly would improve the incentives although I'm not ready to say that it will make a big difference because I think the DME and IME payment is perhaps overwhelmed by other factors, you know, some of the

attractiveness of providing residents in some specialties that are very profitable for the hospitals. And even when it comes to primary care, the need to have the primary care resident often overwhelms the fact that they might not be profitable.

I think it's intriguing to devote some of the resources to performance-based, although I worry a little bit that unless we can fairly quickly make a compelling argument that, you know, these things that we can measure are really important and really -- you know, it could undermine the bigger part of the proposal to me, which is to shift the payment toward the outpatient departments.

DR. CROSSON: Okay. Let's focus on the last slide, the discussion points, the questions the staff has. I see Brian, Warner, Jonathan, Kathy, Pat.

Brian.

DR. DeBUSK: Well, first of all, again, thank you for a great chapter. I really, really support the work. I think re allocating the funding is an outstanding idea. So I think you guys are off to a great start. Shifting it to the outpatient setting, I'm completely on board with.

Also, introducing a performance-based component, I

think that's an excellent, excellent idea.

I guess, in summary, I'm wildly supportive of what I see in this chapter and really look forward to the next iteration of this work. I hope it comes sooner rather than later.

The one passing comment I would like to make, I'd like us to look at performance a little bit holistically because it's not -- I realize there are some performance standards on the quality of the teaching and what's being done, but it would also be nice to look at performance within the context of what do we need in the workforce. What skills sets, what specialties do we need?

The other thing I do hope we can take into consideration is the relative profitability of the different specialties, because I think that's an element of performance too. I think one teaching center that's producing a lot of primary care physicians and a lot of psychiatrists and things that Medicare really needs versus a -- and, obviously, we need all specialties, but versus something that's, say, in relatively greater supply, a specialty that's in relatively greater supply that has a better revenue stream attached to it, say, to those fourth-

and fifth-year residents, I think those are fundamentally different needs.

I guess my whole point was I love the work. I think this is a material amount of spending, but I think more importantly, it's a material amount of spending that's shaping our entire work force. So I think there's some leverage here in this area. So I hope the work continues.

But performance to me means so much more than did they make it through the program. Performance to me is how effectively is this money shaping our workforce into training physicians that Medicare and their beneficiaries need.

DR. CROSSON: Okay. Warner.

MR. THOMAS: So I think this has obviously gone a long time without being looked at and needs to be looked at and evaluated.

I would say, at the same time, I think we've got to be mindful of the magnitude of change we have because, once again, I think more shifts should be to outpatient. I think that makes a lot of sense. I mean, care has changed a lot in the last three decades, so we get that.

But, at the same time, a lot of care done in large

academic medical centers is inpatient, and if you look at outcomes, it's in the Health Affairs articles. We've seen it over and over. Outcomes in large academic medical centers for high-acuity patients especially is better than what you see in other organizations. So I think we have to be mindful of that and just kind of balance that look.

I agree that more should be shifted to the outpatient area, and I think that that makes a lot of sense.

On the Figure 4, where you kind of did the chart looking at the analysis by entity, kind of the percentage change, I'd actually like to see that broken into kind of dollars as percent because I think it's important to know and the magnitude of dollars that would move around. These could have material impacts on major programs. So it would be helpful to understand that piece.

On the performance, I agree. I always think all of our patients should be tied to performance. I think the question is, What is that performance going to be?

I do think looking at unfunded positions, especially if they're in areas that we need to train more folks, like primary care, psychiatry, other places where we have a shortage, medical subspecialties that are more in the

cognitive nature, I mean, there's just a tremendous shortage of these folks. I think we ought to be looking at perhaps more of those dollars ought to be redistributed in that way, and maybe there should be higher payments for these types of specialties that we want to train more people in going forward.

I'm concerned about how are we going to actually develop the performance metric. What are they going to look like?

I think Jay's point about are we putting out people that are trained in quality, that are trained in value-based payments is great, but I'm kind of going back to how are we going to evaluate that. I think that's the thing I'm challenged with.

I like the idea of modification. I think we need to be mindful, and I think we also should think about, if we're going down this road, some sort of transition to give people time to adjust to these types of things.

I wouldn't totally discount the importance of funding this through proportion of inpatient care and looking at that carefully because, I mean, we want to make sure these centers are good at inpatient care and they are taking all

the high-acuity transfers. More and more, they are coming from places that can't take care of folks because they don't have the medical staff in more rural areas. People are getting transferred to places like this. We need to make sure they can do it.

So I just would kind of use that as a caution as we look at it.

DR. CROSSON: Just on Warner's point, I want to emphasize that you gave those two examples as just examples.

MR. THOMAS: Yeah.

DR. CROSSON: I think the commission's position at the time was that we were not equipped, and we were not at all certain that CMS was equipped to be able to design the right way to measure performance, outside of the question of the specialty issue, but that the industry itself should do that --

MR. THOMAS: Yeah.

DR. CROSSON: -- because I think it's kind of hard to imagine that we would accept the position that there is no way to measure the success of training programs, that we ought to just accept the fact that as long as someone, a

resident, is put out of a training program, then they're all the same in terms of their capabilities to meet the needs, in this case, the Medicare beneficiaries going forward. It would be, I think -- I still think it would be incumbent on the industry to address that question.

MR. THOMAS: Jay, I think that's a great point, and I think there's good training programs and ones that are not as excellent. So I think that's a great point.

I have no issue with that. I think the question is it would be a good challenge to the industry to think about how they come back and provide new feedback around that. So I think that would be great to hear ideas about that.

DR. CROSSON: Okay. Jonathan.

DR. JAFFERY: Yeah. Thanks, Jay.

So, first of all, thanks, Alison. It was a great, clear presentation. Jeff, it's good to see you finally doing some work around here.

DR. STENSLAND: [Speaking off microphone.]

[Laughter.]

DR. JAFFERY: So echoing a lot of the support that others have already given, I think some of the concerns about how this would impact individual teaching hospitals,

I think there's an opportunity to do some modeling. I think somewhere you talked about how 18 different hospitals would have greater than 5 percent of their payments, and you could just imagine that every single teaching hospital is assuming they're one of those 18, and that grade of 5 is going to be significantly greater than 5. So that could just be important going forward.

I think Amol's comments, suggestion about looking at Medicare margins and overall margins is actually a really interesting idea. If you think about the initial purpose of IME to sort of cove some of the inefficiencies that we might get from having resident care and then you combine that with what we've seen and observed around how more efficient hospitals and organizations may have -- less efficient ones may lead to lower Medicare margins, and maybe because they're getting higher overall payments, and how that all connects, I think we want to make sure that those payments are rewarding the right things.

I wonder if we can -- on page 17 of the report, you talk about how IME policy doesn't reflect the contemporary spectrum of settings in which hospital care occurs, and I just wonder if there's any reason or ability to consider

even more broadly where all care occurs. We're making all these shifts to value-based care, and if we're interested in training more of a workforce, including maybe a focus on primary care that's going to spend time in nursing homes or -- we're launching a home-based primary care program this fall. So we'll actually have people, hopefully, at some point helping care for people in their own home. How do we measure that exactly, and how is that accounted for?

I think in terms of the performance-based payments, I really appreciated Jay's context about the 2010 report. I worked for Senate Finance shortly after that report came out. I remember it coming out, and we talked about it a lot and thinking about how maybe this would create opportunities to shift more slots towards primary care then and just reflecting on the fact that now it's basically a decade later and we're still having the same conversation.

And I appreciate the idea that maybe the industry is best positioned to come up with some metrics that would make sense, but maybe there is an opportunity for us -- and this is maybe a later conversation, but to frame, even in broad strokes, what that might look like, to try and align with the commission's principles and goals around improving

care for Medicare beneficiaries and creating a good stewardship of taxpayer dollars.

Resource utilization, for example, and affordability was not something that was nearly in the front of the conversation as it is now, I think.

I think there may be some opportunities to push the industry to think about other things. What about workforce diversity and matching that to populations, the populations served by a particular teaching hospital?

Again, I'm not sure that I would know right now how to measure that exactly or that we would be equipped as a commission, but we could put that out there as something we'd like to see.

Thanks.

DR. CROSSON: Thank you, Jonathan.

Kathy.

MS. BUTO: So, first of all, I support the recommendations that you have laid out wholeheartedly. I think it's definitely an improvement.

I would ask -- I think others have brought this up -- that we actually do an impact analysis by large teaching hospitals, by geography, by other things that we think are

important, so we can see where the impact actually is.

For some hospitals, even though the impact overall in terms of Medicare payment is relatively small, for some hospitals, it could be significant. So I think we really want to understand where that's happening, and it could have to do with distribution of low-income beneficiaries versus not, et cetera.

So one thing -- I think Marge brought this up -- I really think it's important for us to separate and yet bring together both the GME direct medical education and this IME component, which is more -- it was always envisioned as the extra intensity related to teaching programs and recognizing where that intensity adds cost and so on.

The ability to actually influence sort of these specialties that are being trained, I think, really resides more directly in direct medical education. If we could tie, somehow, this performance-based payment element back to payment direct costs for those interns and residents, I think that would be important or at least to acknowledge that we want to have some connection there.

The performance-based payment looked to me like trying

to do that light, sort of the light version of can we make policy preferences and influence decision-making at the hospital level by having this pot of money, which isn't very big.

So the other thought I had was maybe it needs to be bigger if we really want that to be significant, but I actually think it has to be tied more to the actual slots.

Then I started thinking about performance-based payment in a teaching program, where the time frames are very long, I think we have to think about that. How would you do performance-based payment? You would probably not want to change the performance metrics or things you're measuring year to year.

Let's say it was something like directly providing more opportunities or training around treatment disparities by race and ethnicity, something like that. You're not going to do that one year and not do it the next year.

So I just really think we need to think about that element with a little more granularity and see how much we can tie these performance metrics back to direct medical education.

Then, last, I thought when we do get around to doing

our chapter, our analysis on direct medical education or maybe even in the next iteration of this one, I think it would be really helpful for us to have a refresher or an update on sort of the supply of physicians by specialty. What are we seeing? What's the trend? I know we've done this before, but I just think it would be helpful as we think about where we think there are shortages, we all say primary care. I'm now concerned there are specialty care shortages that we tend to not focus on, especially in the area of Medicare beneficiary treatment.

So I'd like to see us update that analysis of impact or, rather, what the pipeline looks like, even though it's not directly related to IME, per se.

Thank you, Kathy.

Pat?

MS. WANG: So I echo what others have said. I think this is a very important paper, and that the concept is very, very attractive. It's time to have this conversation.

I agree with what others said about the need for sort of much more information disclosure, I guess, and transparency. When we were right at the start of this, I

understand about what the impacts are and where they fall.

To Amol's suggestion about looking at impacts on margins, my recollection is that teaching hospitals in general have higher Medicare margins but lower all-payer margins, and I think that we have to be very sensitive about any impact on both of those and the viability of access to Medicare beneficiaries to excellent teaching hospitals. I think that's been part of the historical concern around calibrating these teaching programs.

You kind of touched on it. I just don't know, but in the next round of this, what the operational issues would be about extending to the OPPS settings. That's a lot of claims. That's a lot of shadow bills. I don't know whether there's some complexity there that would need to be addressed and operationalizing anything.

I do want to say that even if not to Jaewon's point earlier, even if not a dollar shifted from hospital to hospital, I still think the value of the concept here is to sort of unshackle or equalize the value of all settings in a hospital to get paid for what is owed for IME, so that it's not such a heavy burden, like you got to put the head in the bed in order to get the IME payment, whatever the

level of payment is, and that you can still get what you are supposed to get by treating people irrespective of the setting and find the most appropriate.

I'm not saying the teaching hospitals unnecessarily admit, but there is a handcuff to the bed in some ways in order to get your full IME budget.

So I think that even if dollars don't move, just equalizing the value of the settings to get paid for IME is a good thing.

For capital, honestly, I didn't even know that there was an IME adjustment on capital. It's a relatively small amount. I guess I'm a little concerned about whether there's a reason that it's there, and if you take it away, whether you're busting a hole in the adequacy of capital payments. So I wouldn't start with taking IME off of the capital PPS. I probably would just leave it alone.

As far as the performance pool is concerned, I really understand the impulse here, but I think that some of the things that people have mentioned as performance goals, which have to do with competencies of the physician workforce are more effectively done through the accreditation bodies. I think program directors will be

much more sensitive to accreditation standards of how the skills that physicians -- that residents need to have when they emerge from a residency program, I'm not sure that IME, which was supposed to be part of the operating payment structure, is the way to do that.

Others have pointed out -- so I feel like payment policy from Medicare is more appropriately -- if we were going to target money, it's really around workforce supply, and as far as that's concerned, I do think that DGME is an important component there, and that even if you were -- it's less about IME, and it's more about DGME.

Just a very crude example would be we need more geriatricians. We're going to weight the DGME payment for a geriatric resident at 1.2, and then you have to down-weight some. You know, it's that kind of thing that I think Medicare payment policy is more equipped to handle as opposed to some of the important nuances that Jay was describing.

I think Jon raises a good point. As care even moves out of the OPPS setting, hospital at home, all these innovative things, at some point, IME will have to catch up with that. But I think even just starting with outpatient

is a positive thing.

Then, finally, because of what I just said about the performance pool, if you leave capital alone, there's less kind of access. I would just use it for transition, and I would use it to prevent untoward gaps and impacts on teaching hospital programs.

DR. CROSSON: Paul, on that point?

DR. PAUL GINSBURG: Pat, on this, the capital, initially, under prospective payment, capital was paid on a cost basis. I think it's because they weren't sure how to do it. I guess then when they went to prospective payment, they had to do one for capital. I mean, once they put capital on prospective payment, they did an IME, presumably, because of an argument that having residents means more capital cost.

That's probably valid. I could see looking into it, but I wouldn't just blow it away, which I think you're suggesting and kind of make it a slush fund for other things.

So I'd be very cautious on doing anything other than to make it consistent with operating cost IME in the capital area.

DR. CROSSON: Karen.

DR. DeSALVO: Actually, a quick point about that. I suspect that the utility of it on the ground, the capital, is call rooms and conference rooms and IT necessary to webcast grand rounds, all those things that probably aren't part of a normal hospital's infrastructure. So there's probably some real use to the resource.

Let's see. I think this is a really great step to move in from a sickness model to going upstream, to thinking about how to create a workforce that can understand how to care for patients and populations in a variety of settings and not just in the hospital.

My own experience in training was pretty sickness hospital-based and that we've tried to evolve that over the course of the last 100 years, that it's still really difficult on the front lines to get agreement on having training opportunities in the clinic environment. There are residents running around and it creates a mess. So I really appreciate the idea of giving the hospitals the flexibility, even if it's just a message rather than any major financial shift.

But I want to agree also, though, with Jonathan's

point, which is that what this does is it kind of moves money around in a very hospital-centric model, and there are other places that we want to train residents. He mentioned some of the settings. It might be post-acute care settings. It might be models that are primary care at home. It might be telehealth. It might even be in federally qualified health centers or in non-hospital-affiliated community environments, rural clinics.

And these are real impediments every day to making sure that there is a way to support our partners that want to train residents and they don't fall under our tax ID, so it doesn't necessarily allow that this kind of a shift to support new sites of training. It just may be worth thinking about are there ways to -- instead of a performance-based pool, is there a way to do some piloting of a different model of payment? It was kind of mentioned here, it's definitely mentioned by NAM, but thinking of bringing together DME and IME, as an example, rather than having separate payments. Is there a way to more directly drive the development of certain skills and categories of doctors, based upon leveraging both pools of money but thinking of new ways to combine them, and trying to free

ourselves from this -- sorry, this hospital-centric model, the way that we've been paying for resident training.

And the last point does also relate back to the question I asked earlier and the strategy that was mentioned in the NAM report, which is they are a set of medical education experts and they need to be a part of this development of new workforce that they're going to be responsible for on the front lines. On the other hand, people have equities, other entities like the VA. There are experts at places like HRSA. And so this idea of a council, a DME council.

Again, I know that's beyond the scope, potentially, of MedPAC, but I think as we're considering this I would like for us to just make sure that we're not -- we're asking the Secretary to really think about how to put Medicare IME, DME, any other pilots, demonstrations, performance standards in alignment with other programs. And they could do that in a structured way with some sort of a council, because I wouldn't want us to only use the -- I'd like for our levers to be more strategically aligned with other folks' levers, because the stakes are high.

I do have one more small thing, which is just to say I

do think that Jay -- I don't want to speak ill about medical education. We're all right now, too, being a part of it. But there's a lot that we know in med ed, but there's a lot that we don't know. And I think where Jay is going with some of his value-based care and thinking about quality improvement and other skills that you need on the other side, sometimes there are things around technology, team-based care, social determinants of health, that horizontal view of what we need to train physicians for that probably there would be some benefit add to having stakeholders help define the new workforce skill sets beyond just the current medical education community. Does that make sense?

DR. CROSSON: It does to me.

DR. DeSALVO: Or we can just pitch it all over to med ed. I think that there needs to be a broader array of folks thinking about how to build a future workforce, because it goes beyond, I think, what even the med ed community has currently got in their portfolio of things they're trying to think about. I'm being ginger about this, but I could be a little more direct afterwards if you want.

DR. CROSSON: Karen, just on your first point. When we looked at this in 2010, we did, as part of our proposal, consider more than the hospital outpatient department in terms of training sites should be included in that. In this particular proposal we're sort of going back and starting with the first part, and then I think, Pat, you mentioned, or someone, that at some point later that could be extended. But the concept that you have in mind was, in fact, part of our initial thinking.

MS. BUTO: Does this require legislation? I think it does, doesn't it?

DR. CROSSON: I would imagine so.

MS. BUTO: I think that's another reason to think about eventually linking it up to DGME rather than a standalone, because it really doesn't make sense not to have the two together at some point.

DR. CROSSON: Okay. Bruce.

DR. PYENSON: I think we have a terrific opportunity here because of the data analytics that we've done, and it's interesting for me to hear the history of IME and to read about it, and the history of medical education. I think not only are the formulas we're using old but I think

the narrative probably needs updating. You know, when the narrative that says, well, residents do more procedures and order more labs, that's been around for a while and it sort of sounds kind of counter to what we'd expect of evidence-based medicine and all the investments in electronic medical records and other kinds of things.

But I think through the data that we have we could actually parse out better what those extra costs are, where they're coming from, which cost centers and maybe which revenue centers, maybe also look at the connection to the inpatient Part B side perhaps, to get some insight into that. So I think that one of the benefits of this is it would update the narrative that we have.

DR. CROSSON: Thank you, Bruce. Jaewon.

DR. RYU: Yeah. I'll be brief. I think a lot has been said. I think this makes sense to revisit. It's shocking to me that it hasn't been revisited really meaningfully in quite some time.

I like the concepts of what this is setting out to do. I think the place where I struggle a little bit is it's tough for me to decouple this form the payment adequacy conversation. And I get that, you know, when we have the

annual payment adequacy session we do it in an all-in, all-hospital way. And maybe the impact analysis that Kathy referenced, or the margin question that Amol referenced, I think that will help inform this a little bit.

But it feels like those two lanes converge, for me at least, as far as, you know, this particular proposal and then the payment adequacy discussion that we have. So to the extent that we can tease that out a little bit, through that impact analysis, and just understanding what the implications are I think that would be helpful.

And then to Karen and Jonathan's point, what I like about this is that it does get us out of the inpatient environment and incenting through the actual formulas -- not even incenting but properly reflecting where the cost of education may be, but it still doesn't get us to untethering from, or distethering, whatever the word is --

[Laughter.]

DR. RYU: -- disconnecting from the hospital institution-associated programs. I mean -- and that's why it still feels a little bit like squeezing toothpaste, because the dollars, I think, still land in fundamentally the same kinds of organizations, and it feels like there's

more we might be able to do to actually get into those other sites and other organizations.

DR. CROSSON: Thank you, and Dana, once again you have the last word.

DR. SAFRAN: Okay. I'll be brief. I like the direction that you're going. I like the concepts so would echo a lot of what's been said.

The only two incremental adds I have are, one, as we think about the beginning of including outpatient care, I wonder if we are not going far enough in terms of some of the shifts that others have pointed to in health care since this formula was developed and whether we should be looking at payments related to at least certain specialties for community-based work in order to encourage that work.

So I think the point I want to make there is both let's think broadly but let's also think about where do we want the emphasis to be, in terms of residency training, and how do we use these payments to help get it there.

And then on the performance question, I don't have an easy, good answer to that. I just wanted to suggest that maybe it's helpful to think about what are the areas of performance, both inpatient hospital, outpatient hospital,

and community, that we think are supported by having residents, and then create accountability for those things. In other words, by paying for performance on the things where residents really can be a value-add, do we start to create the right emphasis on the use of residents in the settings where we want to see them?

So that's just a thought that's a different way to think about the performance-based component of this, from what I've heard so far, where it was more like what are the skills we're trying to teach, and are we teaching them, and so forth. You may have already thought of this, probably have, but I wonder whether also conferring with the boards could be helpful here on how they would think about it.

So that's all I have.

DR. CROSSON: Thank you very much, Dana. Yeah, I'm sorry. Marge, I didn't see you.

MS. MARJORIE GINSBURG: Several people have looked at the performance-based issue and are sort of questioning it, and I wanted to actually come right out and say I think we should dump it. I think this whole plan is a really major change, and I think everything we can do to make it as easy as possible for this to get incorporated means that maybe

we ought to try to simplify it somewhat. And I think we can always come back in five years, after this is all in place, everything is perfect, and then add the performance-based measure then. But I think it complicates something that's already pretty big as it is, and I'm just not sure the benefit is worth the risk of adding it.

DR. CROSSON: Okay. I think then we're done. Again, Alison and Jeff, thanks for the presentation. This is work that we're going to be doing over some time, and I think you've given us a great start here.

So we now have time for a public comment session. If there are any of our guests who would like to make a comment please come to the microphone. I will ask you, in a minute, to begin. Please identify who you are and what organization you're affiliated with, although I have a good sense of that already.

[Laughter.]

DR. CROSSON: And I would ask you to keep your remarks to two minutes, and when this light comes back on the two minutes will have expired.

Please proceed.

DR. ORLOWSKI: Thank you and good morning. I'm Dr.

Janice Orlowski. I'm the Chief Health Care Officer at the Association of American Medical Colleges. The AAMC represents medical colleges and teaching hospitals.

Four quick comments. One, we truly appreciate the work and the proposal by the MedPAC staff to keep total IME dollars intact. Number two, we agree that an outpatient IME payment should be studied as more care moves to the ambulatory setting and the complexity in the teaching environment rises, and so we support this.

Number three, we question the statement that Medicare overpays, as both inpatient and outpatient Medicare margins are negative. And we need to keep in mind, as a number of folks have said, that recent studies continue to demonstrate that Medicare patients enjoy a significant mortality benefit when treated at a teaching institute. Any proposal change in the resources need to be carefully studied.

And four, finally, we respectfully ask the MedPAC staff to not only study the IME, but we need to also study the continued issue with the 22-year freeze on the GME slots, so that we look at payment in a holistic manner.

And with that I appreciate very much the opportunity.

DR. CROSSON: Thank you very much for your comments. Seeing no one else at the microphone we are adjourned until October 3rd. Safe travels, everyone. Bye-bye.

[Whereupon, at 11:33 a.m., the Commission was adjourned.]