MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:
FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
PAUL GINSBURG, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD
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DR. CROSSON: I would like to welcome our guests to this October meeting of MedPAC. This morning we are going to return to an issue that the Commission has discussed before which is of great concern and interest to the Nation, and that has to do with the epidemic of opioids, and particularly opioid overdoses and deaths as a consequence to that.

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

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

MS. SUZUKI: Good morning. Today Rachel and I are here to provide you with information on opioid use in Part D. This work is in response to Commissioner interest and updates our earlier work from a few years ago looking at opioid use and polypharmacy. The session is intended as informational, but we are interested in hearing from Commissioners about future direction for work on this
We'll start the presentation with background information that provides context about use of opioids by Medicare beneficiaries. We'll present updated data on the patterns of opioid use in Part D. And we'll conclude by describing steps CMS and plan sponsors are taking to monitor opioid use and manage overuse and misuse.

Opioids such as hydrocodone and oxycodone are commonly prescribed for both acute and chronic pain, but they can also bring serious harm when misused. Here's a quick summary of the context in which opioids have become commonly prescribed to Medicare beneficiaries. Use of opioids to treat non-cancer pain became widespread during the 1990s. A couple of things appear to have contributed to this change. First, new extended-release formulations were approved in the 90s, and some manufacturers began to aggressively market them as being less prone to misuse. There was also a growing sense that pain treatment was inadequate, and support for using opioids for chronic pain grew among clinicians. But clinical guidelines around opioid use were unclear, and clinicians faced ambiguity about what constituted safe prescribing.
Increase in the use of opioids for chronic pain coincided with a very concerning nationwide increase in opioid overdose deaths. CDC reported that in 2016, there were over 40,000 deaths due to opioid overdose, and at least 17,000 were from prescription opioids. The benefits and risks of opioids are especially apparent in the Medicare population because of higher illness burdens which may make them more likely to experience pain. But side effects of opioids can interfere with other treatments. In addition, because the elderly patients are more likely to have reduced kidney and liver functions, there is higher risk of toxicity and harm, even with a lower dosage. Multiple government reports by OIG and GAO have found evidence of potential opioid overuse, misuse, and fraud and abuse in Part D.

To address the ambiguity around safe prescribing of opioids, in 2016 CDC came out with a guideline for prescribing opioids for chronic pain. The guideline states that non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred. It also noted that long-term opioid use often begins with treatment for acute pain and, therefore, CDC recommended that when opioids are used for
1 acute pain, clinicians should prescribe the lowest
effective dosage for the shortest duration needed --
typically three days or less and rarely more than seven
days.

However, the guideline does not preclude the use
of opioids for patients with chronic pain. If a clinician
determines that benefits outweigh risks of harm, the
guideline recommends using the lowest effective dosage and
carefully reassessing benefits and risks when increasing
dosages. The CDC guideline generally discourages
clinicians from increasing dosages and urges them to use
additional caution when initiating opioids for patients age
65 and older.

The chart on the left shows the trend in opioid
use per 1,000 -- on the top -- compared with the use of
non-opioid analgesics per 1,000 -- shown at the bottom --
for 2007 through 2016. The top line shows that the use of
opioids per 1,000 peaked around 2010 to 2012 and then
decreased by about 18 percent between 2012 and 2016.
During the same period, the use of non-opioid analgesics
per 1,000 remained pretty much unchanged. While the
decline is good news, opioid use in Part D continues to be
widespread, with nearly one-third of enrollees filling at least one opioid prescription in a given year. Most opioid use was unrelated to cancer or hospice care. And in 2016, gross spending on opioids totaled $4.1 billion, putting them among the therapeutic classes with the highest spending in Part D.

There is, however, growing recognition that opioid use varies widely. Some patients need only a few days' supply for post-surgery pain while others need monthly fills for intractable pain. This figure depicts the variation in use among opioid users in 2012, around the time we saw peak use of opioids in Part D. The vertical axis shows the variation in the average MME per day, and the horizontal axis measures the number of days' supply. Among beneficiaries in stand-alone PDPs with at least one opioid prescription in 2012, about 78 percent had an average daily dose of 50 MME or less. A cluster in the upper left shows beneficiaries with low-intensity use -- those with 50 MME per day or less and treatment lasting three months or less. About 40 percent had low-intensity use.

In the lower right corner are high-intensity
users -- those with a higher average dose, and treatment lasting more than three months. About 17 percent had high-intensity use. This variation in intensity of use is important in understanding opioid-related adverse drug events, or ADEs, which we will turn to next.

This chart shows the incidence of opioid-related ADEs among those who used opioids in 2012. We looked at a very narrow definition of opioid-related ADEs and included only diagnosis codes specifying poisoning by opioid in inpatient and outpatient claims, including emergency department visits that resulted in inpatient stays. Overall incidence of opioid-related ADEs was 0.6 percent, or six ADEs per 1,000 opioid users. But as you can see by the blue and gray bars, high-intensity users, shown in gray, had a much higher rate of ADEs -- nearly seven times that of low-intensity users. Certain demographic and clinical characteristics appeared to be associated with the risk of experiencing opioid-related ADEs. We show some of them here on the chart, for example, being under age 65, receiving Part D's low-income subsidy, taking more drugs, and obtaining opioids from multiple prescribers. But as you can see across all of the subgroups, high-intensity use
of opioids is consistently associated with a higher incidence of opioid-related ADEs. For example, among opioid users with ten or more unique drugs, incidence of ADEs among high-intensity users was more than six times that of low-intensity users.

DR. SCHMIDT: ADEs related to opioid use are evidence of actual harm that has occurred. But, in addition, we've seen patterns in Part D data that suggest much broader potential for harm. The key reason is polypharmacy -- when beneficiaries use multiple drugs. Medicines can interact with opioids and magnify effects such as respiratory depression. We looked at Part D enrollees who filled at least one opioid prescription in 2015, excluding those in hospice or being treated for cancer. On average, those beneficiaries used nearly six opioid prescriptions during the year. When we compared them to enrollees who had no opioid prescriptions, on average those with opioids filled more prescriptions for all drugs -- an average of 70 compared to 40 -- and used drugs from ten different therapeutic classes, compared with five. Also, 45 percent of enrollees with opioid prescriptions also filled prescriptions for benzodiazepines.
or gabapentin -- drugs that, when used concurrently,
increase the risk of opioid-related death. When we ranked
the Part D enrollees by opioid spending and looked at the
top 5 percent, they filled on average 22 opioid
prescriptions during the year with average opioid spending
of over $3,700; 75 percent of those top enrollees were also
filling concurrent prescriptions for benzodiazepines or
gabapentin. These patterns are concerning signs of
potential harm to beneficiaries.

In 2013, CMS added new requirements for Part D
plan sponsors around managing opioid overuse. Sponsors had
to review claims to identify enrollees who were at high
risk of opioid abuse or misuse, monitor for high cumulative
dosages across all a patient's prescriptions, and plans
could use safety edits or notifications to pharmacists to
check with the patient's prescriber.

Also in 2013, CMS started its Overutilization
Monitoring System to monitor whether plan sponsors were
complying with opioid policy. The OMS uses claims to
identify patients who seem to be exhibiting "shopping
behavior" by having many providers. It also gives plans
opportunities to provide information to prescribers that
could help to coordinate patient care. Each quarter, the OMS notifies plan sponsors about their enrollees who look like they could be at high risk. The sponsor has 30 days to reach out to prescribers to make sure they're aware the patient sought opioids from several providers, check whether the dosage was intended, and then report back to CMS.

Beginning in 2019, plan sponsors will have new authority to limit certain at-risk beneficiaries' access to frequently abused drugs, which I'll describe more in a minute. CMS also monitors opioid use through quality measures and patient safety reports to plan sponsors.

Shinobu showed you earlier that there are different patterns of opioid use, so a one-size-fits-all approach to managing opioid prescriptions is not appropriate. For 2019, CMS suggests that plan sponsors use a tailored approach. For patients newly prescribed an opioid, after surgery, for example, plans must limit the quantity dispensed to no more than a seven-day supply. For enrollees that are at high risk of abusing opioids, plans will have authority to limit access through a drug management program, but must follow a process that I'll
tell you about on the next slide. That process is integrated with the OMS. For other beneficiaries who are chronic users of opioids but whom the plan has not found to be at risk, CMS expects plan sponsors to notify the pharmacist to do a safety check with the prescriber when the enrollee's cumulative dosage reaches 90 MME or more. CMS permits plans to put limits on prescription fills at cumulative dosages of 200 MME or higher. CMS also expects plan sponsors to alert the pharmacist when an enrollee has duplicative opioid prescriptions or takes certain other drugs concurrently like benzodiazepines.

Beginning in 2019, plans may set up drug management programs to manage benefits of enrollees who the plan finds to be at risk of abusing certain drugs like opioids. The plan has to use clinical criteria for defining who is potentially at risk and then review past claims. Beneficiaries in hospice, long-term care, or being treated for cancer are exempt. The plan must conduct case management, that is, reach out to prescribers to see if there are clinical factors that warrant the cumulative dosage. There's a formal notification process to the beneficiary and prescribers, and the enrollee can appeal if
the plan finds that they are at risk. After these steps, the plan sponsor may use a pharmacy lock-in or require the beneficiary to use one or a few designated pharmacies to fill their opioid prescriptions. Plans may also put restrictions on the beneficiary's fills or lock them into seeking prescriptions from one or a few prescribers, but only after several documented attempts to reach the prescribers and agreement from at least one of them. Plan sponsors must review whether the clinical criteria continue to apply to the beneficiary and end their at-risk status if the criteria no longer apply. Normally, enrollees who receive Part D's low-income subsidy may change plans once per quarter in 2019. However, if an LIS enrollee's plan finds them to be at risk, then the beneficiary may not use their quarterly special enrollment period.

CMS also has a separate effort that focuses on providers. Under contract with CMS, the national benefit integrity Medicare drug integrity contractor, or MEDIC, analyzes prescription data and conducts investigations to identify providers who may be committing fraud and abuse. For example, the MEDIC might see a pattern of claims that suggests a provider may be prescribing opioids
inappropriately or operating a pill mill. The contractor may review medical records, conduct site visits and background checks, and interview beneficiaries to investigate cases. If warranted, the MEDIC may refer the case to CMS, plan sponsors, and law enforcement. The HHS Office of Inspector General says that the MEDIC contractor has identified thousands of leads in recent years, but the OIG couldn't evaluate the effectiveness of the MEDIC because they don't know what actions plan sponsors took based on those leads.

Another approach CMS will use beginning in 2019 is to place certain prescribers on a preclusion list -- meaning the prescriber has been revoked from Medicare for engaging in behavior that is detrimental to the best interests of the Medicare program. Part D plan sponsors must reject pharmacy claims written by prescribers who are on the preclusion list.

In summary, our analysis of claims suggests that prescription opioid use continues to be widespread among Part D enrollees. Prescription patterns raise concerns about broad risk to enrollees associated with polypharmacy and high use of opioids. CMS has required Part D plan
sponsors to take steps to manage opioid use for the past five years, and in 2019, sponsors will have new authority to restrict access to frequently abused drugs like opioids for certain at-risk beneficiaries.

And now we're happy to take your questions.

DR. CROSSON: Thank you, Shinobu and Rachel.

Very nice context and level setting presentation.

For this presentation we are going to have one round only, which would include questions and brief comments, starting with Jonathan.

DR. JAFFERY: Thank you for that summary. So, clearly, there has been a lot of attention on the behalf of prescribers in terms of being concerned about past and current behavior about overprescribing. But I think we're hearing -- or at least I am hearing lots of anecdotes about people who may be appropriate for opioids now not getting them, particularly folks with cancer and in hospice. And so any analysis about trends in prescribing patterns for those groups?

MS. SUZUKI: Our analysis has focused on non-cancer, non-hospice care patients. But when we look at the overall use, the share -- well, first of all, cancer and
hospice patients are excluded from these management tools that plans are using, and we don't see any drop necessarily for cancer and hospice patients using opioids. We haven't looked closely at the quantity, but I think, in general, people seem to be getting their drug based on trends.

DR. SCHMIDT: To answer directly, we haven't looked at specific diagnoses like sickle cell anemia or spinal cord injuries or things like that where you'd expect intractable pain and maybe opioid long-term use has been used and might be more appropriate.

I think CMS recognizes that there are those patients out there, and that's why they're arguing for a more tailored sort of approach. And we can get into this more a bit later perhaps, but looking at formularies and Part D plans, it looks as though the high-dosage, extended-release kinds of formulations are not showing up on plans - not a lot of plans are covering those directly. So some of those patients may need to seek out exceptions to get coverage for those. There are some stand-alone drug plans having that, but not a whole lot.

DR. CROSSON: Jaewon.

DR. RYU: Yeah. I had a question on Figure 2.
It shows that the prescriptions per thousand for opiates has been decreasing over the last -- I don't know -- five years or so, but elsewhere you mention that the death rate for beneficiaries from opiate overdose has climbed and in fact increased fastest among all age groups. Any insight into how that disconnect kind of reconciles?

DR. SCHMIDT: Well, I think it just maybe speaks to the magnitude of -- or the degree to which they are being prescribed in this population now and have been. So even though maybe it's cut back some, it's still one in three. It's still a lot of people, and so, again, with the risk of polypharmacy interactions with other things that folks are taking, there's still quite a risk out there.

DR. RYU: Yeah. It just seems like the decrease in utilization rate would correlate with the decrease in death rate, but I just thought that was kind of bizarre. The other question was around any insight into what the precipitating event is. So you remove cancer; you remove hospice. But are these in a postoperative? Are these ER visits that create that first encounter with opiates that then triggers the downstream utilization? Do
we have any kind of evaluation or information on that front?

MS. SUZUKI: So we have not looked specifically into the triggering event.

We have looked at diagnosis codes for people who do use opioids in the Part D program. A lot of them seem to have psychiatric conditions. Some of the high users, over half of them, reported some sort of psychiatrist conditions, like depression and bipolar.

There are rheumatoid arthritis-type conditions that are higher. You'll see more prevalence among the opioid users compared to non-users.

I think there is some neurological conditions that also show up more among the users compared to non-users.

DR. CROSSON: Yes. Dana.

DR. SAFRAN: Thanks. This is really interesting and I'm timely work.

I had two questions. One is on page 9, and I think you have the figure. I guess it is Figure 1 in the report. I think you had it in your slides too, where you have the different quadrants low-intensity use. Yeah,
that.

So what was striking to me about this figure was, at the very top, the high percentage of beneficiaries who even while on a lower average daily Medicaid are on that for a long time. I just wonder what we know about that issue because we sort of call out high-intensity users, and we're sort of focused there. But my eye gets caught by that, being on a low dose for a long time. Who are they, and what do we know about their outcomes? So I just wanted to ask about that.

Then I will just throw out my second question and listen to your response.

My second question is whether we are able to, with the data we have or whether we know of others, maybe academics or elsewhere, who are doing modeling to help us. We should be able to use data to get a pretty good predictive sense of who are the people who are most at risk. What are the factors that really put somebody are risk, beyond some of the things we're talking about here? That could really be used to guide prescribers.

So I'm just curious whether, A, we think we have data like that, that we could do some of that advanced
analytics to do predictive modeling or do we know of folks
who are doing it. It seems important.

DR. CROSSON: Dana, just to be clear, on your
first point, you're talking about the northeast corner of
the slide there; is that right?

DR. SAFRAN: No. I'm talking about sort of the
north middle west, the dark part where it's a sizable
percentage, over 1.61 percent of overall opioid users who
are on zero to 20 Medicaid, but for at least half a year.

DR. CROSSON: I see, okay. All right. Not the
long-term users in terms of nearly a year.

DR. SAFRAN: No.

DR. CROSSON: But somewhere in the middle there.

DR. SAFRAN: Yeah, yeah.

DR. CROSSON: Okay, thanks.

Sorry. Go ahead.

MS. SUZUKI: So on your first question about the
low-dose, long-term users, we don't have a demographics for
that cell separately from the others, but I think in
general, low intensity -- opioid users tend to be under 65,
low-income subsidy, disabled, have more conditions than
other populations. They may be in one of the conditions
where you require chronic pain treatment rather than short-term acute pain. But we don't know for sure whether that's the right demographic.

DR. SCHMIDT: And on your second question, in the course of putting together some research on this and been approached by private-sector consultants who have the sort of analytic skills that you're speaking to, they're doing predictive modeling now for all kinds of providers to try and help with prescribing behavior or kind of guide the inpatient-to-outpatient transition better.

And they're looking at things like past dependent substance abuse, socioeconomic status, disability, those kinds of factors.

But, in addition, for the Medicare population, again, let's look at polypharmacy concerns because of the older body's inability to clear meds as quickly as someone younger.

DR. CROSSON: All right. Thank you.

So I had Brian, Amy, and Kathy; is that right?

Okay. Brian.

DR. DeBUSK: First of all, thank you for a really well-written chapter. It is sort of thought provoking and
alarming.

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

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

DR. DeBUSK: This is truly uncharted territory.

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

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

[Laughter.]

DR. PERLIN: Exactly.

DR. CROSSON: Well, cocaine as well.

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

But the other question I had is, Are there some more radical ideas that maybe we could explore that you've
explored that maybe didn't make it into the chapter, even
more restrictive or more radical ideas on how we could
address the crisis?

DR. SCHMIDT: Well, I think this is a situation
where there's a balance to be had. There are patients who
maybe have been receiving opioids for a long time. They
have a high tolerance. Maybe they have physical and
psychological dependence, and so to do something dramatic
could have some serious consequences on their health.

At the same time, you don't want too much
prescribing going on because there's potential for abuse
and overdose and diversion, those sorts of factors.

So this is a difficult path to walk to make sure
you're allowing high dosages out there where it might be
important, but trying to pull back generally where it's
causing public harm.

DR. DeBUSK: Again, thank you for that, but when
I read the chapter, I guess my clarifying question would
be, What we saw in the meeting materials, was that sort of
the middle of the road of the policy options, where maybe
you clipped some of the higher or the more radical ideas,
or have we inventoried those? I mean, do we have a pretty
good feel for what those ideas would be?

DR. MATHEWS: If I could take a stab at that Brian. I think that the material that we've presented here is largely informational. We're looking at trends. We're looking at some of the actions that CMS has taken to monitor and provide appropriate feedback to prescribers and provide information to pharmacies that again might be conveyed to prescribers. But we are not talking Commission policy at this point.

If you have ideas you'd want us to pursue, by all means, you're free to articulate those, but this is a largely informational discussion.

DR. CROSSON: Amy.

MS. BRICKER: Thanks for the chapter and something that I'm personally very, very passionate about. A couple questions. Do we know how many high opioid utilizers age into the Medicare program each year?

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

MS. BRICKER: So, likely, without knowing, I'm just going to take a guess. Because the system has grossly failed this population on the commercial sector, this program isn't inheriting, I think, this burden, and it is
incumbent upon us to begin to solve it and address it in a real way. So I'll hold that one on some ideas there.

The preclusion list that you noted for '19 and then the requirement of pharmacy claim to be rejected, are those prescribers still being reimbursed by Medicare for their physician services, for getting paid for the office visit, even though they're on this list as a bad actor? Do you know?

DR. SCHMIDT: I need to verify this answer, but my sense is no. I think that they are on the reenrollment bar for Medicare, so I think at this point, no.

MS. BRICKER: Okay. So they have been excluded from the Medicare program entirely, this 800 physicians. So I don't know if this is common knowledge, but 120 Vicodin costs $25. So to reject a claim at pharmacy just means that we lost track of it. It doesn't mean that the patient walked away without it. So I just want to emphasize that.

It's incumbent upon, I believe, us to begin to either -- I believe through a stick, not a carrot, to begin to change the rhetoric around this topic. There's such a stigma around addiction, and what struck me as -- in the
chapter we are going to talk about later today around
psychiatric services, the very small percent of Medicare
beneficiaries that are seeking addiction treatment, it's
tiny.

One in three are getting an opioid prescription, and yes, I know not a third of the population is addicted
to opioids. But it's a very high number in this population, and yet they are not seeking treatment. Why
aren't they seeking treatment?

We have got to take this as a public service announcement. "Wear your seat belt," that worked. We've
got to take this on I think in a more bold way and to pull out those prescribers, those that are continuing to -- this
is a revenue stream. Once you understand who will prescribe for you, that becomes something that the
communities rely on, and it's really hard for physicians to walk that back. So I would encourage us to do more.

I know that we're going to talk about this in the next section also, and Jon Perlin sits on the National
Academy of Medicine. There are many, many groups that are studying this, and so I think we should learn from those
and take what's working and then expand upon that. But
there's just really not enough that we could do here. We are not the only country in pain, and yet it's a disproportionate amount of opioid prescriptions that are dispensed and utilized in this country. And so we've got to figure out how to begin to do the right thing for these beneficiaries.

We are at an alarming rate. Seeing them age into this population would be my guess. So I would just urge us to be bold here.

DR. CROSSON: Thank you.

Amy. We've got Kathy and Warner and Sue.

MS. BUTO: You may have covered this, but I was wondering if we can differentiate beneficiaries of both the high- and low-intensity users by MAPD and PDP, both in terms of enrollment. So do we see a disproportionate in enrollment and say the PDP versus the MAPD and their utilization? So can we make that distinction?

MS. SUZUKI: So for those 2012 analysis, this was part of an adverse drug event analysis, so we had to limit the analysis to PDP enrollees, so we have claims for the A/B service. So this is all PDPs.

But in terms of MAPDs versus PDPs, the
utilization generally is not terribly different. Both
users on average took about five to six opioid
prescriptions. They also had about the same mean number of
days supplied per prescription.

Maybe there is a slightly smaller share of MAPD enrollees who had the very high use, like the top 5 percent, but in general, they were very similar.

DR. SCHMIDT: But among all opioid prescriptions,
there are more in PDPs, more of those enrollees taking opioids are in PDPs, because it's correlated with LIS status, disability, those sorts of things.

MS. BUTO: I also wondered if it was correlated with inpatient versus outpatient, fewer opioid prescriptions that we can, I guess, identify that are bundled into the DRG on discharge.

Anyway, we can come back to that later.

DR. CROSSON: Okay. So I have Warner, Sue, and Bruce.

Just to be clear, we're going to have time for additional input after the next presentation as well.

Warner.

MR. THOMAS: I'll be real quick. Have we looked
at the usage on beneficiaries that are over 65 versus
beneficiaries that are disabled? Do we make a distinction
there, or do we see any differences in the utilization?

MS. SUZUKI: So we haven't done that specific
analysis, but we do see that under-65 population is over
represented in the highest use group. So that's the one
where we saw an average 22 prescriptions per year compared
with 5 to 6 per year for the rest of the population.

MR. THOMAS: And is that a significant enough
population to skew all the numbers or not?

MS. SUZUKI: I'll have to go back and look.

I know that LIS, which also has high share that's
disabled, they accounted for about two-thirds, roughly, of
the population that was in the highest use group.

MR. THOMAS: Just a last comment, and it really
kind of speaks to the language.

I would just encourage us, going to Amy's point,
to have more stronger language, more urgency in the chapter
around the importance of this issue. I know there's a more
informational chapter, but I just think continuing to raise
the awareness, I just don't think we're doing enough. So I
would hope that we could build that into this chapter going
forward.

DR. CROSSON: Sue.

MS. THOMPSON: And I'll be quick. I really want to underscore what Warner just said and in support of Amy's comments.

I remember the days of when accrediting bodies, reviewers were critical of providers and are skimping in adequately managing pain, and a movement towards pain is what the patients says it is and how we through that narrative were able to, I mean, move 180 degrees in terms of the liberal use of this drug or these drugs.

So my question becomes, Does it become a matter of a new narrative around moving back to some center place? Because, certainly, pain is real, but what's the middle ground? The power of that narrative surely shifted us.

I am very curious about what education are we assuring that our providers have around pay management. What's that minimum understanding?

With that, I just want to underscore a strong narrative here because it certainly worked in the opposite direction.

DR. CROSSON: I think it's a good point, Sue, and
I remember that too. We had this in California, but in other parts of the country where physicians were being sued not for malpractice, but for elder abuse, which, of course, in most jurisdictions was not covered by malpractice insurance. That was one of the precipitating events that you described, which brought about, on the part of physicians, I think the notion that they were at risk if they did not liberally, more liberally anyway, provide opioids.

I think in part -- not in total, but in part contributed to where we are right now. And I think as a consequence of where we are now, I think policies need to be directed in a balanced way to stop this epidemic, but also not deprive individuals who legitimately need pain relief from those services.

Bruce.

DR. PYENSON: Thank you very much for a lot of great information.

My question is, Do you have any insight or data on how formulary design in Part D might influence or either attract the selection of members or prescribing patterns in particular with brand, higher-intensity opioids versus
other opioids?

DR. SCHMIDT: Well, as I alluded to earlier, we haven't done a look over time at formularies, but I've been spending some quality time with the plan finder over the past few days. Since then, new information has just come up for 2019 plans.

At least for looking at branded, extended-release, high-dosage OxyContin, for example, there's a handful of PDPs that have that on formulary, and most MAPDs do not appear to have it on formulary.

All of the plans seem to have low-dosage or immediate-release formulations of opioids.

So there may be some strategy there to simply not cover the higher-dosage and extended-release versions of drugs, which means that people who have been taking those will probably need to seek exceptions to their prescriber and the plan.

DR. CROSSON: Okay. Again, thank you, Rachel and Shinobu, for an excellent context chapter.

We will now move on to the second presentation for this morning, which is on a similar topic and will introduce us to some mandated work by Congress.
DR. CROSSON: Okay. So Jennifer is going to take us through this set of questions, including a congressional mandate, which asks whether certain Medicare payment systems may be influencing the overuse of opioids. Jennifer?

MS. PODULKA: Thank you.

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

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

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

Second, the identification of incentives and
adverse incentives under the hospital inpatient and
outpatient prospective payment systems for prescribing
opioid and non-opioid treatments, and recommendations as
the Commission deems appropriate for addressing these;
And, third, a description of how opioid use is
tracked and monitored through Medicare claims data and
other mechanisms and the identification of any areas in
which further data and methods are needed for improving
understanding of opioid use.

On the first item, Medicare uses bundled payments
to pay for pain management drugs and other goods and
services in both the inpatient and outpatient settings.
They're applied somewhat differently in the two settings.
The inpatient prospective payment system, or IPPS, assigns
days to categories depending on patients' conditions and
sets payment bundles that reflect the average cost of
providing all goods and services, including drugs that are
supplied during the stay.
The outpatient prospective payment system groups
services into categories on the basis of clinical and cost
similarity and sets payment bundles to cover the costs of
providing directly related and integral goods and services
along with the primary service.

Additional goods and services are either paid separately or not paid by the outpatient prospective payment system. And you may remember in prior reports and presentation we have described situations where outpatient drugs are usually self-administered or separately payable or paid on pass-through status, but none of these rules apply to pain drugs in the outpatient hospital setting.

So, to sum up, the IPPS payment is fairly straightforward, but the OPPS payment is not, so we'll dig into that one.

Pain drugs in the outpatient setting may be paid under Part B or Part D or not paid by Medicare at all. Determining which is a bit tricky, so we'll walk through this flow chart.

The first question shown in the top left diamond starts with: Is the drug for pain? Drugs that are not are outside the scope of our study today. If the answer to the first question is yes, we move along the top to the diamond shape that asks the second question: Is the drug directly related and integral to a procedure or treatment and required to be provided to a patient in order for a
hospital to perform the procedure or treatment? CMS has affirmed in multiple rules that post-surgical pain management drugs are directly related and integral. So following the yes across the top to the box that indicates that in these situations pain drugs are paid under Part B as part of the OPPS bundled payment.

But pain drugs can be used in outpatient settings for other reasons. Rather than being directly related to a procedure or treatment, pain drugs can be the treatment all by themselves, for example, when a patient goes to the ED with an injury and pain. In these cases, Part D doesn't pay for the drug, and the hospital usually charges the patient. If the beneficiary has a Part D drug plan, the plan might pay for the drug if it is included in the plan's formulary and the hospital's pharmacy participates with the plan. But many don't.

And one last note before moving on. CMS' guidance about determining how drugs are paid for in outpatient hospital settings is directed to the MACs, or Medicare administrative contractors. In practice, this means that implementation of these rules is up to the discretion of the individual MACs, so there may be
variation across geographic regions.

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

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

To better understand the extent to which there might be a financial incentive that influences opioid prescribing, we have begun an analysis of the difference in prices between opioid and non-opioid drugs commonly used in the inpatient and outpatient hospital settings. And I'll
note that we are also looking into options about non-drug alternatives.

This analysis, however, has a key caveat. We do not know the actual prices that hospitals paid for these drugs as hospitals do not report their drug acquisition costs. Average sales prices, which are weighted averages of manufacturers' sales prices for a drug for all purchasers net of price adjustments, are not available to us for many of the opioid and non-opioid drugs in our study. In lieu of these, we will attempt to examine list prices that may be publicly available, such as wholesale acquisition cost and average wholesale price.

We acknowledge that if we use these prices, they will represent an upper bound, but the relative differences between the two categories of drugs should be informative. And we plan to present on this topic at a second meeting and hope to have results from the analysis to share with you to inform your discussion.

On the third item from the mandate, as you just heard in detail in Shinobu and Rachel's presentation, CMS tracks opioid use through data available in the Part D program. To briefly review, CMS monitors opioid use in
Part D in multiple ways, and there are three categories that might be most relevant to Parts A and B.

First, the Overutilization Monitoring System shares feedback securely with Part D plan sponsors and ensures that they implement opioid overutilization policies effectively.

Second, CMS uses quality measures to track trends in opioid overuse across the Medicare Part D program and drive performance improvement among plan sponsors. These include publicly available display measures and confidential patient safety reports that are sent to plan sponsors.

And, third, CMS makes data on clinicians' opioid prescribing patterns publicly available on the website through the Medicare Part D opioid prescribing mapping tool that shows comparisons at various geographic levels.

All three efforts rely on prescription drug event, or PDE, data, which are a summary record that prescription drug plan sponsors must submit every time an enrollee fills a prescription under Medicare Part D. The PDE data are not the same as individual drug claim transactions, but are summary extracts using CMS-defined
standard fields. The distinction is important, and I'll come back to it in a bit.

And, finally, the agency does not operate opioid tracking programs in Part A and Part B.

So this brings us to the question: Given concerns about the opioid crisis, should CMS track opioid use in hospital inpatient and outpatient settings? And if yes, what lessons learned from CMS' tracking of opioid use in Part D should be applied to similar efforts in Part A and Part B?

Reasons for undertaking a tracking program include the severity of the opioid epidemic, the gap in knowledge about the degree to which Medicare beneficiaries are exposed to opioids while in the hospital, and the opportunity for program oversight of hospitals' use of opioids versus non-opioids.

On the pro side, I'll note that CDC's recommendation to limit opioids for acute pain to three days or less clearly has implications for opioid use in the inpatient setting where the average length of stay for Medicare fee-for-service beneficiaries in 2016 was four and a half days. The recommendation may also play a role in
1 the outpatient setting given that patients may begin an
2 opioid course during their outpatient visit and then
3 complete the course at home.

Balanced against these reasons for tracking in A
5 and B are the current lack of claims and other data
6 infrastructure to support a tracking program and questions
7 about how to interpret the appropriateness of opioid
8 prescriptions identified by a tracking program.

If Medicare were to undertake an opioid
10 monitoring program in Parts A and B, there are structural
11 differences from the Part D program that would require
12 adaptation of current tracking efforts. In Part D,
13 Medicare relies on plan sponsors to report PDE data
14 summarizing the claims and to use the analytic results
15 along with their own data to implement drug management
16 programs. On the Parts A and B side, there are no
17 equivalent entities to fill this role.

Next, Parts A and B claims mostly do not include
19 compliance information on pain management drugs. CMS could
20 take steps to require hospitals to include the information
21 on claims, and then some entity, such as MACs or another
22 contractor, would need to extract the opioid data from the
Claims for analysis. Alternatively, prescribing clinicians or hospitals could be required to report summary information—similar to the PDE data—about pain management drugs. Another key difference from Part D is that once any Parts A and B opioid use data are analyzed, policymakers would need to determine to whom and how the results should be communicated. Are hospitals, individual prescribing physicians, or both the right recipients? In Part D, plan sponsors fill this feedback role and are expected to educate and communicate with prescribers about plan policies. Policymakers would need to determine what entity in Parts A and B should communicate analytic results and what, if any, additional steps beyond communication and education should be taken.

So there are undoubtedly additional issues to work through, but I'll stop there for now, and please let me know if you have any questions on the material in either the paper or presentation; also, if there are additional items that you would like us to explore before we revisit this study at the January meeting; and a reminder that the final product here will be a chapter in our upcoming March
Thank you.

DR. CROSSON: Thank you, Jennifer. Very nice. We'll have clarifying questions. I see Pat, Brian. We'll move down this way.

MS. WANG: Thank you so much for this report, which dovetails nicely with the presentation that we just heard.

On Slide 3, when you outline the three items and the work plan that you have, which is very well thought out, in Item 2, incentives for prescribing opioids and non-opioid alternatives, are you considering including or is it part of the scope of work to examine the adequacy or feasibility of Medicare payment for non-opioid pain treatments, alternative therapies, whether it be acupuncture or biofeedback or some of the other things that people are trying to substitute for opioid utilization? You know, I think it might be -- I don't know how developed that field of alternative pain management is, but to the extent that it exists, I would just suggest it to be included in the analysis of payment systems and, you know, whether there are treatments that could be available that
are not adequately paid for now by Medicare.

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

MS. PODULKA: We can check on both of those. We have had some initial discussions about some of the additional replacements such as acupuncture, so we can include some discussion. We are probably lacking some data sources, if we are talking about payment or cost for
1 providing these services.
2 And then there could be mechanisms for comparing
3 Part D scripts filled for opioids and tracking
4 longitudinally back for those beneficiaries. I don't know
5 that we're going to have the scope for this study, but it's
6 something that you might want to consider for CMS' scope in
7 the future.
8
9 DR. MATHEWS: Yeah, Pat, I would concur with
10 Jennifer's answer there. What we're trying to do is
11 balance, you know, the scope that we could potentially do
12 with the timeline that we've been asked to report out on.
13 So just in order to get through the work and be responsive
14 to the mandate, our initial take is to scope the work
15 fairly narrowly. But as Jennifer said, as resources
16 permit, we would be happy to explore these other potential
17 issues that you want to put on the table.
18
19 DR. CROSSON: Yes, I was going to ask the same
20 question. This is a summary of the mandate here, but it's
21 how Medicare pays for opioids and non-opioid alternatives.
22 The question I think on the table is: Does that include
23 how Medicare doesn't pay for the alternatives? And that's
24 kind of the boundary you're talking about.
DR. MATHEWS: Right.

DR. CROSSON: Okay. Brian.

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

MS. PODULKA: I had not a considered hospital-acquired conditions program. We have had internal discussions and we have spoken with CMS about, you know, how quickly or how readily could these data be collected and analyzed. The short answer is it's not overnight. There's nothing immediately available that comes to mind for us or the CMS group that was tremendously helpful in discussing this with us. So if we were or if CMS were to begin collecting the data, there is some ramp-up time to get that set up.
DR. DeBUSK: Consensually, wouldn't an opioid addiction originating from a surgery be a hospital-acquired condition?

MS. PODULKA: Yes.

DR. CROSSON: Okay. Amy and Paul, and then we'll come over here.

MS. BRICKER: You made the point about the CDC recommendation on three days and how an average inpatient stay is four and a half days, and that was a complexity or a consideration. I actually found that to be a good thing. So the patient, if we were to recommend or to encourage hospitals to maintain that three days, they still have a day and a half with the patient, or more, to help them manage, you know, their pain in a different way versus exiting them and saying, "Go take a Tylenol."

So I think it actually might be an opportunity, but I wanted to understand if I'm missing something there.

MS. PODULKA: No, not at all. I think you're raising a very good point. And we're not suggesting that we tip into not using opioids within the inpatient. I personally would think if there's a time to get opioids, it's in the hospital following a major surgery when the
nursing staff is there to supervise and check on you and make sure you don't go into respiratory depression. It's that there's this question of, you know, might the first introduction to opioids happen not with your community physician and your community pharmacy, but might it have started within the hospital, either inpatient or outpatient? And we don't have the data to have eyes on that necessarily right now.

MS. BRICKER: Okay.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: Jennifer, on page 17, what you sent out, you're talking about the situations where patients are prescribed both opioids and drugs which are dangerous when taken in conjunction with opioids. Is there any information about the degree to which these situations are coming from the same doctor or from different doctors and it's more of a -- is it more of a coordination issue or more of a physician issue?

MS. PODULKA: With the gabapentin and benzodiazepines, that's something I will have to check on and get back to you.

DR. PYENSON: Okay.
DR. CROSSON: Kathy.

MS. BUTO: I just wanted to go back to Pat's point and make sure I understand. Are you saying that there isn't a way to track Part D opioid prescriptions back to a discharge, hospital discharge? It just strikes me that's an important link that we ought to be able to make. Did you say that, or did I just mishear it that way?

MS. PODULKA: Right now, the data don't necessarily -- one could do a study and track back and say there is a Part D script filled at a retail community pharmacy and look back and say that beneficiary was recently discharged from the hospital.

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

MS. PODULKA: Right.

MS. BUTO: And so we also don't know what proportion of the issue arises from a hospital discharge versus in community Part D prescription, if I'm hearing you correctly --

MS. PODULKA: Correct.

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

Thank you.

DR. CROSSON: Questions?
Jonathan.

DR. JAFFERY: So this may actually relate a little bit to Paul's question or inform that, but you mentioned a couple times in the report and in today's presentation around track, prescribing, prescriptions and patterns at the hospital level or perhaps at the prescribing physician level. I just wonder, thinking about inpatient care, which spans days, you have different physicians who cover, and the prescribing physician -- quote/unquote, "prescribing physician" may not always be the person who prescribed.

So I don't know if you have any thoughts or concerns about that or how you would manage that or if maybe that pushes you towards thinking about it at the hospital level rather than at that prescribing physician level.

MS. PODULKA: We had thoughts and discussions, and hence, we raised it as a question.

I don't have a solution. I can certainly envision that there's a management team in many inpatient settings where there's an anesthesiologist and other
physicians who are managing the drugs, and it might be more
of a one- or two-physician team on an outpatient visit.
I don't know if you need the same response or
different responses, and I'm sorry I don't have an answer
for you.

DR. CROSSON: Okay. Thank you.

So we're going to proceed with the discussion
now, the point of which is to help Jennifer prepare for the
second presentation in January. Because of the timeline
that we receive, it will be our last opportunity to bring
our thoughts together and to help the staff prepare the
final report to the Congress.

We have Jon Perlin here who has been working in
this area and will start off the discussion.

DR. PERLIN: Thanks, Jay.

Let me thank Jennifer as well as Shinobu, Rachel,
and the MedPAC staff for really terrific insight on this on
a critically important topic.

It is a critically important topic, but you've
been asked a difficult question, difficult because the
answer to that question may not be through the means that
were identified in the question to achieve the answer that
I think Congress is seeking. And I think that's the sort
of conundrum that we need to work out here a little bit.
By way of preface, Jay mentioned I have been
working in this area. Actually, earlier, you said, "Jon
has experience with opioids." So, to qualify that --
[Laughter.]
DR. PERLIN: -- my Ph.D. is molecular
neuropharmacology, the obvious course to health
administration, but more importantly, of late I've been
working with the National Academy of Medicine's Action
Collaborative on combating the U.S. opioid epidemic, the
main thrust of this effort.
I think there will be great resources and linkage
to working on your question that has to do with really four
or five groups of activities -- pain management, prevention
of overuse disorders, treatment of overuse disorders, and
then things associated with that, community resources, the
stigmatization, both of patients as well as providers in
this space, and some of the complexities of therapy, which
really do get at one of the issue I'll talk about
specifically and comparing opioid to non-opioid or
alternatives to traditional opioid therapy and further
research that's necessary.

I think to contextualize, this point about the hospital being the starting point or medical encounters being the starting point is really important because when we talk about the opioid epidemic, we're really talking about a sequence of three epidemics, the first of which was with the promulgation of these synthetic opiates, which is why they're called opioids, and a belief that they perhaps were not as addictive.

There was an escalation in the use of these, and that led to an awful lot of overuse, dependence, and addiction, all of the untoward outcomes.

In turn, that led -- and I'll explain why in a moment -- to a heroin epidemic and more recently to a third epidemic, predominantly imported synthetic opioids, very high-potency opioids like fentanyl.

The reason I make this point is that 70 percent of the people who overdose and die from opioids actually had their start with a prescribed opioid, which is why it's so important to trace back both to patients who graduate into the Medicare programs as well as patients who initiate opioids in the Medicare program, and this notion that
health care encounter, especially as Brian indicated the hospital is gateway, is tremendously important because as your work and what you've highlighted shows so eloquently in the data is that there is an absolute correlation with the duration of exposure and the intensity of exposure. So those data points in terms of answering Congress' question are tremendously important and helpful. The question is, How do you get that most easily, and how do the incentives that Congress also asked you to opine on operate?

As we all know, there are multiple categories of incentives. There are both financial incentives, which is one question, but in this particular area, as the clarifying questions of both the first and second presentation brought out, there are also other incentives, including quality measures and experience measures. And there has been concern that some of the HCAHPS measures have driven in the interest of both meeting and a desire to ameliorate pain, but also patient satisfaction have driven potentially excessive prescribing.

It's interesting. I looked up the specific language of the measures, and they've been changed, but the
change or nuance in the way they operate toward the incentives may be informative to your conversation's nonfinancial incentives.

The former pay management domain had three questions. During this hospital stay, did you need medicine for pain? New pain management question. During this hospital stay, did you have any pain?

Second question. During this hospital stay, how often was your pain well controlled? New question. During this hospital stay, how often did hospital staff talk with you about how much pain you had?

Third question. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain, do everything they could?

Important and best answer in HCAHPS was always. During this hospital stay -- new question -- how often did hospital staff talk with you about how to treat your pain?

What's interesting is that I'm not sure -- and I think further research needs to be done -- whether this completely ameliorates the implicit incentive toward prescribing for pain. Certainly, it addresses management pain.
What I can tell you from the health services research is that it changes these questions from drivers of overall satisfaction to drivers of nurse communication as a secondary factor. So just note that in terms of the nonfinancial incentives.

In terms of this particular question of tracking, there's an implicit assumption -- or an explicit assumption, actually, the bundled payment which includes the payment for pain management, including drugs for pain management, would be driven by the lowest cost. After I stipulate that that could be, I have to note that there may be other factors as well, such as the implicit incentives for pain remediation, as I mentioned, under HCAHPS and that they in fact may work intent.

So you have this conundrum where you need to analyze and assess the cost as a driver, but that's challenging for the reasons, some of which you noted, that the costs of the drivers are bundled. And unlike Part D and elements of Part B, there is not a tollgate that collects the data at every encounter. So to other points, how do you get the data that really answers the question that it appears that Congress is interested in?
Second, you note that the cost of the drugs are obfuscated by very arcane purchasing process, so proxies for the cost of those drugs aren't clear. But I would actually say, even more importantly, the alternative drugs may not be exact therapeutic substitutes.

It's kind of like comparing the past completion rate for a quarterback with the ERA of a pitcher. They're both measures of sports, but they're different sports. And here, the problem is that different classes -- the closest may be non-steroidal, but there are also anti-inflammatory. There's a gabapentin that really relieves certain sorts of nerve pain. There are topical anesthetics. There are injectable anesthetics that bundle with the procedure, as Pat mentioned, very viable alternatives or nontraditional approaches. They're not necessarily captured even with modifiers.

One of the most important alternatives is complicated by the arcane law and regulation around its administration, and that's the mixed agonist, buprenorphine, which offers some analgesia and blocks the euphoric effect. And that has a set of training requirements for a prescription that make it very, very
So I'm going to come back to that as an important point because I think your work can actually be even more informative than just combating. I think if you play the data right, you can also get insights to what's working in terms of better outcomes for Medicare beneficiaries.

To this question of how do you get to an answer that's not confounded by the factors I just mentioned and other factors such as, frankly, the supply and the effectiveness of regulatory requirements, potential adverse effects of some other alternatives -- ketamine as an example, antipsychotics as an example -- you've still got the fundamental question. Should CMS monitor opioid use? I think it would be irresponsible for anyone to suggest other than an emphatic yes in terms of answer yes on that, but it leaves you with a question. If you can't disentangle that monitoring through the Part A mechanisms and it would create undue burden to put mechanisms there, what are your other proxies?

So here are some suggestions since there is not an overutilization monitoring system equivalent from Part D in the hospital.
I think opining on the prescription drug monitoring program and consistency state to state would give you some insight into prescribers and the quantity of prescriptions that are being written for Medicare beneficiaries.

Second, there is not only the post-marketing surveillance system, which as you note in the report is voluntary, but the Sentinel system actually accrues data from provider organizations. And you can actually send questions into it so you can look at patterns of use. Now, it's not encyclopedic because it doesn't include all providers, but it can give you directionally correct information as to what the trends are among beneficiaries. And it now, including alignment with insurers, has over 100 million individuals, many of whom are obviously not Medicare beneficiaries, but many of whom in fact would be.

Jay, unless you think there's some Tennessee conspiracy, I don't think Brian and I talked about this. But this notion of a hospital-acquired condition is I think one of the ways of getting a handle on adverse outcomes, particularly since this phenomenon of overuse, dependence,
1 and even addiction often starts with the exposure and the
2 health care environment.
3 My team and I actually have a Health Affairs blog
4 that we'll enter into the record here, "A Case for
5 Confronting Long-Term Opioid Use as a Hospital-Acquired
6 Condition." In it, we find actually looking at some data
7 that 5 to 15 percent of those individuals with use
8 disorders post-hospitalization started almost with
9 predicable excess duration, excess dose, and I think the
10 scary part is that there are subsets of individuals who
11 started with single exposures as well.
12 So I think it's something, if we look at that, we
13 could drive not only curbing overuse of opioids, but
14 actually moving toward alternatives that serve Medicare
15 beneficiaries even more effectively.
16 Finally, as we think about the remainder of the
17 questions that you've been asked, I think we need more
18 sensitive and specific measures. Clearly, the measures
19 that you indicated -- high dose, multiple prescribers, both
20 high dose and multiple prescribers, and concurrent
21 administrations with other potentially addictive drugs --
22 are good measures.
But I think we need to go further into that. Those measures -- and this is why I am suggesting the prescription drug monitoring program -- need to be a transparent byproduct of care, not an add-on to the care process, and you just don't have the tools in Part A that you got for Part B and Part D.

Second, good measures could provide insights into alternatives and better outcomes. That's, I think, a recommendation for the Sentinel database, and I think you have additional tools that have been alluded to, such as your geographic mapping of hot spots of prescribing that would allow a different sort of investigation into the liability.

Let me conclude where I began, which is that I think you've got a critically important question. I think you've got directionally good guidance in terms of what you need to answer, but I think the specific pointing to trying to replicate the measurement systems that applies on Part D to the inpatient won't work for any number of reasons that I've outlined and would suggest that you provide feedback that directs toward some of the alternatives, including other sources of data, prescription drug monitoring
program, and potentially Sentinel and consideration of
overuse disorders among Medicare beneficiaries and some
window post-hospitalization or post the index event where
those drugs are prescribed as a safety even, a safety
failure, and either a hospital-acquired condition or a
care-acquired condition.

Thanks.

DR. CROSSON: Thank you, Jon.

Let me just ask you. So you've pointed out the
problem of confounding variables, particularly the
potential or actual incentives created by hospitals seeking
to perform well no HCAHPS. So I don't have an answer here,
but can you think of a way or an approach that the staff
could use to try to tease those apart, or is there any way?

DR. PERLIN: This is a tough one because I think
pain still needs to be addressed, and at the heart of that
is how do you separate incentives for addressing pain from
incentives that lead to overuse or a particular modality of
pain therapy.

I think further health services research may be
necessary there. Let me ponder that.

I would certainly welcome input from my
colleagues on that question.

DR. CROSSON: Jim.

DR. MATHEWS: One other additional clarifying question. So we're happy to pursue this notion of considering opioid addiction as a hospital-acquired condition, but I have a question. At what point can you define addiction, and for what duration of time would a hospital need to track a patient on a post-operative basis in order to ascertain addiction?

DR. DeBUSK: In theory, wouldn't it be in the Part D claim? I mean, if I see a claim or a hospital discharge and then I follow that claim for 30, 60, 90 days, and they're still filling 100 MMEs a day, I mean, it should be right there in the data, shouldn't it?

DR. PERLIN: I think that's the nidus of a surveillance system because I was thinking about the same question: How do you operationalize this concept? I think there are probably clusters of diagnoses that shouldn't be associated with chronic use of opioids, and so right there is one sort of data clue.

Second, here's the challenge. I think operationalizing. It may not be in the same calendar year.
It may be for patients who have service in January that you can track later in the year, but in December may not be the end of that calendar year. So I think you need some sort of rolling marker of that, but associating particular diagnoses with prescriptions in excess of what would be predicted for that diagnosis might be a means of operationalizing.

I think Karen wants to weigh in on that.

DR. DeSALVO: Yeah. As the Commission has talked about hospital-acquired conditions and having that drive behavior and the delivery system to assess for conditions on entry into the hospital, one potential positive impact of a model like this would be a heightened questioning upon admission to the hospital and a checking perhaps of the PDMP to look for prior prescriptions. So it might improve processes up front to identify whether someone is at risk for addiction.

DR. CROSSON: Okay. So now we'll continue with the discussion, and I'm trying to think where I've started. But I can't remember anywhere.

All right. Kathy.

MS. BUTO: So I think we probably all can agree
that our goal is appropriate pain management but reducing
unnecessary use and long-term addiction and abuse as part
of whatever Medicare policy we recommend.

We want hospitals and physicians to have the
flexibility but within some parameters that we've been
struggling with and accountability.

I think part of the paper that I found the most —
I guess the area where we've already identified we need
to do some additional work is inpatient hospital in
particular. That the DRG bundle, as I see it -- and I
think as Jon pointed out -- it does encourage cost
effectiveness but not appropriate use.

So I don't think we can just say DRG bundle, that
sort of takes care of the issue of incentive, because I
don't think it gets at the incentives that drive
inappropriate use. It might get at cost incentives.

I really think it's important, even if we don't
have time to do it in this go-round for the report, to
point out how much we need to develop data that allows
Medicare to differentiate between a hospital inpatient
stay-generated opioid use and potentially overuse versus
outpatient prescription because I don't think we can get at
the issue even of hospital-acquired condition until we know better what that difference is. So that can be done concurrently with trying to look at either HACs as a way of getting at this or other aspects of value-based purchasing that could provide at least an initial handle on what's going on with prescribing related to either surgeries or other MS-DRGs.

I think it's really hard to come up with benchmarks. I started thinking about this whole thing of the tournament model, et cetera.

I think one place to start would be if we could find out which MS-DRGs have associated with them the prescription of opioids.

So I'm thinking that's going to be some of the major surgeries, like bypass surgery and so on, but I don't think we know. We need to know more about what those are, and it's possible you could develop some intermediate benchmarks related to the extent to which opioids are prescribed in relation to those particular diagnoses.

I think you could then figure out -- you might then be able to have the data to look at long-term addiction, but it seems to me, at least initially, we'd
want to see which ones are generating opioid prescriptions that start in the hospital and then maybe are continued through Part D.

It just strikes me that we may need to kind of go stepwise into the measurement area just to figure out what's going on, and I think that will help a lot.

DR. CROSSON: Thank you, Bruce.

MR. PYENSON: Thank you very much, Jennifer. I noted on page 18 that there's mention of some of the benefits that Medicare Advantage plans can cover as outside of fee-for-service, and I believe one of those is acupuncture that you mentioned. I believe it's not covered by fee-for-service Medicare. And it struck me that because this is such -- the topic we're addressing here is such an important topic that just a caution that we don't expand Medicare coverage to things that Medicare should not cover.

There's all sorts of advertised solutions to pain. Placebo effect is important, of course. But as our concern over this is substantial, we need to also keep in mind that there's for sure interests that would like to see expanded Medicare coverage, and in particular, it's not just things like perhaps acupuncture. There's novel therapies that
perhaps would like to receive an add-on payment through the
DRG system, and there's medical devices.
So I just want to note my view that we need to
make sure that that doesn't sneak into this very serious
problem.
DR. CROSSON: Thank you, Karen.
DR. DeSALVO: I'll just add to the call that this
is extremely important and we should have visibility into
everywhere that we can be of help.
I want to just acknowledge this multiple
incentives issue and just bring a little bit of frame
around that. This issue of the HCAHPS question came up a
lot historically. It was recently changed. There may be
some pre- and post-data that would be informative, though
it's going to be heavily confounded by all of the other
efforts that are happening. But that work is probably not
done, meaning that there were some other suggestions about
phraseology for those questions that were not taken up by
the prior administration. So perhaps there's some
assistance you could get from some physician groups and
others who had strong ideas, including our current Surgeon
General, who had a lot of ideas about this when he was in
Indiana.

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

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

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

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

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

DR. CROSSON: Jonathan.

DR. JAFFERY: Thanks, Jay, and this is a great discussion as I track the Madison, Wisconsin, chief of police report on a monthly basis of opioid overdoses and watch it be a straight rise. It's hard not to really be shocked and start to think we need to be creative and do what we can.

Maybe building on Karen's last point and thinking about how to bring some things in scope, this demand side idea, Amy mentioned, pointed out the barrier of stigma to getting treatment, but there's also a prescribing of -- and, Jon, you touched on this -- the prescribing of medication-assisted treatment, which is really seen as a very big barrier. So any of us who have tried to get our physicians to get the waiver recognize that barrier, and some of it is time and some of it is money. But there has actually been some interesting studies that look at additional barriers, even amongst individuals who have already gotten the waivers. There's a reluctant to use those to prescribe or to prescribe for many patients. And
there has actually been some analysis of what those barriers are, and it really seems like the things that -- the fixable things that really rise to the top are around support for the prescribers, because they need the counseling support and they need the other things that are maybe a little bit outside the scope of their normal practice, but still I think solidly within health care.

And so I know we've talked a lot about attending to payment around prescribing patterns, but there might be some room for thinking about how do we support physicians and support practices to not only get the waivers, but then also actually prescribe, and I think we can look to Vermont's hub-and-spoke model as the one that jumps out as being the most developed, the one that other States are trying to replicate to varying degrees of success, and has had a lot of success in increasing the access to medication-assisted treatment.

DR. CROSSON: Okay. Thank you.

So here we'll start with Paul.

DR. PAUL GINSBURG: Yeah, presumably a major motivation for Congress asking for this report was a concern that there were situations that non-opioid
alternatives to opioids are more expensive, and that's the basis of your plans to look at the price data. It hasn't come up in our discussion at all yet, and I was wondering, you know, what were the anecdotes that got Congress concerned about this? And how likely is it that we're going to find that this is a real issue?

DR. MATTHEWS: So I'm not sure we want to kind of pre-anticipate our findings once we obtain the data. So in terms of the likelihood that we will find something or, you know, what anecdotes might have motivated the Congress to ask these questions, I would prefer to hold off until we actually have something to come back to you with.

DR. CROSSON: Amy.

MS. BRICKER: In wild support of tracking this in Medicare A and B population, I appreciated the idea that was -- you know, it centered around hospital-acquired condition. I think it's going to be difficult to determine and would look to Jon and others to inform at what point is there a problem, in fact? And then how is that then tracked back? I think that would be certainly a debate amongst the stakeholders that, you know, essentially would be impacted by this. But I think it's a worthwhile
I think there's been such a focus so far today around prevention of, you know, starting a naive patient presumably on an opioid and then, you know, therefore, preventing addiction. I think we've got -- building on what Karen mentioned a moment ago around intensifying the conversation or putting a stronger requirement around questioning patients around their current utilization of an opioid and the likelihood that they, in fact, you know, are drug seeking or in an addictive state, or the predisposition of a patient to addiction. And it's not about then putting -- you know, refusing to treat and, oh, you're just here because you're seeking a narcotic -- which is typically what happens. Those people just get pushed back out of an ER or what have you -- but embracing them, okay, you're here, you're in the right place, and we're going to get you help, and trying to lean into that, because what absolutely happens -- and if you don't believe it, go to any rural community in America. They will find a resource, and it is heroin or fentanyl or the combination of both.

And so I implore us to think about, of course,
preventing but also starting to swing the pendulum back the other way around we have an issue and the hospital systems and the communities are best readied or have the ability to start to address the issue with the right level of resources.

The other thing that I find fascinating is we haven't even talked about the manufacturers and what role does the pharmaceutical manufacturer play in this. I could envision a tax like we put on cigarettes, but paid by manufacturers. They're benefitting. You want to know who benefits from this? They benefit from where we are today. No one else is benefitting from this crisis but manufacturers of these products. So what role do they play? Could they be, you know, forced to stop promoting product but educating physicians about the risks associated? Should they be using their dollars to fund, you know, substance abuse education prevention treatment? That's where I would like to see this go. I realize that's provocative and likely not something that this Commission has the stomach for, but I would encourage us to think more boldly around, you know, where did this start, who's profiting, who's benefitting, and at the expense of, of
course, our beneficiaries and America at large. So thanks.

DR. CROSSON: Thank you, Brian.

DR. DeBUSK: First of all, I'm really glad to see us working on this really important subject. It's probably overdue that we do more work here.

What I want to mention, in the next round of work if we could focus on tailoring some solutions, and I know the work spoke to this. This one-size-fits-all model doesn't work. I am hoping that we can identify some tranches of beneficiaries, for example, degenerative spin patients or post-traumatic osteoarthritis patients where we could almost bucket the high-use beneficiaries and develop some very specific tracks to try to address them, because I think you're almost going to be treating a series of conditions here, not just opioid use in general. And, again, I could tell in the reading materials that's, I think, the direction you're taking us. But I hope we really build out that direction and look at those specific conditions and try to identify them and develop policy around some of the specific ones.

The other thing I would want to encourage, I really liked in the reading material the pharmacy lock-in,
the prescriber lock-in. A lot of those conventional tools I think are great. I hope we explore this hospital-acquired condition idea a little bit more. But also, to Amy's point, I hope that we can at least look at some of the more radical ideas that are out there. You know, tough to watch sometimes, but I hope just for the sake of completeness that we can look at those and have them out on the table.

And then the final thing -- and this was something Warner mentioned -- just like we're looking at the cost of opioid versus non-opioid therapies and trying to figure out where the financial incentives are, I would love to see the financial -- almost a pro forma, let's say I'm a primary care physician and I do have someone on 120 MMEs a day. What would it look like if I tried to wean them through just E&M visits or through -- you know, I'd love just to see is it a financial disaster for me? I mean, what does it really look like? And is there some type of incentive that you could give me, almost a CPT code I could bill. Let's say I do walk you down over 90 days or 180 days. Would we consider a CPT code that I could bill that has a lump sum payment as a result, you know, sort of
an end cap or an end to that series of E&M visits.

DR. CROSSON: Thank you.

Further commentary? Jaewon.

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

DR. DeBUSK: Again, to your point, we're trapped by venue. We can't look at the bigger picture here. And, you know, then a final thought. Maybe you fund the new CPT code with penalties from the hospital-acquired condition program. Just a thought.

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

DR. PERLIN: Sure. Well, thanks. I really appreciate the terrific conversation. I think we're in emphatic agreement around the importance of this issue and tremendous work that you've done and the need to monitor and the complexities.

You know, I think we also have agreement that some of the tools that were offered may not be tools to answer the question that's really asked, implied. We go a little afield of that.

I think the other thing that scares us both in the area of prevention as well as -- I'm glad we got to the conversation of treatment as well -- is that we guide by the evidence. And when you actually look at the evidence for treatment, the area that really is a clear leader is
what we refer to as medication-assisted therapy, which is a horrible term. It's kind of like "food-assisted lunch."

[Laughter.]

DR. PERLIN: Not that I'm hungry, but the problem with that treatment is it implies that the medication is adjunctive. And the medication is actually if you look at any of the dates on recidivism, it is medication that's associated with actually the recovery or the abstinence from the addictive -- more addictive drugs. And it's associated positively with survival -- in the health services research literature, it's associated with survival in older patients, i.e., the Medicare beneficiaries.

And so I would hope that we'd also take a proactive stance noting that consistency with the evidence would be the facilitation of the appropriate means of therapy. I think it's worth noting the undue regulation around training for the prescription of buprenorphine in particular, and the complexity of getting patients evidence-based therapy in that regard, and that actually implies, I think, another set of measures for tracking, which is -- you know, I realize some of these are process, but the percent of beneficiaries who actually have
evidence-based approaches to the overuse disorders.

Thanks.

DR. CROSSON: Thank you.

Okay. Good discussion. Jennifer, I hope that's helpful to you, and we look forward to hearing from you again in January.

That ends the presentation portion of the morning session. We now have time for questions from our guests. If there are any members of the audience who would like to make a comment, now is the time to step forward to the microphone so we can see who you are.

[No response.]

DR. CROSSON: Okay. I'm not seeing anybody, so we are adjourned until 1 o'clock.

[Whereupon, at 11:43 a.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]
DR. CROSSON: Okay. I think we can sit down here. We've got -- wait one minute here.

[Pause.]

DR. CROSSON: Okay. Well, we're almost assembled, but I think we need to start.

So we're going to begin the afternoon with a topic that we've been talking about for some time, which has to do with concerns about primary care workforce availability, now and in the future, for Medicare beneficiaries. And today we're going to talk about payment policies for advanced practice registered nurses and physician assistants. And we've got Brian and Kate here, and who's going to start? Brian is going to start out.

Thank you.

MR. O'DONNELL: Good afternoon. In this session we'll discuss Medicare's policies surrounding APRNs and PAs. This work is in response to Commissioner interest conveyed during our January 2018 meeting on rebalancing the physician fee schedule. Specifically, Paul, you asked us to look into a practice known as "incident to" billing.
Amy, you asked what Medicare knows regarding the specialties in which APRNs and PAs practice. And Brian, Sue, and Jon, you discussed issues related to APRNs' and PAs' increasing roles in delivering primary care. This presentation will address these topics, but before we get into them I'd like to thank Carolyn San Soucie for her assistance with this project.

This slide lays out a roadmap for our discussion today.

Given that the Commission has not directly addressed this topic in a few years, we'll first go through several slides of background material. We'll then discuss our analyses on Medicare billing trends and the prevalence of "incident to" billing. Finally, we'll discuss two policy options for the Commission to consider.

MS. BLONIARZ: Okay. Starting with definitions, the term APRN groups together four categories of advanced practice nurses that can bill Medicare directly: nurse practitioner, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse midwives.

All APRNs must be credentialed as registered nurses and complete additional education and training, most
commonly a master's degree. They are licensed by the state to practice, and the state may impose certain additional requirements for their practice.

PAs take a similar path. They must graduate from a physician assistant program, which is generally a post-baccalaureate master's. PA education includes a clinical rotation, and then the state licenses them to practice.

The requirements that states impose on APRN and PA practice is referred to as scope of practice, and it affects APRN and PA ability to diagnose, treat, and refer patients and their ability to prescribe medications, order services, and interpret tests. Their requirements vary by type of credential, and for NPs, specifically, a little less than half the states allow NPs to practice the full suite of medical care consistent with their education and training without significant constraints or limitations.

Sixteen states impose a moderate level of oversight, such as counter-signatures of medical records or chart review. Twelve states have more significant constraints, either requiring ongoing direct supervision or restricting prescribing. And the trend has been, over time, for states to increase the scope of practice for
One area of interest, that Jon asked us to look into, is comparing NP and PA care to care delivered by physicians on the basis of quality, cost, and patient experience. Although this is a well-studied area of health policy, there are limitations to the research, given the small number of randomized studies, the limitations of claims data, including "incident to" billing, small sample sizes, and short follow-up.

Overall, for the services they provide in common, the evidence appears to be that NPs and PAs provide roughly equivalent care in terms of quality and patient experience. For cost, the evidence is more mixed. Some insurers, including Medicare, pay a discounted rate for NP or PA care billed directly. But NP or PA care could also affect total episode costs or utilization through differential effects on downstream services, such as imaging and tests, additional follow-up visits, hospitalizations, or emergency department visits. And a few studies have found higher ordering if diagnostic imaging among NPs and PAs than for physicians, but others have not.
Turning to the practice specialty of APRNs and PAs, there is scantier information about their current practice specialties than for physicians and less uniformity in credentialing. In addition, APRNs and PAs may be more likely to work across different fields during their career than physicians.

But turning to the specialties in which NPs and PAs appear to practice, two point-in-time estimates are that about half of NPs work in primary care and 27 percent of PAs work in primary care. Shares of primary care NPs and PAs both appear to have declined over time.

With respect to what Medicare knows, the system that providers use to enroll in and bill the Medicare program and be paid for their services classifies all NPs and one specialty and all PAs as one specialty.

Medicare covers nearly all medically necessary services provided by NPs, CNSs, and PAs under Part B of the program, as long as the service is delivered in compliance with state law. There are a few limits on what NPs and PAs can order or certify the need for certain types of services, and a particular example is that only physicians can order home health.
In terms of billing and payment, APRNs and PAs may either bill Medicare directly, using their own provider number, or bill "incident to" a physician service, meaning that the physician bills for the service that the APRN or PA provided, and there is a payment differential for direct and "incident to" billing.

This slide walks through the two methods of billing, using NP services as an example. Down the left side of the graphic is if the NP billed Medicare directly. They would report their own provider number and meet a general requirement for collaboration with a physician, or meet a state requirement if it is stricter, and the NP would be paid directly at 85 percent of the fee schedule amount.

On the right side shows the process for billing for the NP service "incident to" the physician service. The physician's ID would be on the claim and the physician and NP would need to meet the "incident to" requirements for direct supervision, and the payment would be 100 percent of the fee schedule amount.

"Incident to" billing is only permitted in the physician office and cannot be used for new patients nor
for existing patients with a new problem. In those
circumstances, the NP would have to bill directly. I'll
turn it to Brian to go through the data work and policy
implications.

MR. O'DONNELL: So as Kate mentioned, we are
going to switch gears and talk about some of our analyses
regarding the billing patterns for APRNs and PAs. Before
we get into the numbers, one thing to keep in mind is that
the billing statistics we'll present generally
underestimate the services APRNs and PAs actually provided
because of "incident to" billing.

Having said that, this slide looks at allowed
charges billed by APRNs and PAs in 2010 and 2016. As you
can see, total allowed charges billed by APRNs and PAs grew
rapidly over the period, more than doubling from roughly
$3.1 billion to $6.5 billion.

NPs and PAs represented a large majority of all
allowed charges billed by this group of clinicians and
their allowed charges also grew quickly. NPs' billings
increased by 158 percent over this time, and PAs' billings
increased by 118 percent.

Just to put these growth rates in context a bit,
the number of Part B fee-for-service beneficiaries has
grown by about 5 percent over the same time period and
Medicare spending on the physician fee schedule has grown
by about 13 percent over the same period.

In your mailing materials, we show that NP and PA
billings are concentrated in E&M services, so this next
slide drills down on the number E&M office visits billed by
APRNs and PAs, primary care physicians, or specialists,
from 2010 to 2016.

Over this period, the number of E&M office visits
billed by APRNs and PAs increased from 11 million to 28
million, an increase of 149 percent.

This rapid increase is consistent with the
overall growth in allowed charges I mentioned earlier and
the growth in the number of APRNs and PAs billing Medicare,
which I did not discuss today but is included in your
mailing materials.

Before I leave this slide, there are a few other
trends worth noting. First, the total growth in visits and
visits billed by specialists have grown by amounts roughly
similar to the growth in the number of Part B fee-for-
service beneficiaries. However, the number of visits
billed by primary care physicians has declined by 13 percent over the same period. This suggests that APRNs and PAs could be billing for visits that were once billed by physicians, especially in primary care.

So the next few slides deal with "incident to" billing.

A service that is performed by an NP or PA and billed under Medicare's "incident to" rules appears, in the claims data, as though a physician performed the service. This means that Medicare's "incident to" rules obscure the number of services actually furnished by NPs and PAs.

Given the rapidly expanding supply of NPs and PAs, Medicare's "incident to" rules could apply to an increasing number of services. However, existing research on the prevalence of "incident to" billing is limited. Therefore, we conducted original analyses to try to give the Commission a rough sense of the prevalence of "incident to" billing.

The analysis I'll walk through today estimates the prevalence of "incident to" billing for E&M office visits.

This slide shows the percent of E&M office visits
billed by NPs in physician offices and in hospital outpatient departments, HOPDs. For established patients, the right hand side of the figure, NPs billed a much higher share of visits in HOPDs, the blue bar, than in physician offices, the green bar.

For established patients, NPs must bill under their own NPI in HOPDs but can bill under a physician's NPI in the physician office setting, so the difference we see between the bars could reflect NPs billing under physicians' NPIs in the office setting.

In contrast, for new patients, the left-hand side of the figure, NPs must bill under their own NPIs in both settings, and as you can see, NPs billed only a slightly higher share of office visits in HOPDs than in physician offices.

Given the minimal differences between HOPDs and physician offices for new patients, where we think the billing data accurately reflects who performed the visit, we conclude that most of the difference between the green and blue bars for established patients is due to "incident to" billing.

So based on this conclusion, we estimate that
approximately 40 percent of E&M office visits NPs performed for established patients in physician offices were likely billed "incident to" in 2016. This means that for every 100 such visits NPs performed, we think roughly that 40 appear in the claims data as though they were performed by a physician.

We also conducted the same analysis for PAs and conclude that roughly 30 percent of such visits by PAs were likely billed "incident to" in 2016.

To put these numbers in context, we think that the rates of "incident to" billing for NPs and PAs mean that roughly 5 percent of all E&M office visits billed by physicians were likely performed by an NP or PA in 2016.

The next two slides provide an overview of two policy options for the Commission to consider. Both policy options are designed to improve the information the Medicare program has on such clinicians.

The first policy option is eliminating "incident to" billing for APRNs and PAs. This means that APRNs and PAs would be required to bill under their own NPI when they furnish a service to a Medicare beneficiary.

Requiring direct billing could have several
implications, including reducing Medicare and beneficiary expenditures, as all services currently billed "incident to" and paid standard fee schedule rates would be paid at 85 percent of those rates; improving fee schedule valuations by enhancing the program's ability to detect potentially overvalued services; enhancing program integrity by narrowing a rule that Medicare currently has a limited capacity to enforce; and improving the ability of policymakers to directly compare the care furnished by APRNs, PAs, and physicians.

The second policy option is improving Medicare's specialty designations for APRNs and PAs. Under this option, APRNs and PAs could be required to self-select a specialty in which they practice when they enroll in Medicare and then update that information regularly. Refined specialty categories would help Medicare identify primary care clinicians because assuming that all NPs and PAs provide primary care, as is sometimes done, is imprecise, as roughly three-quarters of PAs and half of NPs do not predominantly provide primary care.

This brings us to your discussion. After answering any clarifying questions, we would like the
Commission's feedback on any analyses you would like us to conduct or any additional material you would like us to include in future iterations of this work. We would also like the Commission's feedback on the two policy options. With that, I turn it back to Jay and look forward to the discussion.

DR. CROSSON: Thanks very much, Brian and Kate. I am going to start off with one question. It was in the chapter mentioned, but could you review for us, to the best of your knowledge, what the original intention of "incident to" billing was supposed to be?

MR. O'DONNELL: Right. So when we started on this project we went out and asked folks that question, and we heard this refrain constantly, that, you know, the "incident to" regulations were not intended to cover APRN and PA services. And so we'd say, "Well, what does that mean?" and we kind of got fuzzy responses.

And so what we did was we went back and looked at the origins of the "incident to" rule, and it came into being with the Medicare program. So in terms of coverage, in the original 1965 act, you know, physician services were covered and also services provided "incident to" those
physician services. And so we went back and looked when NPs and PAs were created as entities, or specialties, and the first programs were created in 1965, with the first graduating classes a few years after that.

So based on that conclusion, we say in the paper that we don't think rule was intended to cover NP and PA services, originally intended, because they didn't exist at the time it was written. And so I think that what that leaves is that, you know, services provided by kind of non-licensed folks or lower-end folks than NPs and PAs. I think that was the original intent when this was written.

DR. CROSSON: Good. Thanks very much. Other clarifying questions? Sue.

MS. THOMPSON: Thank you. Important chapter and one that leads nicely into the next discussion on primary care.

So looking at the state scope of practice laws, is there anything about the fact that there's great variation across the country, state to state, in terms of the autonomy of these categories of workers, that impact recommendation number one?

MS. BLONIARZ: So I don't think that this would
affect -- scope of practice would affect this recommendation. In most -- in all states, NPs and PAs are permitted to bill any insurer or be credentialed, and what we think, with "incident to" is that it's adding on a layer of kind of supervision that doesn't, you know, it doesn't replace state law, and in some ways it's more restrictive than some state laws.

And so I think, if anything, it would probably be the reverse. It's kind of there's a financial incentive to bill "incident to." Once that's no longer there, physicians and NPs and PAs would not have to meet the kind of direct supervision requirements, but whatever state law was still in place, you know, would govern kind of their practice.

MS. THOMPSON: Thank you.

DR. PAUL GINSBURG: If I could add something, I am under the impression -- you may tell me I'm wrong -- that the scope of practice issues and controversies mostly come up with independently practicing, usually, NPs. PAs tend not to practice independently.

But that for the most part, I think for those employed by physicians, they can do whatever the physician
asks them to do, and I don't think the laws interfere with that.

So, in a sense, the actual variation in practice is probably less significant than what appears on the basis of the laws.

DR. CROSSON: Further questions. Over here, I've got Kathy, Dana, Pat. Kathy, Dana, Pat.

MS. BUTO: So I wondered whether we have an idea of why the growth in NPs is faster or more than the growth and the number of PAs. Is there a difference in scope of practice? Is that your sense between the two, even from state to state? Or what makes one more attractive than the other is what I'm trying to get at.

MS. BONIARZ: Yeah. So there is differences state to state in terms of scope of practice, and what we kind of tried to convey in the paper is that PA scope of practice, PA state law often defers to the physician and says the physician -- a physician that's in a collaborative or supervisory arrangement with a PA would kind of define what services that PA would provide and what circumstances, whereas a state's scope of practice laws for NPs is a little more prescriptive in terms of saying an NP must have
an established relationship with a physician. They may have specific practice protocols. They may have more restrictions around prescribing, particularly for controlled substances.

But I would also add kind of to the point you were asking about. The orientation of both specialties is a little different. NPs, generally, their education and training historically has been a little more focused on them kind of fitting into an independent practice, whereas a PA has always been historically kind of part of a physician team.

And what that's meant in practice is that some settings, like retail clinics, see more benefit from hiring NPs because they are directly diagnosing, treating, and prescribing.

MS. BUTO: That's really helpful.

So I'm hearing more flexibility for the PA but always in relation to a physician supervision or relationship, where NPs can actually set up independently -

MS. BONIARZ: Right.

MS. BUTO: -- under certain circumstances.
MS. BONIARZ: And the one caveat I want to make is that that is recently changing on the PA side, and I think Brian included some material in the paper about their optimal team practice, which is a little bit -- I would say moving a little bit farther away from kind of that physician-headed model.

MR. O'DONNELL: That's right.

and I would say to support that is that the trends in NPs and PAs, it hasn't always been that NPs were growing faster. If you looked at a previous decade, there was some evidence that PAs were growing faster. And that was the period of time when physician billing was growing much faster. And then around 2010, when you see docs being employed by hospital systems, the NPs started to grow faster.

DR. CROSSON: Okay. I've got Dana, Pat, and I think I saw Karen.

Dana.

DR. SAFRAN: Thanks, Jay.

I just have two questions. One is back on the issue of differences in state scope of practice laws.

Apology if I missed this, but has there been any
research? You talked about the research around looking at quality of care, cost of care, patient experience too, relative to physicians. But has there been any research to see at the state level for the states that have more liberal or more strict scope of practice laws, how those quality and patient experience and cost parameters play out?

MS. BONIARZ: Yeah. We did look at that, and there's a fair bit of data, a fair bit of research on is there something different about the states that have made changes to scope of practice, then kind of looking at time trends.

DR. SAFRAN: Yeah.

MS. BONIARZ: I would say that, again, it's kind of mixed, and it's very -- I would say the research is a little dependent on what your priors are. Some of the states that have enacted scope-of-practice changes are systematically different than ones that didn't, and I think I would say there's kind of evidence on both sides there. And I wouldn't say that any of the evidence is super strong in one direction or another.
DR. SAFRAN: I'd be really interested to see some of that data because I think there's a lot in there, understanding any problems that have to be dealt with. My second question is on Slide 10, and it's in the first two rows there. Do we have any insight or could we from the data as to whether the increase that we see in the first line and the tradeoff being made in physician visits has anything to do with ACOs looking to not do incident billing and make the most out of the budgets that they're given by using folks to the top of their license and not billing that extra 15 percent? Any insight on that?

MR. O'DONNELL: Unfortunately, I think the answer is no. I think we saw this trend where we saw the decline for PCPs and APRNs, and we wanted to highlight it, but we talked internally. We think there's two or three different possible explanations -- and I guess maybe four now -- that we hadn't thought of.

So it could be just kind of a billing versus a performing issue as to where there's differential trends and incident to billing, so it just looks like PCPs are going -- it could be that PCPs are doing different
services, so the distribution of services have changed, or it could be that they're doing less. And I think at this point, we haven't explored past what you see right here.

DR. SAFRAN: Yeah. So I think that would be an important thing to look into, and you probably have the data that would allow you to look to see. Do you see different patterns inside of ACOs versus elsewhere?

DR. CROSSON: Pat.

MS. WANG: Thanks.

I was wondering if I could just focus on Slide 13, the conclusion that 40 percent of E&M office visits, blah-blah-blah. I just want to make sure I understand this.

So I guess focusing on the NPs, because I do think PA services are a little bit different, but just focusing on NPs, is it clear that the visit that -- here suggests there's a substitution of the physician billing when somebody has actually performed the service.

Number one, it really is very distinct, like the NP has actually performed independently an entire visit. I mean, this sort of suggests the doc had nothing to do with it, but they're billing for it, anyway, as opposed to the
physician maybe having had some involvement in that visit.

And I guess that I'm a little confused here because whether or not the scope of practice differentials among states may effect that -- I guess the question is, Is this 40 percent cleanly -- this is the work of the NP, but it's being billed as incident to the doc?

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

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

For instance, in the hospital outpatient department, there's rules around what they call split visits or shared visits. So when we made this estimate, the kind of baseline that we are looking at -- and that's NPs and HOPDs -- that already excludes split visits or
shared visits. So I think that it kind of accounts for that. So I'm not sure that's driving that issue.

MS. WANG: Okay. It's just --

MS. BONIARZ: Actually, I can answer just, I think, the point about whether it interacts with state scope of practice.

I will say as far as I can recall, no states have scope of practice for NPs or PAs that is as high as direct supervision under the Medicare "incident to" rules. It's less oversight than that, so that's actually kind of the highest bar.

MS. WANG: I guess policy option 1, which would be to eliminate "incident to" billing -- I may be misunderstanding the thrust here -- is with the potential of saving Medicare money. It kind of suggests that that NP really is performing -- maybe the physician is doing more than we think because it is kind of a collaborative.

I'm a little confused by the suggestion there because maybe the NP is doing a certain amount of work, but the physician is also doing a certain amount of work for that same patient and that's why the --

MR. O'DONNELL: Right.
And I think your point is valid. There's a chunk of services that NP furnish, right? A portion of that, they might be performing independently, whether you think it's simple sprains or colds or what have you. Then there is another portion where there's likely collaborative care. Maybe these are complex patients, things of that nature.

So for the first chunk of visits, we do think that if you require direct billing, there will be savings because their NPIs will appear on the claim.

Now, for that second chunk -- and we don't know the distribution between the two chunks, but for that second chunk, if you were to require direct billing, you'd have to have a wraparound policy saying if the NP performed 51 percent of the visit, then their NPI would appear on the claim, or if a doc did 51 percent, their NPI would appear on the claim.

The HOPD already has a rule similar to that, and the rule is that if a physician performs a substantial portion of the visit, then their NPI appears on the claims.


And then the final question I had, do you know how malpractice expense is handled when NPs are employed by
1 physicians in their offices? And how does that show up in
2 the fee schedule calculation? Do they have to carry their
3 own malpractice insurance?
4
5   MS. BONIARZ: They do, yes.
6
7   MS. WANG: Okay. And so if they're employed by
8 physician office, is it likely that the physician office is
9 paying for that malpractice? How does that work?
10
11   MS. BONIARZ: I'm not sure, if they were
12 salaried, if that would be part of their compensation, but
13 they are required to carry their own malpractice. And then
14 from the Medicare side, it's considered direct practice
15 expense.
16
17   DR. CROSSON: Okay. I've got Karen and then Amy.
18
19   DR. DeSALVO: It's not a Round 1, but it's a
20 point on to Pat, which is one of the expenses for the
21 physicians who are collaborating physicians is malpractice
22 and linkage to licensure. So there is some added cost also
23 for the physicians.
24
25   With the caveat that -- first of all, thank you,
26 guys. This is really thought-provoking and kind of drives
27 me to some of the questions you're hearing about team-based
28 care, which is where we've been pushing primary care and
inpatient care and ERs and how this might not -- this kind
of analysis in thinking and some of the recommendations
might go against that kind of a move, but nonetheless, it's
good to understand the practice patterns.

I wondered if -- maybe I missed it in the
chapter, but if we understood how these kinds of chart
billings look for other payers outside of Medicare to
understand that these trends are reflected in Medicaid and
the commercial marketplace -- and you're shaking your head
vigorously as if you are six steps ahead.

MR. O'DONNELL: Yeah. So we have a survey in the
field right now looking at private payer policies --

DR. DeSALVO: Okay. That's what you were --

MR. O'DONNELL: for "incident to" billing, and it
does over time -- it seems like private payers have moved
more in the direction of requiring direct billing or at
least allowing direct billing for NPs and PAs.

So we have some examples. I think we cite
Montana Blues in the paper, and we have some examples like
that.

DR. DeSALVO: Thank you. Yes. That as well as
I'm trying to understand if there's a practice pattern that
1 reflects a big increase in NPs billing in the way that
2 we've seen in the data and a decline in primary care
3 physicians. Is the pattern similar, not just the rules?
4
5 MS. BONIARZ: I know on the Medicaid side,
6 there's been growth in NP and PAs, both in billing and in
7 volume, but I don't know about other --
8
9 DR. DeSALVO: For me, I'm asking because if it's
10 something about "incident to" that's special to Medicare,
11 but we see the pattern even where payers are not using that
12 kind of a model, maybe it's not the "incident to," but
13 something else about what's happening in the clinical
14 environment.
15
16 And I had a question on Slide 12 to make sure I'm
17 understanding this right, which is -- so this is hospital
18 outpatient departments, which means they have got a
19 facility fee associated with this also that the hospitals
20 are billing?
21
22 And so I wonder if there's any way to tease out -
23 - I don't know if it's possible, but how much of this is a
24 business decision on the part of hospitals that are
25 employing primary care because they can also charge a
26 facility fee. So the growth in NP employment and use in
outpatient setting is a lower salary expense, but then
still, it doesn't hurt them on the reimbursement, even if
it's only 85 percent, that if they can bill. Does that
make sense?

MR. O'DONNELL: So I'm not sure I tracked that
question entirely, but certainly -- so in the OPD, you're
prohibited from billing "incident to," right?

DR. DeSALVO: Okay.

MR. O'DONNELL: But they do get --

DR. DeSALVO: So I can understand that.

MR. O'DONNELL: Yeah. Sorry.

DR. DeSALVO: All right. That's perfect. Thank
you.

DR. CROSSON: Amy.

MS. BRICKER: Just so I am ensuring that I am not
oversimplifying, is there any other contractor or advantage
to "incident to" outside the financial?

MR. O'DONNELL: So for folks like RNs and LPNs
who provide services in physician offices who can't bill
Medicare directly, that's the only manner in which they can
be reimbursed for those services.

But for APRNs and PAs who can bill directly, I
think there was a little bit of a stretch for us to find any other benefits.

MS. BRICKER: Okay. And then the 85 versus -- the 15 percent delta, 85 versus 100 percent, can you quantify that? If it's 5 percent of E&M are actually NPs or PAs and if "incident to" billing were not allowed, what is the cost, the savings to the program?

MR. O'DONNELL: So we have calculated that, and I don't want to give an exact point estimate, but it's a few hundred million dollars a year, we think. In the ball park.

MS. BRICKER: Okay. We might then think about that in the next chapter around consideration for primary care. So maybe we can link it. These are very correlated, yes.

Thanks.

DR. CROSSON: Okay. Sue, one more question. Jaewon, is your hand up?

DR. RYU: Yeah.

DR. CROSSON: Sue.

MS. THOMPSON: I'm trying to recall, and I'm not remembering. Do we have any information about any
compliance to "incident to" billing that we know of from a standpoint -- oh, you're looking at me like you wish I hadn't asked that.

MR. O'DONNELL: No. So we talked to a few medical directors, and I think the ability to enforce these rules are quite limited.

DR. CROSSON: Jaewon.

DR. RYU: A couple questions around the job market. I think going back to -- I think it was Slide 10 or 12, the one with the chart showing the negative, that one. How much of that is driven by supply changes, primary care physician availability? Any sense of that?

MR. O'DONNELL: Yeah. So I think one of the reasons we thought this was particularly interesting is that what Ariel is going to tell you is that the number, the raw number of primary care physicians that have been billing Medicare has actually been going up slightly over time. So you see an increasing number, and then you see them doing 13 percent fewer office visits. So there's a dissonance there that I can't really explain at this point, but --

DR. RYU: And those unique billers, are they
billing in a meaningful way, meaning part-time work versus what seems to be full-time engagement?

MR. O'DONNELL: Right. And that was part of -- if we go the next step, if you guys want us to explore that, that's one of the first things we're going to do, is to say, "Okay. Are they billing more? Are they billing" - "Is it just a minimal level? What does the distribution look like?"

DR. RYU: And then on a related point, I think you mentioned in the send-out materials that it was anticipated that this would not have an impact on the job market necessarily because the salary differential between advanced practitioners and physicians are still significant enough to create rationale.

I guess the question is are there other dynamics -- and I don't know the answer to this. But are there other dynamics that would suggest the business case, so to speak, of employing advanced practitioners weakens with the 15 percent delta and the payment?

MR. O'DONNELL: So I can't think of any off the top of my head, but we talked to folks who work at medical schools for PAs. And we asked them, "What does your
application rate look like?" and they said they're getting applications from a lot of people. They have to deny a lot of folks. So there seems to be a desire to go into PA school or NP school, and so when we look at the employer market, folks have continued to speculate that at a certain point, there might be a glut. You might have a leveling off of interest, but that is why we put the statistic in about the increasing salaries. I just don't see it right at this point.

DR. CROSSON: Okay. I'm sorry. Warner.

MR. THOMAS: Just one comment kind of tied to that. I think where we see the workforce challenges is actually more in the nursing area, because we've seen nurses that are, you know, progressing to be nurse practitioners. I think that creates more pressure, and I think that will discontinue as we see an escalation in this profession and will create more challenges in the nursing world.

DR. PAUL GINSBURG: If I can make a comment on this. I suspect that because of the incidence of billing rule, this is probably pulling up salaries of NPs and PAs
artificially, and in a sense -- which might actually be a problem not only spending too much money, but in a sense challenging the RN markets as people are pulled out of the RN market. So I wouldn't have any qualms about not paying too much and getting fewer NPs or PAs in the process.

DR. CROSSON: Okay. So we're going to move on to the discussion. Put up the last slide. We're going to talk about requests for additional information -- we've already heard some -- but then ask for Commissioners' perspective on the incident-to billing options that were -- well, the incident-to billing option or the other specialty designation option that were on the table. So sue is going to begin the discussion.

MS. THOMPSON: Well, again, thank you. I think this is an incredibly important topic and one that we likely haven't spent enough time on, and it's a component of our health care workforce that is growing, and it's been growing, and we haven't talked about it since 2014, I think. So I think it's all connected.

I think the comment that Warner just made about the impacts that the APRN opportunity is having on our registered nursing workforce is profound. And, yeah, we
push a balloon here, and it comes out there. So I cannot
overstate the importance I feel that we focus on the work
of nurse practitioners and PAs and how they contribute to
solving for providing care to our Medicare beneficiaries.

My perspective comes from a rural perspective in
this country where we are very, very dependent on and value
very much our nurse practitioners who, within the state of
Iowa, have a scope of practice that allows for independence
practice. But from a system where I work, we employ a
goodly number, and many of these nurse practitioners work
in clinics serving rural communities without a physician in
the clinic. So they are practicing quite independently.

Likewise, PAs plan an important role as well but
also, you know, from my experience work very much in tandem
with a physician specialist for the most part.

I want to go on record saying that I would
support eliminating the incident-to billing if for no other
reason, to be quite honest, is to create some dollars for,
as I think Amy began to suggest, the next chapter, but also
to clean up the data. I think one of the biggest
challenges we have as we look to understand attribution is
who was actually putting hands on that patient. And this
incident-to component blurs the data. And I think, again, for no other reason than if we could just get our data to clean up, there's good reason to continue exploring that recommendation.

Also, in terms of the component about the specialty designation, I do think we didn't spend a lot of time talking about that in our discussion. I think there's value. And as I would hope we continue to understand the value and put increasing value on understanding the role that APRNs and PAs play in our working complement, that at the same time with increasing that value we also increase the responsibility and accountability for appropriate education, because I think if there's a prejudice out there, and even in an environment where we use nurse practitioners a great deal, it is that they don't have the same education. They haven't put the hours of residency that a physician has invested. And so with that, I just think there's a complementary set of accountabilities that we would want to attend to in this conversation. And I think I would go on record saying this is a very important group of individuals that provide a lot of access to care, particularly in rural parts of our country. And in terms
of assuring that we provide the same quality of care, that we clean up the data so that we can confidently put forth data that assures us that our beneficiaries are receiving a complementary level of care.

DR. CROSSON: Thank you, Sue. Very clear.

I think I had a right-table bias this morning, so I am going to have a left-table bias and start with Paul.

DR. PAUL GINSBURG: I'm really very glad you did this project, and you did a great job. And I'm enthusiastic in supporting both recommendations, and the way I would explain it is that to me incident-to billing is a relic of the Medicare of the late 1960s where the program was completely passive. It just wanted to pay bills for whatever was going on. And we have a different Medicare today. We have a Medicare that's more accountable, that's more interested in quality issues, that wants to know what's going on in the program.

I first ran into the incident-to issue really as a researcher, seeing that there was just a big black thing that I couldn't see through because of this ability. So to me that's the virtue of the specialty designations, so we have a much better sense of what's happening in the
Medicare program. It makes certain policies feasible that wouldn't have been feasible otherwise, making use of specialty designations.

I think for the incident-to billing, it is leading to overpayment, and some incentives that we probably don't understand, which, if we did, we probably wouldn't like what they're incenting.

DR. CROSSON: Thank you. Amy.

MS. BRICKER: Also supportive of prohibiting incident-to billing, but want to think about redeploying those dollars back to the physician. I don't know that -- I had assumed that it wasn't necessarily an upside for the actual nurse practicing, but instead the larger practice, that they're generating additional revenues associated with incident-to billing, and not necessarily flowing down to the nurse practitioner him- or herself.

So, clearly, this policy is a takeaway from, you know, general revenues of those practices, and we're all very attuned to the decline in primary care. And so, you know, I'm not typically in favor of, you know, when we find opportunities for savings, redeploying that. But I think in this case, given the specialty or the general practice
of primary care, we may want to consider that. How then you identify those practices -- I mean, does everyone get a bump equally? I don't know. Do we instead ask for folks to identify themselves as, yes, this is part of my practice and this is a takeaway, so then is there a way for them to begin monitoring? Did they, in fact, stop doing it if you said that it's difficult to monitor or to ensure that this is no longer occurring?

So, I don't know, things we still need to flesh out, but I think that there's value in that and in identifying specialties of those nurse practitioners, because for no other reason, I thought it was interesting and a good point you made around it's quite easy for these folks to switch specialties. You don't see that -- and the physician, of course, is readily -- and so then the quality of the care that's provided if you go from general practice to some other specialty and outcomes associated so in favor of both.

Thanks.

DR. CROSSON: Brian.

DR. DeBUSK: Great chapter, really nice work.

I'm glad we're addressing this.
I think eliminating the incident-to billing I think is an obvious thing. I think it's great that we're exploring this now, and I fully support that, as well as having them specify their specialty designation and updating -- and, again, I'm very much in favor of that.

The thing I want to focus on, though -- and Warner touched on it and Paul touched on it -- we need to pay close attention to the economic and time arbitrage here between a nurse practitioner -- you're probably talking about 24 months postgraduate, probably $35,000; a PA, which is 27 months, probably $72,000, $75,000; and then compare that to, say, a primary care physician. You look at what they're going to spend and the time they're going to invest, there's a lot of economic and time arbitrage there.

And, again, to Warner and Paul's point, you're pulling nurses out of the field into this new -- again, it's an economically beneficial place to be. We can't argue against what they're doing. They're making a good decision. But there's another issue, and this is slightly beyond the scope of this chapter, but this is going to roll right over into the discussion we have here in a few minutes on primary care. What are you going to do as these
mid-levels get independent practice autonomy? We're sitting at 22, 23 states now. I noticed the reading materials didn't really talk about the momentum, but there's really good momentum. I mean, we could be having this conversation next year, and it would be 35. I wouldn't be surprised -- or at least 30. So when you look at that and you look at these degree completion programs that are available -- and I don't know if you guys have had a chance to explore that yet, but, you know, there are now doctorates in nursing practice. There are now PA programs where they complete a doctorate. These are terminally degreed people. These degrees confer the title of "doctor." Now, they aren't a licensed physician, but what do you do with this combination of terminal degrees being conferred and independent practice autonomy? This is something we need to keep our eye on because there will be people running around with the title or at least calling themselves "doctor," practicing medicine with independent practice autonomy, and it could further undermine some of the issues that we're having with primary care physicians and further implode the primary care pipeline.
DR. CROSSON: Okay. Pat, Dana, and Jon.

MS. WANG: Again, I think that this picks up on some of the comments that people have made, but just to draw it down, if incident-to billing is eliminated, then there does, I think, have to be a next step of work of determining what the appropriate fee schedule is for NPs and PAs. Eighty-five product is completely arbitrary, and, you know, it does suggest that the RUC or somebody like that is going to have to determine what the appropriate fee schedule level is. You know, people -- you know, the point that Brian was just making, there is the work that NPs in particular do to provide primary care is really, really essential. But 85 percent of physician, given what they train and what they're expected to do, seems pretty arbitrary. So I'd just put a marker down on that, and it will have financial implications all the way around.

The other thing is that this has -- and I guess we'll roll into the next chapter discussion. It has big implications, I think, for the -- after I read this, I kind of felt like, well, I don't even know what to make of the predictions of oversupply/undersupply of primary care physicians if, in fact, a primary care physician's work is
actually -- it is team-based and it is kind of -- they are extending beyond, you know, the FTE physician in the office because they do have NPs and PAs. I just think it has implications for kind of backing into -- well, maybe the physician fee schedule for primary care as it exists today is sufficient because there's all this incident-to billing, and economically they've made it work. You know, once you start separating everybody into their own little silo of billing and so forth, it does -- I think it raises additional challenges for determining appropriate, you know, levels for the physician fee schedule for the pure primary care doc for their own work. And maybe it is just a matter of, you know, spreading around the money that's in there and kind of allocating it more precisely. This is the fee schedule for an NP; this is the fee schedule for a primary care doctor. But I just want to -- you know, I think there are a lot of implications to going down this route, which, you know, for Sue's comments, I agree, it's too murky right now. It would be good to know more without undermining the good that comes right now of these quasi-teams that seem to be operating to provide primary care effectively.
DR. CROSSON: Dana.

DR. SAFRAN: Thanks. So I'm also in support of both of the recommendations, and I won't add a lot to what has already been said other than that, you know, I think that -- I take the points that are being made about concern that, you know, is 85 percent of fee schedule actually going to turn out to be too much by some measure or creating problems in the nursing workforce?

On the other hand, from where I am sitting and thinking about it, you know, with all that we're trying to accomplish through payment reform, delivery system reform, getting folks practicing at the top of their license, I -- you know, to me this looks like a 15 percent saving by having a workforce that's perfectly capable of doing what for years we've relied on somebody with a physician's credential to do that they may not need to be doing, and that, in fact, the more we're trying to focus health care on issues that extend beyond the four walls of the health care setting to where patients live and work, helping them with the behavior changes that they need in order to manage a chronic condition they already have or prevent one that they are at risk for, these are exactly the kind of skills
that we need. And we need to even go, you know, further
downstream from there to community health workers where the
evidence, you know, is quite good about the effectiveness
of their ability to help truly promote health in the
population.

So I absolutely agree with the point that we're
going to have to think about all of the unintended
consequences of what happens around where a payment gets
set and that 85 percent is arbitrary. But at the moment,
from where I sit, it looks like a really good idea, and at
least to begin to get the data clean, as several have made
that point, so that we can actually know with much more
certainty about what the outcomes are associated with these
types of clinicians versus their physician counterparts.

Thanks.

DR. CROSSON: Thank you. Jon.

DR. CHRISTIANSON: So just a question that I
think builds off of Amy's comments in the first and second
round. On Slide 14, we have Policy Option 1. Typically,
when we get a policy option from staff, they're very
meticulous about saying, well, here's the good things that
could happen, but here's the other things that might happen
that are not so good, pros and cons or pluses and minuses, or however you want to term it. This seems like a list of pros without any list of cons or cautions. Do you want to give us any list of cautions or cons or things we should worry about if we do this or negative impacts?

MR. O'DONNELL: So, right, we'll work in the team-based care that we've heard into the chapter. When we read through some of the things that folks objected to, if direct billing were required, I think we -- you know, I'm not sure we found them to be entirely credible. And so we kind of walked through point/counterpoint in the paper, but I think we drew somewhat of a blank on that.

DR. CHRISTIANSON: So there are no negative impacts of doing this?

MS. BLONIARZ: I think one assertion, you know, is that it's taking money away from, you know, team-based care or primary care. I think just, you know, where we see APRNs and PAs providing most of the services, most of that money is not going to primary care. And so I think we kind of don't necessarily agree with that one.

DR. CROSSON: Okay. So just for a change, let's start down there with Jonathan.
DR. JAFFERY: Sure. Thank you, Jay.

So I also am in support of both of these. I won't speak a lot to the incident-to because I think others have articulated it well, other than, you know, as we think about redeploying savings, there might be an opportunity to actually address some of the team-based and primary care issues by redeploying them preferentially to primary care, even though they wouldn't all be coming from primary care.

In terms of the Slide 15 and Policy Option 2, similar to what Jon said about Policy Option 1, I didn't hear a lot of discussion about potential negative impacts, so I would just suggest that there is a lot of positive that could come out of this, and, you know, as a real-world example, we have excluded all of our specialty PAs and ARPNs, of which we have a lot, from our ACO. They're all preferred providers instead of participants. So you can comment -- I believe your point, ACO has done the same thing because it perturbs our attribution model. And so we don't want to do that, but we didn't feel like we had any other choice. So I'll leave it at that.

MS. BLONIARZ: Yeah, and I just way to say one thing about this option. I mean, this would have to be
basically self-identified specialty. The credentialing and licensure for APRNs and PAs is a little different than physicians, so it's not as if someone -- you know, someone becomes a cardiologist and they may work in cardiology and internal medicine and are boarded in both. On the physician side it is a little bit more discretionary, on the APRN and PA side, so that is a distinction. Maybe not a downside but it is a distinction here.

DR. JAFFERY: But your report did lay out some of the requirements you have to do, and there are some other places where that has impact, like inpatient consultation and follow-up and things like that.

DR. CROSSON: Warner.

MR. THOMAS: So one other question, and I know I should have done this in round one but I just thought of it. There's a comment about quality indicators, that there's really no discernable difference in quality. Do you know exactly what was looked at, in reference specific articles, do you know exactly what they looked at?

MS. BLONIARZ: So -- and again, this was very -- this was just very general, right. And so we looked at a number of different meta analyses or studies, you know,
that different organizations had put together, and then Carolyn pulled a little over 100 articles herself. And a lot of them are, you know, okay, for a set of discrete outcomes, like diabetes outcomes in an outpatient setting in the Veterans Health Administration, or HIV/AIDS care in a certain setting. You know, there are a few kind of quasi-randomized trials, quasi-randomized studies that allocated among, you know, NPs and physicians, and then it's, you know, did you -- just kind of patient experience type measures. But it was a mix. It was kind of all over the place.

MR. THOMAS: Okay. So I guess I definitely am in favor of the policy recommendations. I think that the one word of caution I would have is on the 15 percent, you know, cost savings. I'm not quite sure if it would net out that way, just given that there are utilization differences, at least in our experience, of ancillaries, and it's kind of referenced in the chapter, and I do think that's an important distinction. It doesn't mean that we shouldn't continue with what we're talking about doing, but I'm not quite sure it would be a kind of a straight 15 percent savings, kind of service for service, once you kind
of look at the total cost of care.

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

DR. CROSSON: Karen.

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

I don't know if that's the fact or not, but I would just want to think about that a little bit more than I have. And secondly, that there are some implications for the physicians in the states where they have collaborative relationships, because it does take time to review cases and charts, so it's not perfectly clean. Not that I'm against it. I just think we should be thinking through if the results are going to be what we're considering, whether that's cost or access, et cetera.

And I want to just go back to this thing about trying to understand the goal, in general, and we'll maybe talk about this in the next chapter. But if the goal is for the beneficiaries to have access to great quality care and great health outcomes, how the teams work together to make that happen. In a primary care, patient-centered, medical home kind of model you'd want to give them maximal flexibility as opposed to thinking about adjusting the fee schedule. That's where I would really want to go for global payments.
And so my initial reaction in reading this was a food fight, almost, about who's going to be the primary provider for the patient as opposed to thinking about the patient and how we would best attend to them. It's not necessarily a recommendation. It's just a general comment about where this work could take us, which I think is antithetical to where the field needs to go, around really encouraging global payments to focus on outcomes and for teams to meet patients where they are, with the skill set that best works for that person, not only based on disease acuity but on their overall situation.


DR. PYENSON: I support both recommendations. Thinking about our commitment to site-neutral payments, which might argue that in the absence of other information we should not pay 85 percent but 100 percent, but I'm happy with the recommendation as it is.

MS. BUTO: Bruce gets the award for the shortest input.

So I support both recommendations. I think it's an excellent direction that we're moving.
I would point out a couple of things. One is that the issue of direct billing in the physician's office seems to me is very gameable. You pointed out that it's hard to monitor now, or impossible, when something is "incident to" or not. It seems to me equally hard to figure out if a physician starts billing within an assertion that the physician provided more than 51 percent of the service. So I just point that out. I mean, we think we might be getting a 15 percent savings but I suspect we won't be getting that.

I'll also point out, as you have in the paper, that this shouldn't be a big deal if we're already not paying -- we're doing direct payment to the nurse practitioner and physician assistant in the hospital setting for new patients and for established patients with new problems. So it seems to me that levels the playing field between physician office and hospital settings and for all patients.

Then I was struck by the fact that when you've got an existing patient with a new problem, why wouldn't the physician be involved? That seems like exactly the case where you'd want the physician to take more of a role,
not necessarily the NP or the PA. So, anyway, I just raise
that question.

To other people's points about the 85 percent and
it's arbitrary, I wonder if we don't want to do it here but
we ought to think about a separate fee schedule for a non-
physician workforce.

Karen brought up the issue of global payments,
and I think that's a really good point. That would really
combine more of the physician payment and the NP payment
around something, a service, and I think that's one way to
go.

Another thing to think about, it seems to me, is
if we want to promote more organized systems of care, maybe
there's a different model for the NP or PA primary care
service that provides more of a per-month payment or
something else that's closer to per-beneficiary payments.
And I'm thinking back to our recommendations around the
per-beneficiary primary care payment to physicians.

So I'm just wondering if we can think differently
about how we pay them instead of 85 percent of what a
physician gets, and actually try to advance the idea of an
organized system of care, because I think many of us have
1 had the experience that the nurse practitioner is kind of
2 the core of organized care around any episode -- surgery or
3 a long chronic disease or whatever.
4 So I just ask us to think outside the box, in
5 terms of payment.
6 DR. CROSSON: Okay. Thank you, Kathy. So my
7 sense is here that we've got enough agreement on the
8 recommendations that we could consider asking you to come
9 back in December with draft recommendations for us to look
10 at, given the caveats that Karen and Jon and others have
11 brought up, try to see if we can't answer those, and
12 consideration for inclusion of this material in the March
13 report.
14 Okay. Thanks very much. Brian and Kate, you're
15 done early.
16 [Pause.]
17 DR. CROSSON: Okay. We're now going to continue
18 with our discussion about primary care workforce, and Ariel
19 here is going to take us through the next analysis of the
20 issue regarding primary care physicians.
21 MR. WINTER: Good afternoon.
22 As Jay said, I will be talking about Medicare's
role in the supply of primary care physicians, and before I begin, I want to first thank Emma Achola for her help with this presentation.

So here's the outline for the presentation today. I'll start with some background information, including a review of the Commission's prior work on primary care. I'll describe beneficiaries' current access to primary care physicians and discuss the factors that influence physicians' choice of specialty. Then I'll talk about HRSA's programs to increase the supply of primary care clinicians and then conclude by discussing some options for Medicare to increase the supply of primary care physicians.

High-quality primary care is essential for creating a coordinated health care system. Physicians who focus on primary care are generally trained in family medicine, internal medicine, geriatric medicine, and pediatrics. These physicians accounted for 19 percent of all health professionals who billed Medicare in 2016. As Kate and Brian talked about, other health professionals, such as nurse practitioners and physician assistants, may also provide primary care.

The Commission has been working on primary care
issues for several years. Although we have made several recommendations to improve payment accuracy and better support primary care, the Commission has recently expressed interest in approaches that could have a larger impact on the supply of primary care physicians.

This slide lists some of our key prior recommendations in this area.

In 2008, we recommended that Congress create a budget-neutral bonus for primary care services, which eventually became the Primary Care Incentive Payment program, or PCIP.

In 2011, we recommended that Congress repeal the sustainable growth rate formula and provide higher updates for primary care services relative to other services.

Also in 2011, we recommended that CMS identify overpriced services in the fee schedule and reduce their payment rates. To accomplish this, CMS should collect data on clinician time and practice expenses from a cohort of efficient practices.

And in 2015, we recommended that Congress establish a per-beneficiary payment for primary care clinicians to replace the expiring PCIP.
According to a beneficiary survey and beneficiary focus groups that we conducted last year, most beneficiaries reported that they are able to obtain care when needed.

Their access to care is comparable with or better than access reported by privately insured individuals ages 50 to 64.

However, a small share of beneficiaries who are looking for a new doctor reported trouble finding one. They were more likely to report trouble finding a new primary care doctor than a new specialist.

This is a cause for concern because it could signal a problem with access to primary care for the small share of beneficiaries who are seeking a new doctor. We monitor the situation very closely every year when we redo our survey.

Next, we will look at changes in the supply of primary care physicians in Medicare.

I first want to point out that there are more than twice as many specialists treating beneficiaries as primary care physicians. This could be one reason why some beneficiaries are having difficulty finding a new primary
care physician.

The second thing to point out is that the absolute number of primary care physicians treating beneficiaries increased between 2011 and 2016, although the number per 1,000 beneficiaries declined modestly, from 3.8 in 2011 to 3.5 in 2016.

Likewise, the number of physicians in other specialties also increased between 2011 and 2016, although similar to primary care physicians, the number per 1,000 beneficiaries declined, from 8.4 in 2011 to 7.8 in 2016.

In recent years, there has been rapid growth in the number of Medicare beneficiaries, as the baby boomers begin to age into the program. This enrollment growth shrinks the ratio of physicians to beneficiaries over time, even though the overall number of physicians has been increasing.

By way of comparison, the ratio of physicians per 1,000 U.S. residents has increased slightly between 2011 and 2016.

There is mixed evidence on the adequacy of the pipeline of future primary care physicians. In recent years, the number of active residents in family medicine
and internal medicine has increased faster than the total number of active residents.

Between the 2013-2014 academic year and the 2017-2018 academic year, the number of family medicine residents grew by about 18 percent, and the number of internal medicine residents grew by almost 16 percent. During the same period, the total number of residents across all specialties increased by almost 13 percent.

Although family medicine residents usually end up practicing primary care, internal medicine residents may decide to enter subspecialties, such as cardiology or gastroenterology, instead of practicing primary care.

According to one estimate, 49 percent of internal medicine residents who began their residencies in 2001 were predicted to stay in primary care, compared with 43 percent of internal medicine residents who began their residencies in 2010.

Also, there are significant disparities in compensation between primary care physicians and specialists that could deter medical school graduates and residents from choosing to practice primary care.

This chart shows differences in median annual
compensation from 2016. Median compensation for primary care, which is the second bar from the left, was about $236,000. By contrast, median compensation for radiology was almost twice as high at $466,000, and for nonsurgical procedural specialties, it was $435,000.

Based on a review of the literature, here are some key factors that influence physicians' choice of specialty, lifestyle preference, such as work hours and family time. Characteristics of medical students; for example, rural background, lower SES, and lower parental income are correlated with the choice of family medicine. Another factor is the characteristics of medical schools and curricula; for example, medical schools that graduate a higher share of primary care physicians are more likely to use community hospitals as teaching sites instead of academic medical centers.

Income expectations also play an important role. One study found that students entering specialties such as orthopedics and general surgery were more motivated by income than lifestyle concerns. Other studies found that students who chose specialties other than family medicine were concerned about
1 the low-income potential of family medicine.
2 Evidence of the effect of student debt is mixed.
3 Some studies find it has a modest impact or no impact on
4 specialty choice, but other studies find that students with
5 no debt or high debt are less likely to choose primary
6 care.
7 The finding that medical students with high debt
8 levels are less likely to choose primary care is
9 particularly concerning because median medical education
10 debt has been rising.
11 According to data from AAMC, median debt among
12 medical school graduates grew from almost $165,000 in 2010
13 to $180,000 in 2016, and these numbers are adjusted for
14 inflation.
15 But the share of students graduating with no debt
16 increased from 16 percent in 2010 to 27 percent in 2016.
17 This indicates that debt is becoming more concentrated
18 among a smaller share of students. It also suggests growth
19 in the share of students from affluent backgrounds, which
20 is consistent with prior Commission research.
21 Now I am going to switch gears and talk about two
22 programs run by HRSA that are designed to increase the
supply of primary care clinicians. This information is meant to give you some background, and it may also help inform your thinking about the design choices for a program to encourage medical school graduates to provide primary care to Medicare beneficiaries.

The first HRSA program is the National Health Service Corps, which provides scholarships and loan repayment for primary care clinicians. It will receive $300 million in mandatory funding in FY 2019. Recipients must commit to practicing in an underserved area for at least two years.

There are currently 10,200 NHSC clinicians, who provide care to 10.7 million people. This is a substantial increase from 2009, when there were only 3,000 NHSC clinicians.

Participating clinicians include primary care physicians, who are 20 percent of the total; nurse practitioners, who are 21 percent; physician assistants who account for 11 percent; nurse midwives; dentists; and mental and behavioral health professionals.

Participants must serve in a health care site approved by HRSA. Fifty-seven percent of clinicians serve
in federally qualified health centers. Other approved
sites include rural health clinics, community mental health
centers, private practices, and Indian Health Service
facilities.

The second HRSA program that I want to talk about
is the Primary Care Loan program, which provides low-
interest loans to medical students who commit to practicing
primary care.

Recipients must practice primary care for 10 years, which
includes their residency, or until the loan is paid off,
whichever comes first.

Unlike NHSC, there is no requirement to work in
underserved area. Medical schools that participate in the
program must match one-ninth of the loan amount received by
their students.

There is much less information available about
the Primary Care Loan program than about the NHSC.
According to most recent public information, this program
provided $30 million in loans to over 400 medical students
in 2009.

Due to concerns about the future supply of
primary care physicians, the Commission may wish to
consider options for Medicare to increase the supply of primary care physicians or change how Medicare funds graduate medical education. Today, we will talk about an idea for a scholarship or loan repayment program for medical students or graduates who commit to providing primary care to Medicare beneficiaries. Such a program could encourage more students to choose primary care by alleviating their concerns about repaying student loans.

At a future meeting, we'll discuss ways to increase accountability for Medicare's GME payments. As a reminder, in 2010, the Commission recommended that the Secretary create a new performance-based GME program to support workforce skills that will improve the value of the delivery system. We said that the funds should be distributed to institutions that meet ambitious goals for practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

In thinking about Medicare scholarship or loan repayment program, there are some important design issues to consider.
The first is the size of program in terms of dollars and the number of physicians. As one reference point, the NHSC will receive $300 million in funding in 2018, and there are 10,200 physicians and other health professionals in the program.

The second issue is how to finance a Medicare program.

Third, which types of medical students should be eligible for the program? Should it be open to all students or focus on underrepresented students, such as those from minority, lower income, and rural backgrounds? A scholarship or loan repayment program would probably be more attractive to lower- or middle-income students because they are less likely to have access to family financial resources to pay for tuition.

The fourth issue is which types of specialties should be considered primary care and therefore eligible for this program. The Commission's recommendation in 2008 for a primary care bonus included the following specialties as primary care: family medicine, geriatric medicine, internal medicine, and pediatrics.

Assuming that Medicare is financing this program,
it could prioritize specialties that are in relatively short supply, such as geriatrics.

The fifth issue is how to define the requirement for physicians to treat Medicare beneficiaries. One option is to require that they treat a minimum number of beneficiaries, which is a measure that could be validated with Medicare claims data.

And the sixth issue is the length of the service commitment. This could be related to the amount of the scholarship or loan repayment received by a physician, with the length of the commitment increasing as the amount increases.

For example, students who participate in the NHSC's scholarship program serve for two to four years upon graduation, depending on the length of the scholarship.

So for your discussion, is there additional information that you'd like to see? Do you have an interest in developing an idea for scholarship or loan repayment program for medical students who commit to providing primary care to Medicare beneficiaries? And do you have any comments on the design questions that we've raised?
This concludes my presentation, and I look forward to your questions and discussion.

DR. CROSSON: Thank you, Ariel.

I have one I'd like to start with. Did you happen to run across or do you know whether the uniform services still provide scholarships? I know they did at one time in exchange for some certain years of service. Is that over with, or is that still good?

MR. WINTER: I will look into that. Last I heard, that still exists, but we'll check into that and get back to you.

DR. CROSSON: It might be interesting to know the parameters for comparison as we get to that point.

MR. WINTER: Yeah.

DR. CROSSON: Okay. Other questions?

Start with Jon.

DR. CHRISTIANSON: On Slide 11, Ariel -- and you noted the big increase in the number of clinicians that participated in the NHSC since 2009. Does your data show you whether that increase is concentrated among NPs and PAs versus primary care physicians?
MR. WINTER: So since 2009, the share of clinicians who are physicians has decreased sharply. In 2009, it was 35 percent of the total. Of course, there was a smaller base, and currently, it's 20 percent, according to HRSA data.

DR. CHRISTIANSON: So that suggests that --

MR. WINTER: That's gone down.

DR. CHRISTIANSON: -- the uptick is probably among the NPs and PAs as opposed to primary care physicians, then?

MR. WINTER: The biggest increase has occurred among mental health and behavioral health professionals.

DR. CHRISTIANSON: Ah.

MR. WINTER: They've gone from, I think, about 10 percent to something along the lines of 27 percent.

DR. CHRISTIANSON: Okay.

MR. WINTER: NPs and PAs, I'll check and see what the change has been.

DR. CHRISTIANSON: But the bottom line is it's not been among primary care physicians? That's not what's driving this increase?

MR. WINTER: That's correct.
DR. CROSSON: Over here. Dana, did you have your hand up? No. Go ahead, Jon.

DR. JAFFERY: Thanks.

DR. PERLIN: Great presentation.

I want to come back to in the realm of additional information, implications for design issue, this question of access. You noted in the presentation that access was generally comparable, small share looking for a new doctor or poor trouble finding one. Do you have any insight into characteristics of patients who had trouble finding a doctor? Does that vary by market or by the age of beneficiary?

And I'm going to mention exactly why I'm asking that second question in a moment.

MR. WINTER: So Kate is in charge of that survey, so I'm going to look over to her and see if she wants to join me up here and address your question. She's the most qualified to do so.

Here she comes.

DR. PAUL GINSBURG: While Kate is getting there, I can say I think a lot of it is beneficiaries who move,
they bear some of the brunt of these problems in access.

MS. BLONIARZ: And then generally, so access is fairly comparable between urban and rural. There are some geographic locations that have more trouble, but then by demographic, the under-65 have much more trouble, and people with behavioral health conditions have much more trouble.

DR. PERLIN: Any difference in age?

I'll tell you what. I realize the anecdote is not data, but it gives me pause to be sanguine without looking at differences between the very old and the old. I have found more difficulty placing patients into primary care who are older and/or have more simultaneous chronic conditions because the practices will often try to sort of balance the impact with the load of their practice by distributing as to not having too many with multiple comorbidities or the older old. And I just think as we think about the implications for program design and the parsing toward which specialties like geriatrics that behind the data, there may be another set of data driving the metrics as to those who may have more trouble. I'd just encourage us to see if we can't find any data that
would have that next-level nuance.

Thanks.

DR. CHRISTIANSON: Brian.

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

I had a question about the grants and the loan programs, and I suspect I know the answer. But is there any way to measure the efficacy of these programs? Has GAO or anyone gone in and looked at how -- I mean, what would the counterfactual even be?

And maybe as a follow-up question, knowing that it's virtually impossible to do, do we have a feel for how subscribed or oversubscribed these programs are? I mean, are they $300 million programs where there's $900 million worth of requests, or is that -- where does that stand?

MR. WINTER: Both good questions.

When we did our 2010 chapter on graduate medical education, we pointed out that there's not been a comprehensive evaluation of NHSC, and that was years ago. And I've looked online. I've not been able to find a comprehensive evaluation by GAO, by OIG, or by HRSA.

HRSA does produce an annual report to Congress,
but it's sort of descriptive, like here's the number of clinicians, here's some statistics about where they locate, and that sort of thing.

DR. DeBUSK: Any information on retention, maybe, or --

MR. WINTER: Yeah, there's information on retention, and we cite that in the paper.

There's an evaluation by contractor, which found that 55 or so percent of NHSC clinicians were still serving in an underserved area 10 year after the program, 10 years after they left the program, and underserved areas defined by health professional shortage area.

Your second question was about -- just remind me.

I lost track.

DR. DeBUSK: How subscribed or oversubscribed was the program?

MR. WINTER: Yeah. So HRSA notes in a recent report, annual report, about the program that the demand for NHSC clinicians by approved sites exceeds the number of available clinicians. So it could be there's an issue of - it could be the limited funding is what's restricting the total number of clinicians they can accept, or it could be
just interest. I'm not sure what that's a function of, whether it's the money or interest by clinicians in joining the program.

DR. CHRISTIANSON: Amy.

MS. BRICKER: Just a point of clarification. So you note the question around what would be the length of service, and I wasn't clear what was meant by that. So you talk about a percent of Medicare beneficiaries as part of your patient population. Is that what you mean? You must maintain a certain caseload of Medicare beneficiaries for a period of time?

MR. WINTER: Yeah. So I was trying to separate the two, these two requirements. The one requirement is presumably you would want to require physicians to treat a certain number or percent of Medicare beneficiaries in order to demonstrate that they're serving this population. That's one issue. The second issue is: How long do they need to be in this program? How long do they need to --

MS. BRICKER: Do that.

MR. WINTER: Yeah, serving that required number of beneficiaries. And so I gave some examples in the paper and in the presentation from other programs.
MS. BRICKER: Okay. Thanks.

DR. CHRISTIANSON: Back to Pat.

MS. WANG: Going back to Slide 6, given the conversation that we just had, is it possible, does it make sense to try and supplement the number of primary care specialties per 1,000 beneficiaries by the number of NPs and PAs practicing primary care? Because it's grown quite a bit.

MR. WINTER: Yeah.

MS. WANG: So a decrease in the number of MDs in this area may be more than offset compared to the starting number given the growth in the other -- I think it's just - if we're talking about primary care supply, clinician supply, that might be an important extra column to try to add in.

Then the sort of related question is: Is there an ideal number that we would choose to aim for with the aging of the population and the anticipated growth in Medicare from a workforce planning perspective, whether it's MDs or MDs plus alternative practitioners, non-physician clinicians? What should we be aiming for?

MR. WINTER: Yeah, good question. And with
regard to your first question or first observation about
this particular table, in the chapter we noted that over
the same period, the number of NPs and PAs per 1,000
beneficiaries increased from 2.8 in 2011 to 3.9 in 2016, so
really more than offsetting the decline in primary care
physicians per 1,000 beneficiaries. And it's something --
we include that in the table that we have in the physician
update chapter every year. We can certainly add another
column to this that includes -- another column with the NPs
and PAs.

Then the second issue is how do we know what the
right number and distribution is, which a really big and
important question. If you look back at our 2010 chapter
on graduate medical education, one of our recommendations
was for the Secretary to do a workforce analysis looking at
the number of residents in different specialties that would
be required for a high-value, low-cost health care system.
And as far as I know, that recommendation has not been --
that report has not been done.

One of the things we suggested as an example, an
illustration, they could look at a high-performing health
care system that currently exists and look at their
distribution of clinicians as an example or a benchmark.
So we can look into this more. I don't have, you know, a number handy to give you, but it's something we can look at more and see if there's more recent literature on that.

DR. CHRISTIANSON: Let's finish up with this side of the room with Paul, and then we'll come over here.

DR. PAUL GINSBURG: Ariel, you described -- I'm really glad you're focusing us in this direction about scholarships and loan forgiveness. It's really maybe more effective.

You described the National Health Service Corps as having mandatory funding?

MR. WINTER: Yes, which expires in 2019.

DR. PAUL GINSBURG: So does that mean it's not appropriated, that it's kind of like entitlements?

MR. WINTER: So originally their funding was discretionary, so it was appropriated every year. And then they got -- under the ACA they got five years of mandatory funding of $300 million per year for five years, and then that was extended between 2016 -- 2017 through 2019, $300 million per year mandatory funding. After that it expires,
and there's no -- right now there's no provision for additional funding after 2019?

DR. PAUL GINSBURG: So in a sense, maybe the growth in the size of the program really reflects the increase in funding.

MR. WINTER: Oh, yeah.

DR. PAUL GINSBURG: You use that as evidence that it's a strong incentive to be in rural areas.

MR. WINTER: Right. I think definitely the funding is a piece of it, but if there was no interest, if clinicians did not have an interest in doing this program, you wouldn't see an increase in clinicians. You could have the money available, but if people are not interested in making that tradeoff, then the enrollment will not grow.

DR. PAUL GINSBURG: Yeah. But isn't it possible there are a lot of people that would have gone to rural areas anyway, and now they have the opportunity to get a scholarship or loan forgiveness to do it, so it's not really changing anything? And I think we'd need a much more elaborate study to have conclusions.

MR. WINTER: Okay, sure.

DR. CROSSON: Jonathan.
DR. JAFFERY: Thank you. So maybe building on that and some of Brian's question, you may have answered this or maybe I just didn't understand. So on Slide 12, thinking about this other program, the primary care loan program, you've said already that you've had trouble -- it's not easy to get a lot of data on it. But we should be able to know what the budget is. It says it provided $30 million in loans. Isn't that, in fact, the budget for it? Did it spend all of it? And I'm just thinking about design questions. You know, this one has a ten-year practice time frame, which is considerably longer than some of the other ones. It requires matching that might make it more difficult to get, and I'm not sure if medical schools -- how many medical schools are able and willing to do that. Do you know off the top of your head if --

MR. WINTER: We have not been able --

DR. JAFFERY: -- greater than $30 million?

MR. WINTER: We have not been able to get any information about their budget since 2009. We have sent them a list of questions about that and other issues. We have not heard back yet. We have been pursuing this, and --
DR. JAFFERY: So not even just what they spent, but actually what they're allocated, we don't know that.

MR. WINTER: So one thing to point out is that they actually do not get discretionary mandatory funding. The way they finance their program is through loan repayments and penalties when students default on their loans. That's what they say on the website. They have nothing on the website about how much -- the dollar value of loans they've made in recent years or how many medical students are currently receiving loans, nothing about that.

I can tell you that there are 35 medical schools that participate in the program. The list is on their website. They have to meet certain requirements to participate, which I lay out in the draft paper, one of which is matching the grants, one-ninth of the grants. And they also have to graduate a minimum percent of their students as primary care, I guess, residents or clinicians -- physicians. I think it's 50 percent.

DR. JAFFERY: Thanks.

MR. WINTER: We'll keep looking into it [off microphone].

DR. CROSSON: Okay. Karen, are you up?
DR. DeSALVO: I have what I hope is a simple question that may have been in here, Ariel. Do you have a sense of how many Medicare beneficiaries the National Health Service Corps scholarship and loan repayment programs serve currently? What's the impact on access for beneficiaries in the current state?

MR. WINTER: That's a really good question. The reports that I've read from HRSA and a CRS report do not have that information. If we can get data from HRSA on NHSC participants with some kind of NPI or identifier, we can link it to Medicare claims and try to figure that out, if that would be of interest.

DR. DeSALVO: Yeah.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Thank you very much, Ariel. I've got actually a couple of complicated questions. I noted on Slide 13 that today's discussion is about the scholarship loan repayment, but some future meeting we're going to talk about GME payments. So I am going to ask a question about GME payments just in order to get a feel for which is more important. So when we think about the student loan, on Slide 10 you have a figure of $180,000 median for
presumably 2016 graduates. Do you have a figure or could we come up with a figure of what's the total GME and IME divided by the number of 2016 graduate students? And which one's bigger?

MR. WINTER: I'll have to come back to you on that unless one of my colleagues sitting over there has that number off the top of their head. But no one is signaling, so I'm guessing -- we'll have to calculate that and get back to you. I assume you would want the denominator to be the number of residents, right?

MR. PYENSON: I think so --

MR. WINTER: Because that's what they're supposed to fund.

MR. PYENSON: You know, the 180 -- it's not quite an apples-to-apples because debt is not -- but I'm trying to get if GME and IME is just the over -- much, much more important than student loans, then maybe our efforts are better spent in the future discussion than on the loan -- you know, to prioritize which is more important.

DR. CROSSON: Well, I'm not sure I quite get it. The last time, I remember the last time we looked at GME, DME, and IME together, that was --
MR. WINTER: 2010

DR. CROSSON: -- a number of years ago -- yeah, 2010. It was $9 billion a year at that point. It's probably inflated up from that, but it's in that range.

MR. PYENSON: So round numbers, $10 billion. How many residents do we have a year?

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

MR. PYENSON: -- graduates -- anyone? There's roughly a million doctors in the country, so it's...

DR. DeBUSK: I thought it was 140,000 in the program. That's what the report -- the published report, the IOM report on graduate medical education from like 2014, 2015? So I'm sure it's inflated a little since then.

MR. WINTER: You're pretty close. According to the most recent ACGME report, data resource book, there were 135,000 active residents in the 2017-18 academic year across all specialties.

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

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

MR. WINTER: Right, across all years, not necessarily GME-funded.
MR. PYENSON: A quarter of that. So it sounds like doing the division, the GME/IME could be a bigger number. So that's my question. We don't have to figure it out now.

The other question I have is there was a news item recently that NYU is waiving its tuition, and if that is a trend, and there's certainly other universities that probably have more money than NYU -- a few, maybe. Okay. If that's -- you know, is that something that we're going to see? Is there any expectation of seeing tuition actually decrease?

MR. WINTER: The long-term trend is increase, that tuition has increased. I'm not aware of other medical schools that have made the same commitment as NYU for all their students. Some medical schools have done it -- I've heard of one that's done it for students depending on their income. I think Paul wants to get in here.

DR. PAUL GINSBURG: Yeah, I just want to say that I think the NYU money came from a very wealthy donor who wanted them to do this, and they're delighted because now they can attract the very best students. But it seems to me a very untargeted way of addressing the issue of cost to
medical school students.

MR. PYENSON: Well, a natural experiment, we'll see if NYU changes and produces a lot more primary care.

DR. CROSSON: The other point I think is worth making is that having a lot of money and being willing to part with it are two separate things.

Kathy?

MS. BUTO: Okay, so this is a question you don't have to answer right now, but I wondered whether we -- there are surveys where we know that physicians have said that the issue is fees versus loan repayment versus status, other things, lifestyle, that are driving them away from primary care or driving them to specialty care.

MR. WINTER: Yeah.

MS. BUTO: So that's one question. I don't know if you want me to stop. I have two others.

MR. WINTER: So, yeah, I can take that. So we looked at several different studies, and in some studies one factor is statistically significant, and another study the same factor is not. So the ones that I included on Slide 9 were the ones that -- with the exception of the last one were pretty consistently related to choice of
specialty. Lifestyle preference, an example there would be
-- one study -- many studies that surveyed students or
residents when they asked them what factors they
considered, this one often rose to the top or near the top.
Student characteristics, that was pretty consistent across
studies. Type of medical school and curricula, and income
expectations. There was one study that found really no
relationship, but two other studies that found a
relationship, and student debt, as I said, the evidence was
mixed depending on the study, but there was a very large
retrospective study which found that students at either end
of the spectrum, those with no debt or those with high
amounts of debt, were less likely to choose primary care.

MS. BUTO: Okay. I did see that work, and I just
wondered whether we had a sense of dimension or priority
among those, and I guess the answer is it depends.

MR. WINTER: Yeah. So there are a couple of
studies that looked at, you know, many factors, and we can
get back to you with what they found in terms of the
ranking of the different factors. Other studies focused on
maybe just a couple.

MS. BUTO: Okay.
MR. WINTER: So it varies based on study design.

MS. BUTO: Okay, great. Thanks. What I'm trying to get at here is: Would this loan repayment scholarship program make a difference? And so I think we have to sort of tie those together.

The other related question to that one has to do with Slide 12, which is the issue of the primary care loan program for which we have very little information. But I think what would be really helpful, because this sounds a lot like what we're trying to achieve, is whether there's any staying power. In other words, do these students really -- or these physicians stay in primary care for an extended period of time? I don't know if we have a sense of that.

MR. WINTER: That's another one of the questions we've asked them that they have not yet gotten back to us on.

MS. BUTO: That would be pretty important if we could find out for deciding whether to advance this proposal or not.

MR. WINTER: Yes. I agree.

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

MS. BUTO: Okay, thank you. So I really think this is an important topic. We keep coming back to it. We have a couple of assumptions in coming back to it. One of them there is going to be or there already is a primary care shortage that we should try to address before it becomes really acute.

I think the other assumption that we've had for a long time is the physician fee schedule is part of the problem. I have to say for me I've never been convinced that it's the fee schedule. So I think this work is important because I think there's a multifactorial picture of why physicians are not choosing to stay in primary care or even, you know, specialize in primary care in the first place. I think this is one of them potentially, the issue of debt. I also think the issue of debt may be deterring some physicians who we want to be attracted into primary care for beneficiaries, so racial and ethnic minorities, language minorities, as the population changes demographically. So I think this is really important work for that reason, that that could make a difference potentially.
I think the other factors might be things like administrative burden, so things like faster payment, other mechanisms that would advance or make more attractive primary care from the standpoint of it's easier to practice primary care in Medicare. There are others, I know, that have to do with just burden of reporting, coding, et cetera. Maybe there are other things that we may not have time to do this go-round, but we ought to look at as part of a bigger picture of what's making primary care less attractive.

And then I'll go back to our last discussion, which is I really think there's work that we've started to look at advancing a more important role, a more key role for primary care in Medicare so that more of the judgment, decisionmaking, accountability, they are the hub and the spokes are other specialties who provide care to the beneficiary. Some change in status I think is going to be important. How we get there, I don't know.

I just want to make two sort of more technical comments, or more specific comments about the proposal. You asked, among other things, about which specialties should be considered. And I keep coming back to the fact
that diabetes is a root cause condition that has generated
tremendous cost in the Medicare program. If you look at, I
think CBO has done some work on this. If it's a root cause
condition then it seems to me that endocrinologists or
other specialists who become the primary care physician for
a patient with diabetes ought to be considered.

I would actually consider dropping internal
medicine because so many internists go into subspecialty,
but maybe it's internal medicine if subspecialty is
whatever.

So I actually think let's look at the areas where
we want to encourage physician primary care to treat
chronically ill Medicare beneficiaries and figure out if
there are some specialties in there who ought to be
considered for something like this, because we want to
encourage better supply of those individuals.

DR. CROSSON: Thank you, Kathy, and I would just
build on that last comment, and this has come up before, to
include mental health and substance abuse providers as
well. I think there's a problem there.

Okay. So let's continue the discussion. Let's
start over here again with Brian.
DR. DeBUSK: Again, great report. I'm really glad we're digging into this. I know we've talked around the primary care pipeline issue for a while. I'm glad we're addressing it specifically.

Just dovetailing onto the last conversation that we had, where we were talking about nurse practitioners and PAs. There is one obvious solution that we could do, which is encourage a degree completion program for some of these people who have been successfully working in the field, as PAs, particularly, because they have a pretty good basic science background. To me it seems a little crazy that someone can be working as a PA for years, successfully, but if they want to go back and become a doctor or, say, go into primary care, they basically start from scratch in medical school.

So I think going to the accrediting bodies and building a credible degree completion program does two things. It addresses a lot of the quality and utilization issues that we discussed in the previous session. We know we have an adequate supply of these people because we've been producing them at a good rate. And it would address some of the primary care issues, because I think these
people could become primary care physicians.

Now the sticking point is going to be this issue of we're calling them doctors, but that's why I made the point in the last session, the title "doctor" is already lost. I mean, I would make the analogy, if you look at protecting the title, at least in the profession, I mean, it's almost like a car that's skidding off the road. At this point we can either steer into the skid or we can just keep skidding off the road. But I would strongly encourage us to explore a degree-completion program for midlevels.

The other thing that I want to focus on, I love what you're talking about with the grants and the loan forgiveness programs. I think those will be effective.

Kathy, I thought you were about to wander there when you were talking about who's going to administer it.

If you look at the 145-ish or so medical schools that we have in this country, we know the schools that are really good at producing primary care physicians. And if you look at those schools, both the DO schools and the allopathic schools, a lot of what they do is very cultural. I mean, they don't feel like traditional medical schools. They're in rural locations, they recruit differently, they
market differently, their admissions process is different, the composition of their faculty is different, their clinical rotations spots are different. It is a fundamentally different culture for these schools that are producing 60, 70, 80 percent primary care physicians. And there are schools that are producing 80 percent primary care physicians. They're just very culturally different.

So I hope when we go into the final report that we'll consider just a little variation on this. What if we went to any school -- I don't think anyone shouldn't be eligible -- what if we went to a school and said, "Look, we're prepared to give you a block grant." Now let's do matching money, but let's put them on the hook. Let say, "You tell us what you're going to deliver for us, in primary care physicians." We're not going to be as prescriptive on the money. We're not going to say it has to be a loan. As a matter of fact, the school might want to spend some of its money, say, on recruiting.

A great example, you know, we know when we pick rural students in medical schools they tend to not be as academically prepared. I mean, they may want to spend some of that money on remediation. Because when I'm trying to
find particularly a rural primary care physician, I don't
need to be recruiting out of Los Angeles and New York. I
mean, I need to be recruiting out of the locations that are
similar to or exactly where those people are going to
serve.

So I think culturally if we could go to these
schools -- and again, this isn't free money. They would
have to -- there would be limits on what they could spend
the money on. But if they could spend it on recruiting and
faculty and some of the other -- clinical rotation spots
are a great example. I mean, if you could spend a little
more and buy better, more prestigious clinical rotations
spots, yet another good use of that money that would draw
those students in and make them better prepared. And
again, too much detail here, but there are a lot of things
these schools could do.

What I like -- and, Kathy, this one would
dovetail on what you mentioned -- you've got accountability
there. I'd go to those schools that want those grants.
Number one, I'd make them match the grant, dollar for
dollar. If they don't deliver on the primary care
physicians that they promised I'd make them pay it back, so
you've got someone on the hook. And then, on top of that, I would probably do some type of competitive bid process where the schools would submit their bids, and basically I would take the most attractive bids and go right down the list to some cutoff point. But I hate to sound so mercenary, but, I mean, if we want primary care physicians, that's what I'd do.

DR. CROSSON: Okay. Let's go to Jon and Pat and then Paul.

DR. JAFFERY: Just a brief point, because I think it's so important in terms of tying together with Brian's comment on which schools produce lots of primary care, and to Kathy's point about encouraging diversity.

I serve on the board of Meharry Medical College, one of four historically black graduate institutions. Sixty-three to 64 percent per year of the graduates to into primary care. Most come in with the intent of going into primary care and serving vulnerable populations. And just a comment on the survey and the granularity. Actually, really, two comments. First that while some reports may not indicate that compensation, loan debt, et cetera, is the primary driver in lieu of lifestyle, et cetera, it may
actually be more acute amongst individuals who have fewer
resources or at certain schools. So I'd just note that, in
terms of driving diversity in workforce.
And two, you know, I've looked, in preparation for this
discussion, at the general questionnaires that's given out
from AAMC, and even though it identifies that lifestyle
and, you know, sort of intellectual interest in a
profession, et cetera, are the primary drivers, it's hard
to say that it doesn't co-vary with finance as a means to
support lifestyle.
So I'd just note those two pieces. You know, it
is worth mapping out, I think, you know, the
characteristics of those institutions that produce high
levels of primary care. Thanks.
DR. CROSSON: Thank you. Pat.
MS. WANG: I think this is such an important
discussion, so, Ariel, it's great that you've stimulated us
here, and I think all the comments that people have made
are really good and great ideas.
You know, just my struggle with this is that, you
know, the Medicare program is changing. It's not static.
And I struggle because there are so many ideas about doing
more and more and more and more, in all these different areas, and I wonder whether -- I, at least, would benefit from just having some context of, like, what are we striving for? In 12 years, you know, the number of Medicare beneficiaries in the country is going to increase by 50 percent. Like how are we getting our care at that point? It's probably not going to be the old-fashioned Marcus Welby way. We're already beyond that. But maybe there are folks who have already imagined what that caregiving system looks like. You know, it's NPs and PAs when you're relatively healthy, and then when you have events, then you get a geriatrician. I mean, there's a distribution, maybe, that starts happening with the clinician workforce which then sort of suggests that there should be -- all these things are linked -- that suggests that there should be more of a unified strategy in thinking about the last conversation, what should we be thinking about paying NPs and PAs? How many do we want to encourage. The growth in the loan forgiveness programs have been, in those non-physician clinical specialties. Maybe we'd want to encourage that more. I do think that the factors that others have
raised, about what are the financial and non-financial factors that affect people's decision to go into primary care are really important to identify. I would add to those that have been mentioned status. I know a very, very leading geriatrician in New York City who explained to me the pressure he felt in residency at a big academic medical center, to subspecialize, because geriatric is not viewed as a really sexy -- you know, you're dealing with old people and then you're dealing with old, old people in nursing homes. It's just not -- and they said, "You're so bright. You know, you could have a future as whatever." And he really wanted to be a geriatrician. So it's things like status and money, before status, but maybe there are other things.

I think the expectations of primary care doctors today are huge, and there is a reason why they employ NPs in their offices, because they are responsible for everything now. They're responsible for care coordination. They're responsible for readmission rates. They're responsible for coordinating with specialists who never return their phone calls. And, you know, it's just a lot of pressure. So, you know, being mindful of how to make a
PCP office environment or work environment as friendly as possible should factor into it.

I just say these things because I think that they are connected and that we should be mindful of all of these individual actions, whether it's loan forgiveness or fee schedule or what have you, but try to have a touch point of this fits with a philosophy that the ratio of NPs to physicians in the future in primary care is going to be 2-to-1, and I'm making this up. That's the ratio that we're kind of striving for. How are we doing against that? That would be my request, I guess, that we keep in mind as we continue the conversation.

DR. CROSSON: Pat, I'd just add to your story that when I was graduating from medical school, my two roommates, one who became a cataract surgeon and the other become an invasive cardiologist, seriously thought of having me committed when I said I was going to become a pediatrician. I'm sorry. Paul.

DR. PAUL GINSBURG: I mentioned before that I was really glad that our discussion is being steered into loan repayment scholarships. And I came to it, I was doing a project with some colleagues on graduate medical education,
and, you know, concluded that there really was very little scope, that Medicare could make changes in GME funding that would really do much for primary care, because it would be so overwhelmed by the payment discrepancies that are just so much more powerful.

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

DR. CROSSON: Jonathan.

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

DR. DeBUSK: It would have to be equivalent.
DR. JAFFERY: Well, I mean, potentially require incremental GME funding as opposed to what we could do through incentives or mandates around a redistribution of current slots.

But I also wanted to comment on, I think this is a wonderful discussion and I think it's really important to be talking about things like loan repayment and other financial incentives. But I really want to come back to a little bit of what Kathy and what Pat brought up, about really encourage us to think through some of these non-financial incentives. So the burden of documentation is a huge thing and it impacts all physicians, really, but particularly those who are E&M focused and spending 9 or 10 half-days seeing many patients in a half-day session. And we know there's lots of surveys now and information about how much time people spend documenting after hours and how much less time they spend with their families.

And, you know, we really do see a lot, more and more people coming into the field interested in some of these lifestyle issues. And at the same time, again, and Pat, you started to talk about this a lot, I mean, we've been talking a lot about creating this team-based model of
care, and the primary care physician being really at the center of, I think, care coordination is maybe a unifying concept around this, and asking them to take the lead of that and at least implicitly start thinking about non-medical determinants and how to coordinate with mental health and things like that.

So perhaps there's an opportunity for us to think through how do we define, really, the optimal team? I don't think it would be an impossible task to get some consensus about what the optimal team is in a primary care practice. And then how can we financially support a practice to actually have those services -- behavioral health, social work, and so forth, navigators, or whatnot. So really trying to bring that joy of practice back to why people are thinking about going to primary care in the first place.

DR. CROSSON: Thank you. Warner.

MR. THOMAS: So just a couple of comments. I do like the idea of degree completion. I do think that, you know, coupled with this, as we think about, you know, repayment for medical students, I do think we ought to think about the GME programs and perhaps, you know,
additional funding specifically around these disciplines, not just in general but specifically around these disciplines.

And I agree with you, Jay. I think including behavioral health in that area is critically important as well.

The other subspecialty is really around palliative care, that we may want to think about. You know, folks getting additional training there, how do we consider that well.

The last idea, it's a little bit different, but, you know, more and more organizations want to do loan repayment. You know, right now certainly doing it in certain regions of the country is possible. But one of the things we could think about -- it's just kind of a different idea -- is could loan repayment, if it's specific to people in these disciplines, you know, by -- if they become employed or it's by an entity that's employing them -- could it be with tax-free income? So, essentially, if you had, you know, an employer that gave a $100,000 loan repayment, it becomes tax-free income. So it's another way to encourage a loan repayment, specifically around these
disciplines, and maybe get more people to go into these
types of positions.

So just another idea that doesn't necessarily --
well, it does cost money because obviously it would cost
tax revenue, but it's not like you're having to pay the
full amount in a program like this. So it's just another
idea to consider.

DR. CROSSON: Karen.

DR. DeSALVO: When I was deciding what specialty
that I wanted to go into, and decided to do internal
medicine, we formed a club at my med school because we were
considered outcasts, and maybe it was really a support
group. So I empathize with you people who didn't
understand what was wrong with us, that we wouldn't want to
going into ortho or ENT.

And one of the reasons that I was driven that way
or pulled that way was because I was in the National Health
Service Corps in the Scholar Program. So I sit here today
because of the National Service Corps program. And I did
my time at Charity Hospital, in a clinic there, and then
stayed for years subsequently, caring for patients after
the period ended of my scholarship, which, as you’ve heard,
isn't completely unusual for people who go into the program. And I, in fact, stayed in that community for years after that.

So I can't tell you from a data standpoint but I can tell you from a personal standpoint, very rewarding. And part of this thing about going into primary care, and I hadn't thought about it until today, was one of the things the National Health Service Corps does is it creates this national family for you, as a primary care provider working in an underserved community. So they do a good job of making you feel like you're not alone but you have resources and a team and that you're a part of a thing. And so there is something about the culture and the encouragement that goes beyond just the financial incentive of the payback.

In terms of -- so I'm obviously supportive of both the idea of scholarship and loan repayment for people who are not of means and want to go to school, or people who are interested in going into fields or areas of the country where we may not pay back as much. The National Health Service Corps could be a way to operationalize a program like this, so to double their budget, to find some
1 way, if statutorily allowable, for CMS to contract with
2 HRSA, to do the program, instead of creating something new.
3 Even if you did that, though, I think one of the
4 limitations of the National Health Service Corps that
5 wasn't explicitly brought out today is that as site applies
6 it's a matching program. So if there's a community where
7 there's not a federally qualified health center or an
8 Indian health service center, or some other entity that can
9 apply, then they may not be able to grab a provider or a
10 set of providers. So maybe some more flexibility, and I'm
11 going to go hang up a shingle in rural North Dakota, even
12 if there's not a site that's on a list, might be a way to
13 add some of the flexibility. But I think it's worthy for
14 us to explore other ways that this might happen, going
15 forward.
16 I, originally thinking that maybe rural was where
17 we had more need, was leaning towards specialties in
18 medicine that had broader skills, like med peds or family
19 medicine. On the other hand, if it's really like peanut
20 butter we've got to spread, then we ought to be thinking
21 that we need to support all teams. And I just -- all types
22 of specialties but also teams, and I want to end on that,
which is, again from personal experience, in New Orleans, after Katrina, we had a special loan repayment program that the taxpayers gave us, to return health professionals after we had the largest exodus in U.S. history. And we realized very quickly, as we were working with the feds to design that program, it wasn't just doctors that we would need. We'd need mental health professionals and social workers, and everybody who was part of our team, because they also had loans and they also were coming to work in a hardship area.

And to the point about, then, who is on the optimal team, I can tell you, even from the few clinics that I built, that were patient-centered medical homes, in one neighborhood we had more need for legal aid services or social work, and that was where we were building out our team to meet that community where they were, and in another it was that we needed to have more psychiatry, as opposed to just a licensed clinical counselor, maybe even some specialists in that area.

So it's a longer conversation worthy of digging into, but there is no template for the best team, and I think most people in primary care who do team-based care
will tell you that it's really got to reflect the epidemiology and the cultural characteristics of the community, and that's why programs like this, Ariel, need to be probably as flexible as possible in who is eligible for loan repayment and let, in the way that the National Health Service Corps has done, the local community decide where they have the greatest need and put forward an application for that kind of a provider.


DR. RYU: I kind of struggle for the same reasons that Pat articulated earlier. It feels like there are still questions around how aggressive. I think it's a multifactorial issue, sort of like what we were just talking about. It's not all financial. And I think all of these things make sense to do, but I don't know to what degree. And if there was some way to properly size the need, we know that there's a tremendous shortage in primary care, but how much? And maybe shy of doing a full-fledged workforce planning assessment, I'm not sure it's easy to get at that. But I think that would be helpful, just even to kind of put a size and scope on this thing.

We talked a lot about pipeline and ways to
1 encourage more folks coming into the pipeline. I think
2 there's a lot that we should be assessing on the exit line,
3 because a lot of the information I've seen suggests a lot
4 of the primary care workforce that we do have is within
5 five, seven years of retirement. So the shortage may be
6 even bigger than what we think, but to me it just feels
7 like it's tough to know how deep, how aggressive should we
8 going unless we do some sizing up front of what's the gap
9 and what do we anticipate the gap to be, and what forces
10 are coming and what's the optimal model that we want to get
11 to that impacts what that gap would be.
13 Thank you, everybody. Good discussion.
15 DR. PAUL GINSBURG: Yes. Just a couple more
16 thoughts. One is that from this discussion it sounds like
17 maybe a way to think of this topic is not just scholarships
18 and loans but policies that impact directly primary care
19 practitioners, whether they're at the younger or even older
20 level.
21 And the other comment I thought is that
22 throughout today, or this afternoon, we've had a few
1 comments from Commissioners who are thinking about, well, 2 this costs money; here's where we're going to pay for it, 3 or the opposite. This is going to save money; this is 4 where we can spend it. And I just want to caution my 5 colleagues that I just don't think this is an effective way 6 for MedPAC to function, kind of getting into the pay-for 7 business, because it inevitably picks up enemies. It kind 8 of detracts from what we really are focusing on. And there 9 may be situations where we haven't done the work on the 10 accompanying policy that we have on what we really got 11 started on.

12 DR. CROSSON: Okay. There's some wisdom there. 13 Ariel, I hope you've had a significant amount of 14 input here.

15 MR. WINTER: Plenty, yes. Thanks.

16 DR. CROSSON: We will send you off with our good 17 graces, to come back at a later time and help us through 18 this again. Thank you.

19 [Pause.]

20 DR. CROSSON: Now, you look a lot like Dana 21 Kelley.

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

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

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

To be admitted to an IPF, beneficiaries generally must be considered a risk to others or to themselves, either intentional or as the result of impaired self-care. The goal of inpatient psychiatric care is mood stabilization and restoration of the ability to live
In addition, IPFs provide supervision and behavioral management to reduce the risk of harm to self or others. Patients receive a variety of services such as individual and group therapy, psychosocial rehabilitation, illness management training, and electroconvulsive therapy. A majority of IPF patients also receive drug therapy in the form of antipsychotics, mood stabilizers, antidepressants, and anticonvulsants. Patients also may receive care for medical comorbidities such as diabetes or cardiac conditions.

More than half of the beneficiaries who have an inpatient stay at an IPF are under 65 and entitled to Medicare based on disability. Thirty percent are under age 49. About 55 percent are partially or fully dually eligible for Medicaid.

IPF users as a group consume more health care services than other beneficiaries. In 2015, beneficiaries who had an IPF stay on average had 3.1 visits to the emergency department, making them six times more likely to use the ED than all beneficiaries. They also had more than
40 E&M visits during the year, again six times the average for all beneficiaries. They filled almost twice the number of Part D prescriptions.

And consistent with this higher use, the total per-beneficiary spending for IPF users was very high, over $40,000 in 2015, compared with just under $12,000 for all fee-for-service beneficiaries.

This slide outlines the basic mechanics of the IPF PPS, and one thing I want to underline here is that payments are made on a per-diem basis. Payments are adjusted for the diagnosis and other patient characteristics such as age, certain medical comorbidities, and length of stay. Payments are also adjusted for facility characteristics such as area wages, teaching status, rural location, and the presence of an emergency department.

There is an add-on payment for each electroconvulsive therapy treatment and an outlier pool equal to 2 percent of total payments.

So under the IPF PPS, Medicare cases generally are assigned to one of 17 psychiatric MS-DRGs. In 2015, the most frequent IPF diagnosis, accounting for 73 percent
of IPF discharges, was psychosis, which generally comprises schizophrenia, bipolar disorder, and major depression.

Organic disturbances and mental retardation, substance abuse or dependency, and degenerative nervous system disorders each accounted for a little more than 6 percent of cases.

As you can see in the last column, the number of discharges with a principal diagnosis of substance abuse or dependency has increased disproportionally in recent years, climbing almost 9 percent from 2011 to 2015, even as the total number of IPF cases declined by 7 percent.

The aggregate Medicare margin for 2016 in IPFs was negative 2.4 percent, but financial performance under the IPF PPS has varied quite widely.

Freestanding IPFs that were for-profit had an aggregate Medicare margin of 29.2 percent, compared with negative 6.6 percent for nonprofit freestanding facilities. The high margins in freestanding for-profit IPFs are driven by low costs per case.

The very low costs and high margins in some IPFs raises some questions. As with any payment system, Medicare's payments for IPF services need to be well
calibrated to patient costliness, so as not to create incentives for providers to admit certain types of patients and avoid others.

But the wide variation in IPF margins could indicate here that Medicare's payments don't track closely to patient costs, and if that's true, the PPS could be paying too little for patients with high-care needs and too much for patients requiring fewer resources.

As I noted a minute ago, almost three-quarters of IPF cases are in one MS-DRG, so even with the patient- and facility-specific adjusters that are applied to payment, the payments do vary relatively little across patients.

But concerns about the accuracy of Medicare's payments to IPFs are mitigated to some extent because the PPS pays on a per-diem basis, and generally, the smaller the unit of payment, the less costs will vary across patients.

In fact, research on the costs of inpatient psychiatric care in the U.S. and in other countries suggests that the per-diem costs of psychiatric inpatients may be relatively homogenous. But complexity of disease may not be well accounted for in these studies.
CMS's administrative data cannot be used to describe differences across patients in routine nursing and staff time, which is the majority of the resources used in these settings. So that undermines our ability to fully account for how costs vary with patient complexity.

Although we can't use administrative data to fully account for differences in costs across patients, we wondered if it would be possible to identify patients with more complex conditions using administrative data, since Medicare does not collect patient assessment information for IPF users.

MedPAC staff worked with 3M Health Information Systems to develop 22 clinically homogenous groups of mental health conditions based on DRG assignment, such as schizophrenia and alcohol disorder, and then further subdivided the conditions based on the complexity of the mental health condition, as measured by the ICD-9 codes.

So, for example, paranoid-type schizophrenia chronic was considered less complex than paranoid-type schizophrenia acute exacerbation. 3M’s methodology yielded 41 mental health groups, more than twice as many payment groups than are currently used in the IPF PPS.
But under this clinical classification scheme, we still would have just a handful of mental health groups accounting for the vast majority of patients. Eighty percent of all cases in 2011 fell into one of four out of 22 base mental health conditions, shown here. The most frequent mental health condition was schizophrenia, accounting for about 26 percent of cases. The red portion of each bar shows the share of cases in each base mental health condition that was of higher complexity, as indicated by ICD-9 codes.

For IPF patients, several other variables may be more important predictors of complexity or costs than diagnosis is, such as degree of social support, need for assistance with activities of daily living, justice system involvement, and dangerous behavior such as suicidal tendencies. This information is not available in Medicare's administrative data.

Another issue that complicates our assessment of the IPF PPS is a relative lack of information on the ancillary services beneficiaries receive in IPFs. Like all hospitals, IPFs are required to apportion allowable Medicare costs to each ancillary
department unless they have an all-inclusive rate; that is, unless they have one charge covering all services. All-inclusive rate status must be designated by a Medicare administrative contractor, and that status is indicated on the cost report. Medicare cost reporting rules specify that hospitals cannot elect to move to less detailed methods of cost apportionment. So if a hospital apportions its costs, it should not later decide to pursue all-inclusive rate status. Relatively few IPFs have an official all-inclusive rate designation, about 188 in 2016. These facilities accounted for about 10 percent of Medicare IPF days. About 45 IPFs with an all-inclusive rate designation nevertheless reported separate charges for drugs in 2016. But there's a growing number of IPFs who report no drug costs even though they are not all-inclusive rate providers. And I'll call these facilities "non-reporters." There were 190 non-reporters in 2016, up from 50 in 2007. Almost all of these providers are freestanding, and about 80 percent are for-profit. These non-reporters accounted for 21 percent of
Medicare IPF days in 2016. Most of the providers that reported no drug charges in 2016 also reported no charges for laboratory services. Together, these two groups, the all-inclusive rate providers and the non-reporters, account for about 31 percent of all Medicare IPF days. So that means we have no data on ancillary costs for about a third of the IPF days. We expect not to have data on ancillary costs for designated all-inclusive rate providers, but the growing number of IPFs that are non-reporters who submit no costs for drugs or lab services and submit no claims with drug or lab charges on them seems very surprising.

CMS has stated that it expects most IPF patients will need ancillary services and supplies such as drugs and lab, and our analysis of claims data has found that 97 percent of the claims submitted by hospital-based IPFs do include charges for drugs, which would seem to confirm that CMS's expectation is reasonable.

So what explains the lack of reported drug costs? One hypothesis is that some facilities might inappropriately be billing outside of the IPF payment bundle, and we have not yet tested this hypothesis. But
CMS has looked at a sample of claims and doesn't believe that this is going on.

When we asked a provider association about the lack of reported drug costs, we were told that it's common for IPFs to have one flat rate, and so some providers might simply be rolling up their ancillary costs into their routine costs. As I mentioned, this is not allowed under Medicare cost reporting rules, but if this is what is happening, then we might expect that the total costs of the non-reporters would be similar to those of other IPFs that are properly apportioning their costs.

Yet when we looked at the average unadjusted per-day costs of non-reporters, we found that, at $546 per day, they were considerably lower than those of other freestanding IPFs, $745. So it's not clear whether the low costs are indicative of efficient care delivery or a patient mix with lower care needs or stinting on care.

Recently, CMS implemented a cost report edit that rejects cost reports from psychiatric hospitals if they exclude certain ancillary costs. So, hopefully, in the future, we'll have better data on this, but it will be a few years before we see that.
The appropriateness of costs cannot be evaluated without consideration of outcomes, and so this brings us to the issue of quality measurement in IPFs.

In general, there are few meaningful, frequent, and easily collected clinical outcome measures that have been assessed for validity and reliability in the IPF setting.

Developing outcomes measures for IPFs is complicated by the length of treatment required during the acute phase of behavioral health disorders. For example, successful treatment of an acute episode of major depression typically requires six to eight weeks, but patients usually require inpatient care for only a fraction of that period.

To date, most attempts to measure quality in IPFs have focused on clinical process measures. CMS's IPF Quality Reporting program, implemented in fiscal year 2014, requires submission of data on process measures such as hours of physical restraint use, substance abuse treatment provided, and timely transmission of records to subsequent care providers. In fiscal year 2019, CMS will also use administrative data to calculate two outcomes measures --
follow-up after discharge from the IPF and 30-day all-cause unplanned readmission rates. CMS has not begun reporting these outcome measures yet, but our work with 3M looked at similar measures. As shown here, not all beneficiaries who used IPFs in 2011 had follow-up care after discharge. Almost a quarter of IPF episodes admitted for alcohol use disorder had no Part A or B bills for services provided in the 30 days after discharge. Seventeen percent of episodes admitted with a diagnosis of less complicated schizophrenia appeared to receive no follow-up care. This could represent a missed opportunity to establish or strengthen a beneficiary's connection to community-based care and support, and some studies have found that lack of follow-up care increases the risk of readmission. 3M also looked at potentially preventable readmission rates following discharge from the IPF. This analysis looked at any hospital admission in the 30 and 90 days after discharge from the IPF, including admissions to the acute care hospital, and then determined which of these were related to the initial hospitalization and potentially...
We found that the highest rates of readmission for episodes with complex schizophrenia. Twenty-one percent of these episodes were readmitted to a hospital of any type for a potentially preventable condition within 30 days of discharge from the IPF. Thirty-six percent were readmitted within 90 days of discharge.

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

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

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

So, in conclusion, our work to date confirms that IPF users are a high-need, high-service-use population, yet we see a surprising lack of ancillary costs reported by
Although it's possible that this is simply a cost reporting issue, it does raise concerns about appropriate provision of care. Rates of follow-up care after discharge and rates of readmission also suggest room for improvements in care for this vulnerable population.

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

Thank you.

DR. CROSSON: Thank you, Dana.

I have one question I'd like to start with, and it has to do with this peculiar situation where there's a substantial amount of non-reporting of the use of psychoactive drugs. I'm not a psychiatrist, but I would imagine that a large majority of people who are sick enough to be hospitalized are going to be benefitted by the use of one or more psychoactive drugs. So it's either that they're not getting the drugs, or they're not being reported. I'm not sure which.
One thing that would be interesting to know -- and I don't know if this is possible, but as we've seen with some other institutional settings, sometimes the actual cost at the facility is a consequence of how long the patient is there. In other words, depending on the nature of the diagnosis, one could imagine that the cost would be potentially very high in the beginning, the actual cost.

Reimbursement is the same, irrespective of what day; is that right?

MS. KELLEY: So the IPF PPS actually has a declining reimbursement as length of stay increases.

DR. CROSSON: It does. Okay. All right. No, that's helpful. That's what I want to know. Thank you.

Other questions? Jon.

DR. CHRISTIANSON: Yeah, same -- I couldn't tell from your presentation or the report whether there are circumstances under with the non-reporters are actually breaking the law?

MS. KELLEY: I don't think we know the answer to that question.

DR. CROSSON: Okay. Let's start with Brian.
DR. DeBUSK: On page 7 of the presentation, I noticed the psychosis diagnosis or the DRG and then the substance abuse or dependency. Two questions. How do you tell the difference between someone who is experiencing psychosis and self-medicating with substances or alcohol or who is substance- and alcohol-dependent and experiencing psychosis? And is there a financial benefit in how they classify like a per diem rate to the DRG and how they do that classification?

MS. KELLEY: So I'm not a psychiatrist. These are principal diagnoses, so the principal diagnosis on the claim will dictate what MS-DRG is assigned. Under the IPF PPS, the psychosis DRG has an adjuster of 1, and substance abuse or dependency do have an adjuster of less than 1. So there is a higher payment from a psychosis DRG than for substance abuse.

DR. DeBUSK: So there's a distinct financial advantage in the current system to seeing it as a psychotic patient that happens to be using drugs or alcohol?

MS. KELLEY: Potentially, yes.

DR. DeBUSK: Okay.

DR. CROSSON: Other questions? Kathy?
MS. BUTO: Dana, thank you for this. I had questions about the role of the IPF in treating patients as relates to community care. Do we have any sense of whether these are patients who have failed outpatient mental health services or happen to have a readily available IPF versus other options?

MS. KELLEY: I don't think we know the answer to that question. I think we do know that even patients who receive appropriate and adequate community-based care will sometimes need to be hospitalized. So for some patients, I think an inpatient hospitalization does mark a failure of community-based care, but for other patients, you know, the course of their disease and the inpatient stay is unavoidable and necessary.

MS. BUTO: Just to follow up, to our knowledge, there hasn't been any assessment that says some percentage of IPF patients really shouldn't be there, that --

MS. KELLEY: Not to my knowledge.

MS. BUTO: Okay.

MS. KELLEY: But that's certainly something we should look into.

DR. CROSSON: I saw Karen.
DR. DeSALVO: Thank you. Dana, this is really well done and I think a really important topic, so I hope we get to revisit it, which is my question about the timeliness of the data. The 3M analysis used 2011, and there's probably been a lot of changes in the mental health and substance use infrastructure since then. So I wondered if you could share when we might have more current data available.

MS. KELLEY: So the 3M work something we did a few years back, and it's taken awhile to process. We are working with the Urban Institute right now to do more of a deep dive into the payment side where the 3M work was a little more clinical in nature. So that will give us some updated information.

DR. CROSSON: Warner.

MR. THOMAS: Dana, thanks for the information. I think it's great.

A quick question I had. You showed a chart really where there's a lack of follow-up care kind of post-inpatient discharge. Do you have a sense or do we have an idea of how many Medicare participating providers we have in the psychiatry or mental health area and whether access
to mental health providers for Medicare recipients is an issue and maybe leading to some of this? Do we have any information or insight into that?

MS. KELLEY: Kate?

MS. BLONIARZ: I think we do. I think there's a relative undersupply of behavioral health providers in Medicare. The share of psychiatrists taking Medicare is about 50 percent, which is actually pretty similar to private and Medicaid as well. So it's less a feature of kind of Medicare's rules and more just, you know, what -- how psychiatrists have traditionally served and billed for their services.

We did look at LCSWs, you know, finding a fairly high participation rate for social workers, but I think we do think there's a general undersupply in this area.

DR. CROSSON: Seeing no further -- oh, Dana --

MR. THOMAS: Maybe just a quick follow-up. So that's 2011. Do we have any sense whether that may be better or worse now?

MS. KELLEY: We don't. But my analyses of the IPF data itself between 2011 and 2016, I'd be surprised if things had changed that much.
DR. CROSSON: Okay. I think -- I'm sorry. Dana,

and then Pat.

DR. SAFRAN: Thank you. This is interesting.

It's a disturbing set of findings. Lots to think about. I

guess one question is just whether -- what kind of

oversight exists for IPFs? Do they fall under JCAHO, for

example?

MS. KELLEY: Sure. They are certified as

hospitals.

DR. SAFRAN: Okay. And so is there any way

through JCAHO to get insight about the ancillary non-

reporting issue?

MS. KELLEY: That's a good idea and something we

can look into.

DR. SAFRAN: Okay. That would be great. And I

assume, but I don't want to assume just because I don't

think in my year on the Commission we've talked about IPFs

before. We don't have any -- Medicare does not have any

kind of quality-based payment for IPFs? In fact --

MS. KELLEY: No. It's pay for reporting only.

DR. SAFRAN: Okay. Thank you.

DR. CROSSON: Pat.
MS. WANG: Dana, I apologize. This may have been in the paper, but IPFs are not the only source of inpatient care for people who need to be hospitalized for a behavioral health issue. Approximately what proportion of Medicare beneficiaries are using IPFs for behavioral health versus spread throughout the acute-care system?

MS. KELLEY: Yeah, so beneficiaries who need to be hospitalized for a principal diagnosis of a psychiatric condition can also be cared for in a general acute-care bed in an acute-care hospital. And there were about 290,000 in 2016. Did you ask me something else about --

MS. WANG: Two hundred ninety thousand in --

MS. KELLEY: In scatter bed admissions. So there were about 407,000 IPF admissions -- or discharges, and 290,000 scatter bed discharges.

MS. WANG: So more than a third.

MS. KELLEY: Yeah.

MS. WANG: That's interesting. So for information such as you've presented on Slide 15 that Warner was asking you about, is there -- would it make sense to look at follow-up within 30 days for those who had been admitted into scatter beds?
MS. KELLEY: So that is something we could do.

This is only for IPFs, this data here. We did not -- I do not -- well, I do have this information for scatter beds. I don't know it off the top of my head, but I do have this information for scatter beds as well, and I can provide that for you.

MS. WANG: I can tell you at least, you know, for state Medicaid programs, for example, the quality programs expect follow-up within seven days after discharge. So that's what a Medicaid managed care plan will work towards, and it is possible. So --

MS. KELLEY: So one thing I --

MS. WANG: -- it's still pretty extreme.

MS. KELLEY: Yeah, and one thing I might hypothesize -- you asked about how things may have changed since 2011. I think in an acute-care hospital setting where there has been, you know, increased focus on outcomes measurement and follow-up care, I do wonder whether things have changed more for discharges from scatter beds than they have in the IPF setting, where there has been, I think, less attention.

MS. WANG: It might be an interesting -- thank
DR. CROSSON: Okay. Thank you for the questions.

We'll now have a discussion or commentary period for further input to Dana on this report. Jon.

DR. PERLIN: First, let me add thanks for really an insightful report. This is an area that has extraordinary opportunity. As someone who has been a health services researcher and focused on measures, I am not satisfied with the state of quality measurement in this area. That someone wasn't restrained may prevent a safety issue, but it's not therapeutic. And I really encourage our consideration of how to drive measures that imply therapy.

For all the reasons that you so eloquently outlined in the paper, I think it's very difficult to look at some of the outcome measures, but this may be one of the areas where we need to look at a better set of process measures and structural measures that have some degree of reasonable evidentiary base.

In this regard, one of the things that concerns me the most is if the hypothesis that some of the cost differentials has to do with services rendered, then let's
1 look right at the services rendered. And I would want to
2 know what the state of the therapeutic programming is for
3 those individuals. So I think a measure set may also have
4 a hierarchy of those things that are regulatory compliance,
5 those things that are safety, but those things ultimately
6 that are therapeutic. So that's the first point there.
7
8 I think other areas of focus in measures beyond
9 the programs might be the user of extenders. We know
10 there's a shortage of psychiatrists. We know that there is
11 a lot of extension, and I do worry about some of the
12 linkages.
13
14 The second is I think we need to expand our data
15 set in terms of looking at follow-up. I did have the
16 privilege of spending my residency divided between mental
17 health and internal medicine, and for alcohol, in
18 particular, you know, there actually at least evidence for
19 12-step and other sort of social support programs, and I'm
20 wondering if we get the data in that 24 percent that those
21 individuals who are discharged not to a Medicare provider
22 but to a social service agency where we're not getting that
23 back.
That said, that doesn't hold true for the other diagnoses that are up there, and just for the record, a junction with the discussion of opioids, there is absolutely no extrapolation of the evidence to those social service programs versus, you know, medication as therapy. So I think additional measures and extension of the data sources.

Then, finally, one of the things that's noted in the pre-read paper is some contemplation of bundling in this area. This is one of the areas where I think it's good in theory, but in practice I worry about it exacerbating the difficulty in this position. In my organization, the fastest-growing part of our inpatient services in our acute hospitals is psychiatric because these patients had nowhere to go, and so rather than having them languish, we built that out. I could see these bundles potentially operating as a disincentive to the beds in the acute part if all of a sudden there's an obligation to discharge patients to a resource that just doesn't exist. And so I think we need to think about how to cultivate the resources, then think about how to link it.

So those are my three comments and, again, just
brilliant work.

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

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

DR. CROSSON: Okay. Thank you, Jon.

Other comments? Kathy and Warner.

MS. BUTO: Just very briefly, Dana. I keep hoping that we'll be able to expand this analysis or an analysis about inpatient to outpatient and sort of the whole issue of the lack of continuity of care for mental health and behavioral health patients in Medicare. I think
that lack of have an organized -- again, some kind of
organized way of managing or being available to those
patients is really important. And I know that's not the
task here, but something that I'd like us to think about.

DR. CROSSON: Warner.

MR. THOMAS: So one of the things that comes to
mind for me is just especially when you -- number one, this
to me is a very disturbing slide, just having the lack of
follow-up. I'm not surprised by it given, you know, where
things are. And we talk a lot about additional
reimbursement and dollars for primary care. I think we've
got to put mental health, outpatient mental health there as
well, and probably -- it's probably even more important,
frankly, than primary care.

But the question I have is just especially when
you look at the spend that's like, you know, 4X kind of a
traditional beneficiary, I think it was like $40,000-plus
versus 11. Do we have a sense of the population of people
we're talking about, so how large an issue this is just in
aggregate?

MS. KELLEY: So the numbers that I presented
today and that are presented in your paper are only for
users of IPF services in 2015.

MR. THOMAS: Right.

MS. KELLEY: So there were two hundred and -- gosh, off the top of my head, I can't remember now. I want to say there were 290-some-odd beneficiaries who had 407,000 IPF stays. I think that's right.

UNKNOWN STAFF: 409 [off microphone].

MS. KELLEY: 409? Thank you. So those numbers are for that population. You know, there are other ways -- there are plenty of Medicare beneficiaries with behavioral health conditions who did not have an IPF stay, and, you know, that's obviously a much larger population.

MR. THOMAS: It might be interesting, as we revise this or complete this work, to try to size this a little larger just as a total impact, maybe looking at it over a couple of years or trying to extrapolate over a couple years, because I think it probably is a larger economic issue than we realize.

MS. KELLEY: Yeah.

MR. THOMAS: And that may kind of lead us to take a more bold approach in kind of how we want to try to address it.
MS. KELLEY: In some work we had done a couple of years ago, Kate did sort of a wider-lens look, and we can try and bring back some of those numbers in the future.

DR. CROSSON: Kathy.

MS. BUTO: It just occurred to me I remember from the paper and your presentation that a large percentage are Medicaid and/or dual eligibles, and Medicaid dual eligibles or under 65 dual eligibles, a very specific kind of population. And I wonder if -- so I didn't see Alzheimer's on the list or dementia. Is that not one of the major -- oh, okay, it is. Dementia. That actually is a small percentage compared to the other disorders. But is that where the over-65 population resides for the most part?

MS. KELLEY: So these are the data from 2011, but the shares haven't changed that much. Many of the -- the dementia category is almost entirely beneficiaries over 65. But there are beneficiaries over 65 who fall into other conditions as well.

MS. BUTO: Okay. I just wonder if there are special issues that we ought to be considering. I know you brought the IMD issue in the paper in Medicaid, the exclusion, that we ought to think beyond just what's going
on in the inpatient psych facility to whether -- it's,
again, that issue of linkage to other resources in the
community that isn't happening.

DR. DeSALVO: Can I just add? I just want to
agree with Kathy, and it gets back to my question before,
and that may be that changes not only in the care system
but some driven by changes in the way we are approaching
care management for dual-eligible individuals and the
better coordination. So it probably is not better, but it
would be nice to see if in states where they're doing a
better job of bridging between care and bridges between the
inpatient and outpatient sector.

Thank you.

DR. CROSSON: Pat.

MS. WANG: We have a little bit of -- we have
talked a lot about coordinated care models and ACOs and the
importance of MAPD plans. I think it's important to stress
that for this particular group of beneficiaries, it's, you
know, it's times 100. So looking at, you know, what's
going on in an inpatient facility is very important because
of the payment structure. But I think that where folks
have moved is we want to get people out of the hospitals as
soon as possible. And it's not just the availability of
resources. It's active management of the person probably
to a community resource. We are working very hard on this
right now, and it's obviously very difficult. But there's
a whole infrastructure that is required, I would say, a
different kind of network -- health homes, peer bridgers,
folks who can help people get back to the community. And
the availability of psychiatrists is important, but it's
really not the most important thing, I would say. It is
just -- it's keeping medical appointments, it's keeping
medications filled, it's having somebody who perhaps has
experienced something similar when it comes to alcohol
disorders, and substance abuse in particular, to really,
you know, sort of wrap a person w lots of support.

So I just want to -- I think that the field has
moved substantially from what goes on inside of an
inpatient facility, and it's very important to get this
payment right. But the notion of earlier discharge to
community resources is a really big endeavor and requires,
in my opinion, extremely active management. You know,
plans do that if they are in this business to do it, but
it's very, very active. It's care management inside the
plan. It's care managers in the community. It's other
kinds of community resources as well as clinical.
So I think people have alluded to that, but I
think, you know, to kind of hang the bill on the cat, it's
really -- it's much bigger than just sort of the usual
approach.

DR. CROSSON: Okay. Thank you. Good discussion.
Dana, thank you for the presentation. That concludes the
discussion portion of our meeting.
We now have an opportunity for public comment.
If there is anyone in our audience who would like to make a
public comment, you can do it at this time by stepping to
the microphone so we can see who you are.

[Pause.]
DR. CROSSON: We have one individual. I will
just give you a little preamble, if that's okay.
So what we would ask you to do is identify
yourself and any organization that you are associated with,
and we'd ask you to limit your comments to two minutes.
When this light goes back on then the two minutes will have
expired.

MS. FISHER: I will talk very fast. I'm not used
I'm Karen Fisher with the Association of American Medical Colleges. I appreciate the fact that MedPAC today talked about primary care shortages, and always appreciate the discussion by the Commission.

We agree with the discussion and the issue about there being a primary care shortage. Many of you may know that the AAMC has an independent consultant every year do a study looking at projections of workforce shortages, and we continue to see workforce shortages going into the future, up to 120,000 potentially in 2030.

I think what is important to remember is that in our own modeling we predict and include current primary care shortages but there are also going to be other shortages, of other specialists, and that's going to be important as we look at the Medicare population, as it was mentioned previously. In some cases Medicare beneficiaries need a specialist as much more as they need a primary care physician. So we need to make sure that we look at these all globally.

Jim and the staff have reached out to us. We very closely follow the loan repayment programs and the
medical school debt issues and are going to be coming in and talking to the staff about that because I think we have a lot of information we can help provide on some of the questions that were raised today.

But I would say that every year we do a study, since 1978, a survey of the graduating seniors from medical school. This year, the survey results were 80 percent. They tend to be very high. And since we've been tracking information on debt, debt has always ranked lowest in terms of factors influencing specialty choice, as was mentioned here today. As was mentioned, specialty content, personality fit tend to be higher. Work-life balance tends to be higher, role modeling, et cetera. Even those who ranked it high tend to rank personality fit and specialty content higher than debt itself, and I think that's important to factor in.

Income, which was mentioned a little bit, does rank higher than debt, but still ranks lower than the factors I just mentioned. But if you're going to look at income, I think someone mentioned today looking at the payment is very important.

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

PUBLIC MEETING

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

Friday, October 5, 2018
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
PAUL GINSBURG, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD
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DR. CROSSON: Good morning, everyone. This is the Friday session of our October meeting. We have two topics before us today. In the first one, we're going to have Carol and Ledia take us through some excellent refinements to the ongoing project on the PAC PPS. Carol, are you starting?

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

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

In our work, post-acute care refers to care
furnished in home health agencies, skilled nursing facilities, inpatient rehab facilities, and long-term-care hospitals, including care furnished to beneficiaries admitted from the community. Spending across the four settings totaled $60 billion in 2016.

We and others have documented that similar patients are treated in the four settings, yet payments can differ substantially, in part because each setting uses its own payment system. There is limited evidence to guide placement decisions and so, not surprisingly, there is more variation in per capita PAC spending than any other Medicare service. Further complicating the picture are setting-specific patient assessments and outcome measures so that the patients treated and the outcomes of that care cannot be easily compared. Finally, each year the Commission reports that fee-for-service payments for PAC are high relative to the cost of care, which can distort benchmarks for MA and ACOs.

As a reminder, in 2016 we completed a mandated report on the recommended design features of a uniform payment system for PAC. Our assessment of the feasibility of a unified payment system was based on analysis of 8.9
1 million stays in 2016, not a sample of providers, stays, or
2 beneficiaries. The unit of service was a stay, or in the
3 case of home health, an episode, and each stay was
4 considered an independent event. Payments would be based
5 on the average cost of stays and would be adjusted using
6 patient and stay characteristics such as a patient's age
7 and their comorbidities. There would need to be a large
8 adjustment for home health stays to reflect the much lower
9 costs of non-institutional care. The design should also
10 include short-stay and high-cost outlier policies. The
11 Commission concluded that a unified PAC PPS design using
12 administrative data was feasible and could accurately
13 predict the cost of stays for most of the 40 or more
14 patient groups that we focused on.
15 Payments under a PAC PPS would be redistributed
16 considerably, becoming more equitable across different
17 patient conditions compared with current policy. Payments
18 would increase for medically complex patients and decrease
19 for patients who receive rehabilitation care that appears
20 to be unrelated to their clinical conditions. As a result,
21 providers would have much less financial incentive to
22 prefer to treat certain types of patients and avoid others.
Since 2016, the Commission worked on several implementation issues, including the alignment of regulatory requirements that you discussed at last month's meeting. In 2017, the Commission assessed the level of spending and recommended that the aggregate should be lowered by 5 percent when the PPS is implemented.

Regarding timing, the Commission recommended that a PAC PPS be implemented sooner than contemplated by the IMPACT Act with a three-year phase in. To maintain the system's accuracy, the PPS should be revised and rebased over time as needed. To begin to increase the equity of payments within each setting before a PAC PPS is implemented, earlier this year the Commission recommended blending PAC PPS payments with setting-specific payments.

Our initial work on the unified PPS considered each stay as independent, yet about one-third of PAC stays are part of a sequence of care, where patients transition from one setting to another or extend their care. A stay-based payment system encourages stays and discourages providers from offering a continuum of care.

In this diagram, a stay-based PPS is illustrated in the first row, with the two stays in blue and green.
boxes. Two separate payments would be made. In an episode-based PPS, illustrated in the second row, a single payment would be made for both stays in the episode of PAC care. Note that the episode would only include post-acute care, and other services, like hospital or physician services, would not be included in the bundle.

There are three advantages to an episode-based PPS. First, it would encourage a more efficient mix of PAC and encourage institutional PAC providers to offer a continuum of care. This would benefit beneficiaries by reducing the number of transitions a patient may experience over the course of care. Such transitions are often disruptive for beneficiaries and, in addition, put them at risk for poor handoffs. Finally, a more efficient mix of PAC is likely to lower program spending and could lower beneficiary cost sharing.

To conduct the work on an episode-based PPS, we'll start by updating our stay-based design using 2017 stays. This will give us a more recent starting point for our analysis. Consistent with our work on sequential PAC stays, we plan to construct episodes from individual PAC stays that are within seven days of each other. We will
evaluate the overall accuracy of the design and its accuracy by type of episode -- using the same 40 or so patient groups that we've been using throughout the PAC work. That way, we can compare payments under a stay-based design and an episode-based design.

To make those comparisons, we will add up the stay-based payments for individual stays encompassed by the episode and compare them to the episode-based payments for the same stays. Our initial analysis will focus on solo and pairs of stays since they make up 85 percent of PAC sequences, with the idea that if those results look promising, we can expand our analysis to longer sequences.

Now Ledia will talk about the quality measures work.

MS. TABOR: Thanks, Carol.

We'll now turn to our work developing uniform PAC quality measures. The Commission contends that Medicare payments should not be made without consideration of quality of care delivered to beneficiaries. Medicare should score a small set of population-based outcome, patient experience, and value measures to compare performance across populations and PAC providers.
Under a unified PAC PPS, distinctions between settings are less important so Medicare needs unified quality measures to assess provider performance.

The IMPACT Act of 2014 required the Secretary to develop quality and cost measures that span the PAC settings in several domains, for example, functional status and discharge to the community.

Although the IMPACT Act calls for uniform comparisons of quality and cost measures across PAC settings, CMS has tailored many of the measures to each setting, using different definitions and risk adjusters.

For example, to gauge readmissions that occur during PAC stays, the home health and SNF measures include readmissions that occur only in the first 30 days, even though many home health and SNF stays last longer than 30 days. The IRF measure captures readmissions that occur anytime during the IRF stay.

Over the past year and throughout this next year, we continue to develop uniform measures that can be used to measure quality of care across providers.

Consistent with our principles and our discussion of the design features of a PAC PPS, the Commission
recommended in June 2016 that CMS should implement a unified VBP program concurrently with a PAC PPS. By tying a portion of payments to measures of quality and value, or cost, a VBP would discourage overuse of care, stinting on services, and shifting of care to other providers.

In order to assess quality of care in the new PAC PPS and implement a VBP, we need uniform cost and quality measures.

A PAC VBP could consider some of these uniform, claims-based measures: hospital readmissions, Medicare spending per beneficiary, combined admissions and readmissions, and discharge to the community. Based on the Commission’s principles, we could score a unified patient experience survey and infection rates; however, these measure concepts are currently only collected by providers in some PAC settings. For example, only home health agencies are required to administer a CAHPS patient experience survey.

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

While uniformly defined, these measures have two shortcomings. First, the readmission measure does not consider hospital admissions for beneficiaries admitted to PAC from the community. This constraint effectively excludes about two-thirds of home health stays from the measure calculation. Second, we do not consider readmissions from LTCHs because there is no claim to detect short hospital stays.

Overall, we found that the risk-adjusted rates of readmission varied widely across all PAC providers.

This year we plan to develop a combined measure of admissions and readmissions. Unlike the readmissions measure, this measure will include admissions to hospitals for both community and inpatient admitted beneficiaries.

We are also addressing the second shortcoming of the readmissions measure by including LTCHs in the measure calculation. However, because we will not be able to detect admissions and readmissions to acute hospitals for
short stays, which are three days or less, the during-stay rates will be understated. Because observation stays have become more prevalent and longer in duration, we also plan to include them in our definition of admissions and readmissions because from the patient's perspective the observation stay may appear identical to an inpatient stay. Building off our previous readmissions measure, we will work with our contractors to identify planned and potentially avoidable hospitalizations, then develop a uniform risk adjustment methodology using readily available information from claims. The risk adjustment model will consider factors included in the Commission's previous PAC readmissions measure work and CMS' readmission measures. In the spring, we plan to present multiple years of rates of both all-cause and potentially preventable measures within stay and 30 days after in the four PAC settings.

Discharge to home, when appropriate, is the primary goal for the majority of patients in post-acute care settings, making it a priority for quality measure development.
The discharge-to-community measure gauges how successfully PAC providers discharge beneficiaries home with no unplanned readmissions or death within 31 days following discharge.

As part of the IMPACT Act, CMS did develop discharge-to-community measures, but the setting-specific variables included in the risk adjustment models make it difficult to compare the measures across providers in different settings and undermine their inclusion in a unified PAC PPS.

Therefore, we plan to create a uniform measure definition and risk adjustment model and calculate results using multiple years of fee-for-service data.

In the spring, we plan to report results of the episode-based PAC PPS design and development of two uniform outcome measures. In the future, if the Commission would like, we could select from these measures to model the potential PAC VBP.

After answering any clarifying questions, we would like your feedback on our work plan.

Thank you, and we look forward to the discussion.

DR. CROSSON: Thank you, Ledia, Carol. We'll now
be open for clarifying questions.  

[Pause.]  

DR. CROSSON: Every once in a while, we see a presentation that is so direct and clear that no one has any questions. Bruce has one.  

MR. PYENSON: There was mention in the material of the potential for high expense or low expense within a PAC setting so that -- because PAC providers can choose who they decide to treat or not, whether there is a risk of PAC providers avoiding the more expensive cases or inappropriately admitting less expensive cases. And you mentioned in the writeup that there are ways to detect that based on looking at the cost versus the risk. I wonder if you could elaborate on that.  

DR. CARTER: Sure. So in any prospective payment system, because you're paid an average -- the average is set for a group of patients, a provider would have an incentive to avoid what will look like expensive patients. And particularly in PAC settings, since they're not subject to EMTALA rules, you can select who you admit.  

So one of the things we've tried to do in the PAC PPS design work is to include indicators in the risk
adjustment that signal the things that would make a patient expensive, so things like ventilator care, tracheostomy care, severe wound care, patients who have five or more conditions, things that indicate this patient is going to be above average in costs. So that's sort of on the design side, and even if you didn't go with a regression model, you could establish case mix groups that make groups for those -- groups of patients that are expected to be high cost. And I think it's important to say that you wouldn't want to rely on a high-cost outlier policy to compensate providers for groups of patients who are systematically going to be high cost. Outliers are supposed to be for the random events, not the predictable ones. And so we need to not rely on an outlier policy for unusually high cost.

And then in the monitoring phase, we've been clear about sort of the kinds of things that CMS needs to monitor, and I think some high-level analysis of high-cost patients would be relatively straightforward to do and important to do. It's important for CMS to identify providers that are under- and overserving and also systematically selecting. And I think that in the monitoring and doing kind of large-scale data analysis,
some of that would be pretty straightforward.

MR. PYENSON: I have another question. In your material on quality, there is a brief mention of mortality as a potential quality measure. Of course, as an actuary, I think mortality is well defined usually. But you suggest that mortality is very variable, and I'm wondering if there's the potential to either use risk adjustment or multiple years of data or some form of collective assessment of groups of small providers to achieve a quality metric tied to mortality.

MS. TABOR: Yes, I would open that up for the Commission's discussion, if that's a measure that should be included in the PAC VBP. And I do agree that we could pool multiple years of data to increase the potential accuracy of a mortality measure.

I will also say one thing I like about the discharge-to-community measure is that it is both a measure of mortality and readmissions, so it does take away some of the potential small numbers issues as well as also capture the ability to keep people alive.

MR. PYENSON: How does it capture the mortality measure?
MS. TABOR: So the discharge-to-community measure is a measure of how many patients go home after a PAC stay and stay alive and are not readmitted to the hospital for 30 to 31 days afterwards.

DR. CROSSON: Yes. Kathy, John, and Pat.

MS. BUTO: So I love the continuation of this work.

I am wondering whether you're thinking about, as you create an episode payment, keeping that budget-neutral to the two states; in other words, really not assuming any cost related or cost savings related to the combination.

And then my second thought was episodes get to be large enough that the reason for the second stay might be very different from one patient to the other, and I wondered whether the episode is, in a sense, too broad or needs to be adjusted in some other way or whether you're going to look at that.

DR. CARTER: So we had thought that we would use the PAC stays within seven days, so that kind of constrains how far -- well, that's not really true. For some of the home health stays, they're going to be 60 days plus another 60 days. But we are trying to limit the gap, so that helps
1 a little bit.
2 In terms of -- what was the other part of your
3 question?
4 MS. BUTO: Budget neutral.
5 DR. CARTER: Oh, yeah. We'll certainly do that
6 budget neutral. I guess the question would be would we
7 take into account the standing recommendation of the
8 Commission to lower payments by 5 percent.
9 Jim is nodding his head yes; we will do that.
10 And we also probably will think about modeling.
11 In the work that we issued in July, we looked at the
12 alignment of costs and payments for subsequent home health
13 stays and noticed that the later home health stays were
14 considerably overpaid compared to their cost. And so we
15 would probably discount those, just like in the home health
16 PPS that's now in place.
17 So we will probably have a discount factor that
18 reflects current policy, and we'll look at the data. I was
19 looking at it yesterday to sort of see the size that we
20 might think about. But we will think about trying to
21 incorporate work that we've already presented in terms of
22 budget neutrality and the discount on that, and we'll put
in place both the outlier policies.

DR. CROSSON: Jon.

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

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

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

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

DR. CROSSON: Pat.

MS. WANG: My question is actually a little bit
related I think to what Jon was asking.

For the readmissions measure, the discharge to home -- and I have another question about that. What are your thoughts about adjusting for what we have come to call "SES factors"?

In the hospital setting, you did such good work to develop this sort of peer-grouping approach because you could kind of come up with an apples-to-apples comparison of differences in hospital payer mix and proportion of low-income patients, and frankly, what goes on inside of an acute care hospital is more similar to what goes on in another acute care hospital.

Here, you have different types of providers. Some are institutional care; some are sporadic home-based visit care. I suspect that the payer mix among these provider type is going to differ from each other. What are your thoughts about that? Because when it comes to -- you know, readmissions are potentially preventable. It seems like there needs to be some recognition of difference in provider type or provider service, home health versus IRF and some kind of SES recognition.

MS. TABOR: Right. So I'll answer the social
risk factor question first.

Consistent with the measures that we calculated for the hospital value incentive program, we did not adjust for social risk factors. But we do plan on a potential PAC VBP to use some kind of peer grouping so that providers would be compared to providers that serve similar populations, so it's just consistent with kind of the work Commission has been doing in our principles.

And the second question about looking at differences between settings, I think that's part of the analysis that we're going to do this year is really see how are the readmissions -- well, not so much readmissions, but the discharge to community and the admissions and plus readmissions measures or difference across settings and even looking at not-for-profit versus for-provide. So I'd say we'll come back to you on that question.

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

I am glad you are going to look at this. I suspect it will be good to see how you even determine type of patient because there's no DSH fact. There's no -- I don't know what metric you use that would be consistent across all of these provider types.
I do have concerns about the home health type of visit too. It starts to feel a little bit more attenuated when you move from IRF to home health in terms of the provider's responsibility to prevent admissions. So we'll look forward to more on that.

On the discharge to home or discharge to community measure, are you planning to account for the fact that sometimes discharge to community is not purely like the value in and of itself because sometimes a safe discharge might mean a discharge to permanent placement in a nursing home, for example? How are you going to --

MS. TABOR: So the way that the -- since we are using a claims-based measure, the way that the discharge codes are set up now is that we'll include beneficiaries who are discharged home or to a non-state-accredited -- or state-assisted living facility. But if you go to an assisted living facility that is also kind of an intermediate care facility, that does not count as going home.

Does that answer your question?

MS. WANG: If someone determines that the patient cannot live safely at home, even with 24/7 anything, and
the discharge is to permanent placement in a nursing
facility, that's considered home?

MS. TABOR: It is not considered home, so they
are not counted in the measure.

So we're really only looking at beneficiaries who
are seen fit to go home, who are discharged to home and
looking at, for those beneficiaries that did go home, how
many did not pass away or did not go back to the hospital
for 30 days.

MS. WANG: Thank you.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks, Jay. Sorry for my lateness.

So I like where you're going here so much. I
think this is really exciting and really will complement
the episode payment work.

The measurement question I have is on page 10,
you talk about functional status measures -- Slide 10, I
should say, talked about functional status, which I think
is a really important piece of what we'd want to see
included here. And I didn't see any specifics on how you
might do that.

I wondered whether you've considered the measure
that has been in Medicare Advantage, the Health Outcomes Survey, which scores the SF-36 or 12 -- I forget which -- into its physical component summary and mental component summary.

It's something worth considering. I know that it hasn't been a huge success in the plan world because it doesn't really differentiate, but I think in this population, you could see it differentiate.

So I was just curious what your thoughts are specifically about functional status and whether that's one that you've thought about.

MS. TABOR: Thanks for teeing up Carol's and my November presentation because we're coming back in November to talk about some analysis that we plan to do on the functional data that's been coming out of the PAC setting, and we do also talk a bit about the patient-reported outcomes and that potential, so stay tuned.

DR. CROSSON: Yes, Jon.

DR. PERLIN: Actually a very similar question. I was thinking about both the SF-12 and 36. I might comment to you the work of Lewis Kazis with respect to VA because one of the problems with such a potentially debilitated
population is floor and ceiling effects on the sort of broad population, SF-12 and 36 and other indicators of functional status. There's some permutations that are adjusted for populations that have very impaired function.

DR. CARTER: Thanks.

DR. PERLIN: Thanks.

DR. CROSSON: Warner.

MR. THOMAS: Did you guys see any utilization where there is essentially all of these services used by similar patients or many of them? I'm sure you did.

MR. THOMAS: Did you guys see any utilization where there is essentially all of these services used by similar patients or many of them? I'm sure you did.

I think the comment I bring up is where do you see as you go to more of a unified system? Which services do you think would be most likely impacted?

I think about avoidance of service when I kind of think about this, that there's probably duplication between the types of services. So I think about some will be avoided.

I guess just as a comment, it seems like probably this will put more pressure on home health over time because my guess is we'll be discharging a more acute patient home -- would be my guess because there's going to be more pressure to shorten the stay. So any thoughts on
DR. CARTER: So I think just the results that we've seen from alternative payment models shows that home health is being used more often. When patients can go home, I think you were seeing that that setting is used more, and SNF stays are definitely shorter.

So I think that that's sort of the broad backdrop of sort of what's going on in the hospital space that is shaping the use of PAC providers.

In a PAC PPS design, the most common episodes are ones and twos, and the twos are mostly home health and SNF going to home health. So if a design to pay for an entire episode may shorten home health stays, if you're being paid for an entire episode, is probably the most likely pressure, just looking at what are the most frequent types of episodes.

Does that help?

MR. THOMAS: Yeah. It just strikes me that the typical LTCH stay, unless someone is on a vent, is going to basically transition into one of the other historical disciplines, if you will.

DR. CARTER: Right.
MR. THOMAS: So that you'd see -- once again, you'd have folks that are on a vent that are going to be one type of comprehensive patient, and others are probably going to kind of slide into rehab or SNF, which will be a more comprehensive patient.

Given that this is a case rate, you then are going to probably see people move to a home care situation that on the front end is going to be much more intensive. I agree with you that the back end of home health stays will probably be less intensive.

I mean, number one, I'm a huge fan of this model. I think it makes a lot of sense. I was just trying to think. What we've seen is just more elimination of certain types of post-acute care and then higher usage of others. It may just be something that you're looking at that as you go through the model, but I was just trying to understand what your view is of how that shift is taking place.

DR. CARTER: I mean, we are hoping that institutional PAC providers -- if you set the rates so that they're adequate, there may be more institutional providers than the current LTCH folks that are treating the very high end.
We're already seeing some SNFs are in that space -- not most. But if you're paying fairly for taking trach cases, you might have more providers offering that service and then continuing to care for them through the weaning and less intensive care.

I would hope that there would be fewer transitions for patients because they really are disruptive for patients and their families. So if one of the outcomes of this could be just fewer handoffs between institutional providers, I would think that's great.

MR. THOMAS: Yeah. Okay.

DR. CROSSON: Okay. Thank you.

We are going to proceed now with the discussion period.

We have a request on the last slide there to provide feedback. There's already been some to Carol and Ledia about the work plan.

So I think, Brian, we are going to begin with you.

DR. DeBUSK: Well, first of all, thank you for a very exciting chapter. Obviously, this is great work, and it's really great to see it keep appearing in front of us.
So I'm glad to know you are going to be back in November.

There's some obvious reasons that this work is important and that we should continue to pursue it. We are dealing with a $60 billion spend area that clearly has payment equity issues, misaligned incentives, and obviously inconsistent quality measures.

But I want to point out -- and to make a larger point, I want to point out the importance to me of the nontraditional approach that we've taken here by trying to cross all four venues with a unified payment model as opposed to more of a traditional site-neutral mentality.

You guys are doing something that is inherently site-neutral as opposed to transactional.

It's also exciting to see how this -- and I think Warner touched on this -- how it's going to really realign the industry.

Carol, I loved your point about the fact that if nothing comes out of this, but there's just less shifting of patients and more treatment in place, I think that's going to be a wonderful benefit to this.

Then my final point, sort of the larger perspective, it's also nice to see us work, try to solve
these kinds of problems in a $60 billion payment area,
knowing that it's really a microcosm to the $600 billion
issue, because I think a lot of the issues that we're
addressing here, like being able to cross venues, payments
that are inherently site-neutral instead of being forced to
be site-neutral, and then this episodic thinking.

I like in the chapter how you started to
speculate a little bit on who is going to manage that
bundle. Is it a convener? Is it a hospital? Is it a
group of physicians? I think those are all issues that
don't just appear at the $60 billion level, but again
appear at the $600 billion level.

Now, the specifics of this chapter, I'm really,
really excited to see us working on episodes. I'm also
really excited to see that you went with the 85 percent of
the episodes that were one or two stays. Instead of trying
to boil the ocean and fit all of these complex post-op care
patterns, I think it's great that you went after that 85
percent.

I also think that -- even if when you do this
initial analysis, even if it's not quite not as accurate or
even if maybe we could cobble some stays together and get a
1 better fit, I hope we won't blink, and I hope we'll stay in
2 the episode world because I think the learning and the
3 experience that we're going to get from this, not only over
4 time will it get better, I think, but it will also again
5 help us address the larger Medicare issue.

6 The other reason I really like the episode
7 approach is the moment that we start, if we did retreat
8 back the stays, we're going to be right back to, well, how
9 do you deal with serial stays, how do you deal with -- I
10 mean, we'd be trading one problem for another, and I'd much
11 rather be working on a problem that's part of our future
12 instead of a problem that's part of our past.

13 The other thing that was great to see, you talked
14 about the unified value, value-based purchasing program. I
15 mean, this idea of having -- I loved that in the chapter,
16 this idea of having domains that when possible will cross
17 venues, but when they're not possible -- for example, I
18 really like the MSPB PAC measure. I hope it pans out
19 because that's a good example where even in the hospital
20 value-based program, the one we proposed last month, it has
21 MSPB in it, and even if MSPB and MSPB PAC are two different
22 values, at least they're methodologically consistent.
So it's almost like I'd rather have the same domain transcend the venue and then something that's at least methodologically consistent and then again accept the fact that there are just some domains that are only going to work within specific payment models. I don't think we should be held hostage to the idea that we have to reuse all those domains.

I really, really like the peer-grouping approach and again the fact that we're going to be consistent with the proposed hospital program.

I know I've mentioned this before to some of the staff. I hope we will explore peer grouping first, that we'll peer group first and then regress within each peer group to do the risk adjustment.

And long story short there, I mean, it is reasonable to assume that the underlying sensitivities -- let's say, of age or gender or race -- it's reasonable to assume that those underlying sensitivities are a function of SES. So the thought of maybe doing the peer grouping first, doing the regression, I just wanted to plan that bug.

Now, as far as the specific measures, again, I've
already mentioned MSPB PAC. I hope it pans out. This combined admission and readmission measure, I think there's some real novelty there. I like the way you're trying to work around some of the limitations of the data that we have. So, again, I look forward to seeing if that one works out. Then, obviously, I think discharge to community is a great measure too.

I think we're on the right track of finding the right domains, putting them in the right place, and again, it's just very exciting work. And I look forward to seeing you in November.

DR. CROSSON: Thank you, Brian.

Additional discussants? I see Bruce, Kathy, Warner, Jon, and Pat. Bruce.

MR. PYENSON: Well, thank you very much for a terrific chapter. Last year the Commission endorsed a plan to replace MIPS with a system that evaluated groups of physicians based on their quality and outcomes. And part of the thinking of that was that it was important to have groups of physicians rather than individual physicians to have the credibility for measurement but also that the system measures and quality measures are more meaningful
and also promote efficiency on a collective basis rather than an individual physician basis. So that happened last year. I think we're heading in a similar direction with -- or similar issues with post-acute providers because many of them are relatively small, and there's a lot of them.

So as a follow-up to Brian's comments, I think we're inviting ourselves through the quality metrics to look at some form of group measure by clustering individual providers perhaps on a voluntary or perhaps on a regional basis when they're small. And if we think about that by analogy to our proposal to replace MIPS, I think we can come up with useful measures that will be credible because of the larger scale. I had mentioned mortality, but I think it would also bolster some of the measures that you had performed. So I'm not suggesting that as part of the agenda for November, but I think it's something I'd like to see us keep in mind as we move ahead on this.

DR. CROSSON: Thank you, Bruce. Kathy.

MS. BUTO: Yeah, I want to support the direction we're going both on episode-based payment and quality in this area. You know, I especially like the fact that I think the episode-based payment has a lot of potential for
1 bringing home health closer into the overall PAC system.
2 Although we keep talking about a unified PAC, really it
3 feels like it is always a little bit outside, it's
4 different than institutional post-acute care. And this
5 really brings it together where there are two sequential
6 episodes.
7 When I first read the paper, I thought you were
8 only talking about rationalizing single institutional
9 sequential PAC stays, but you're not, as I understand it.
10 So I think that's really good.
11 The one thing I wanted to mention -- and this is
12 down the road -- is as we develop this approach, I think
13 there's a good chance it's going to lead to a lot greater
14 consolidation of providers. And that may be a good thing.
15 We may think that will enhance care coordination. It could
16 be a bad thing depending on how much consolidation happens
17 and whether it eliminates more community-based options for
18 beneficiaries. So just something for us to keep in mind.
19 I don't know where we'd come out on it, but I think we
20 ought to just be aware of it.
21 DR. CROSSON: Thank you, Kathy. Warner.
22 MR. THOMAS: So I agree, I think this is great
work. As I've said, I think going to a unified model in post-acute makes a lot of sense.

Just as I was reading the chapter and thinking more about -- and we build the model facility that kind of is configured this way with all of the post-acute areas in one location. Some things to maybe think about.

One, I think you have to make sure you have the right incentives for organizations in the SNF world to try to upscale to want to take a more complex patient. So as you think about the reimbursement, you want to make sure it's attractive there. Likewise, you want to make sure LTCHs will downscale, right? That they'll take, you know, patients that are of less acuity. So as you think about the methodology, I would think about how those organizations may look at it, because they're going to have to evolve and change and think about what that economic model might look like for them.

The other thing to perhaps think about is, to build this off of -- you know, I know we use the efficient provider model and inpatient hospital. I don't know how that could be applicable here, because I know there's a wide variety of -- especially in home health, there's a
wide variety of performance. And so thinking about what
the efficient provider might look like, it just may be
something to think about as you try to model this, you
know, which ones do you use the model in, maybe not
building it off the outliers, building off the ones that
are higher performing.

The one area I get concerned about is really in
home health because I really do think that they're going to
see much more acute patients, especially on the front end.
And they're going to need to have a different capability to
deal with that. So I would just continue to challenge you
to think about how you engage those folks to understand
what that would look like. And I understand there's a tail
on those stays, and there's a lot of stays at the --
there's organizations that have long home health stays that
we know at the end there's not a lot of costs associated
with that. But I think this is going to be a very
different patient that they're going to see on the front
end, so it's just something to think about.

And then the last comment -- I don't know if this
goes in this chapter, Jay, or not, but it would just be
what could we do in the interim? You know, because this is
still going to take a while. And I just think if we could
reduce some of the regulatory issues around which component
of post-acute you use, there's just so many challenging
regulations around that. There's been some relaxation of
that under the ACO model. But I also think it may give us
a time period to learn more as we go to this unified post-
acute, and it would be nice to see more flexibility in what
post-acute model you use on an interim basis.

And, finally, for skilled nursing, the reason we
don't see a lot of skilled nursing is because the
reimbursement is challenging for skilled nursing. And I
think on those lower-acuity stays you're going to have to
look at making sure that you've got the right economic
model there, because that's why we don't have as many
skilled nursing beds. The economic model doesn't work.
And I just think you need to think about those lower-acuity
stays, making sure that you've got the right reimbursement
mechanism there to make sure that you don't have all the
post-acute providers just trying to go for the higher-
acuity patient and then a lower-acuity patient is a
challenge or gets pushed into home care. So that would
just be something for you to think about as you continue to
look at this.


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

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

So I would like you to keep thinking about that measure and to be thinking about whether there's a way of differentiating situations where discharging to the home is a feasible and desirable thing versus discharging to the home or community is bad for the beneficiary, because the incentives will be for providers to get them out of the system and into something but not -- unless we worry about what something is, that's a pretty strong -- that's a
1 very strong incentive with a potentially undesirable
2 outcome for at least some of our beneficiaries. So I'd
3 just like you to keep thinking about that issue.
4
5 DR. CROSSON: Okay. I've got Pat, Jonathan, and
6 Dana.
7
8 MS. WANG: I very much support the direction of
9 the work, especially on the development of payment
10 episodes. I think I understand that a little bit better.
11
12 On the quality metrics, I have -- you know, I
13 raised the questions before in my comments, or along those
14 lines. I share the same concern that Jon just articulated
15 and that I alluded to before. Sometimes it's a little bit
16 too black and white to say discharge to community is like
17 the best thing. I think about it is as safe discharge.
18 Safe discharge might mean there's no supports at home. You
19 know, when you get to that stage, it's -- different states
20 vary. For example, if it's a dual, there might be personal
21 care available through the Medicaid program. There might
22 be family support for some people and not others. But you
23 can't count on that, and I think it's important to somehow
24 recognize in this measure whether it's through -- I don't
25 think it's an SES adjustment per se. I think, again, to me
it's a little bit more of a safe discharge with a bias towards community, but not sort of like if it doesn't happen that that's a bad thing. Sometimes people really should not stay home or go home because there's nobody to take care of them, and at that point I think the PAC provider, really there's not much that they can do. So I look forward to hearing more details about that in November because you explained it, Ledia, but I'm not sure I got what's in and out of that measure. But I would ask you to kind of think about these other factors as well.

And then just in general --

MS. TABOR: Can I just clarify one thing? In November, we're coming back on the functional status topic only. In the spring, we'll come back to you on this measure.

MS. WANG: Okay, thank you. But the more you can explain about what's in the measure and, if you can, think about the comments that have been raised particularly the situation of the individual beneficiary and what's available to them in the community, that would be great.

And then the other comment is just to reiterate the questions that I had before about the importance of
some kind of recognition or adjustment for socioeconomic status in the evaluation of readmissions, you know, avoidable readmissions and all-cause readmissions.

Thanks.

DR. CROSSON: Jonathan.

DR. JAFFERY: Thank you. I'm also generally supportive of the direction, both from the unified payment system and the quality metrics. I just wanted to comment on one thing that I didn't hear much about in the presentation today but I saw in the report around how the payment would get distributed. Brian touched on this, but it seems to me from some experiences we've had with some of the other -- trying to work with bundled payments and episodic payments with commercial payers, the notion of taking in a lump sum up front and then distributing it, creating the infrastructure for that is a pretty heavy lift for organizations that don't have those capabilities. And so I just want you to consider that as you think about -- you came up with a couple other different ideas at a very high level of the report around how do you apportion it or, you know, there may be some opportunity to look at some other -- CMS' other episodic payments in terms of
1 retrospective reconciliation, creating the infrastructure -
2 - I would hate to see added administrative complexity and
3 costs go into this because organizations need to create
4 that infrastructure.

5 DR. CROSSON: Dana.

6 DR. SAFRAN: Thanks. I have just a couple things
7 to add, just very supportive of this direction. One
8 comment that I don't think has been mentioned but is an
9 important feature of this that I really like is that I've
10 seen in our -- I think it will give lift to the work on
11 ACOs. And I say that based on my experience in our market,
12 commercial, and knowing how it's even more important for
13 Medicare ACOs to address post-acute care and how much I've
14 seen our ACO providers grappling for a way to have metrics
15 on which they can evaluate who their best post-acute care
16 partners are. And there's very little right now.
17
18 So I think that by creating accountability on a
19 post-acute care side that mirrors what we're asking in an
20 even broader way for ACOs to take care of is really going
21 to give lift to those efforts. And, you know, as you note
22 in the chapter and as we've talked about a little bit this
23 morning, quality measurement in post-acute care is really,
really lagging. So I think that's another value of this work, is pushing it forward. I think, you know, some of the challenges of defining a readmission measure, Pat has pointed to, but overcoming those challenges will be, again, really helpful where we're holding the hospital accountable for that, and for them to know that their post-acute care partners are also accountable for that is just, you know, getting everyone rowing in the same direction.

The final thing on that, I already expressed in Round 1 my enthusiasm for the functional status measures, and I think that could be particularly important. Jon's comments made me think about how the time frame we put around accountability for functional outcomes is going to be important, whether it extends beyond the post-acute stay, for example. But it did make me wonder whether we need to consider having a parallel measure on the hospital side, because we don't have that parallelism right now. So it's just something to think about.

DR. CROSSON: Jon.

DR. PERLIN: Thanks. Let me add my general support for this work and the terrific presentation of it.

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

So the concrete suggestion would be actually regulatory relief that allows providers to discuss the known complications of an institution, whether from public data or their own data, on readmission and infection rates. I suspect you could actually channel patients to more appropriate levels of care as well as reduce rates of readmission.

Maybe just as an asterisk to that, the other is that, you know, I agree that home health will be seeing increased levels of acuity. That said, because of the history of home health, it's ironically the most difficult of the post-acute settings oftentimes to get a patient into when it may, in fact, be the most appropriate.
Thanks.

DR. CROSSON: Yes, Kathy, on that.

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

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

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

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

MS. BUTO: I don't remember talking about it in the context of post-acute care, except for discharge planners. Did we do that?

DR. MATHEWS: We did it last spring, I believe it was. We had a session on --

MS. BUTO: [Comment off microphone.]

DR. MATHEWS: Correct, allowing hospitals to use quality information to be more directive about where a patient might go for their post-acute care. And we did not come to a clear consensus on whether or not that was an advisable thing to do. So the discussion is out there, but no Commission position.

MS. BUTO: I think Jon is going a step further, which is actually where that patient actually can go given issues of ownership and financial investment.

DR. CROSSON: Yeah, these are separate but related issues, both constraining that freedom of direction.

Brian?

DR. DeBUSK: Well, on this, I do think one of the issues that will come up is how do we qualify -- for
example, anti-kickback relief, Stark relief, you know, as part of modernizing that, how do we qualify who can and who can't do that? And I think that's something we're going to have to take up almost like in MACRA where you look at, well, if a certain percentage of your revenues come from these A-APMs, we're going to need some type of threshold like that so that we can sort of qualify who's in and who's out of being able to participate in the relaxed regulatory environment.

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

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

DR. PERLIN: Quick. For the record, we don't have those other parts, and so it's relationships with other providers exclusively, and their observation, you know, at significant scale is just how oftentimes we're forced into observing because of the constraints that are there, patients going to less than ideal settings with the predictable readmissions or acquisition of infection, when, in fact, there exists data but preclusions to actually share those data.

I think Brian may offer a way of really thinking about that where actually you can have discharge planners who are, frankly, disinterested but can share those data where it may actually not be a physician who's a member of the same group that also covers the skilled nursing facility or what have you, so that they're disinterested, but simply have the data on, well, you know, we see 47 percent readmission from Facility A and 32 percent readmission from Facility B, and, you know, I know that B actually has a higher star rating -- I'm sorry, that A has a higher star rating than B, which would be the discussion
you can have. But why would you in the face of the data of the actual readmissions or the higher rates of infection send a patient to that facility or be precluded from discussing, you know, the actual data on the readmission? So I think, Brian, you offer wise advice on a means that both appreciates Pat's concerns about making sure we don't fall into where we don't want to go but, in fact, do allow patients the benefit of following the data.

DR. CROSSON: Okay. Warner, last comment.

MR. THOMAS: I'd just make a quick comment. I would agree with Jonathan on this, and I think that, although I agree with Pat as well that you can kind of go overboard, I do think hospitals who have this information and not being able to share it in a direct way is a real challenge, and it would be nice, even though maybe we weren't definitive on this when we talked about it before, if we could have references in this chapter that these are interim steps that could be taken, because I think it would really help us get people in the right place.

DR. CROSSON: Okay. Good discussion. Carol and Ledia, we look forward to seeing you back in November and later on as well. Thanks for this continuing terrific
work.

[Pause.]

DR. CROSSON: We're going to proceed with our final presentation for the October meeting, and that's on Medicare policy issues related to urgent care and emergency room use.

Zach and Dan are here, and it looks like, Zach, you're going to begin.

MR. GAUMER: Yes, sir.

Okay. Good morning.

Today we dive back into the topic of emergency department services.

Before we do, I want to thank Carolyn San Soucie for all of her work on this project.

Last spring, you made two emergency department recommendations, and in doing so, you asked for more information on urgent care centers and their role in providing low-acuity care, some of which is also provided in hospital emergency departments.

You also asked us to give more thought to trends in ED coding practices.

As a bit of context, for the first topic,
Commissioners expressed concern about the rapid growth in Medicare ED use and wanted to ensure Medicare payment policy was not encouraging this growth.

In response, we found that this growth encompassed both emergency and non-urgent care and in part may be driven by higher payment rates, relative to urgent care centers.

For the second topic, you expressed concern about the rapid growth in ED spending relative to service use and the increase in the volume of claims with higher ED code levels.

I will walk through the first topic, and Dan will walk through the second.

Okay. So this is the first time the Commission has examined urgent care centers, so I want to take a slide to review some details about these facilities.

There are over 8,000 urgent care centers operating today, and the industry is expanding. In fact, the number of UCCs increased 33 percent in the last five years.

The majority of these facilities are independent of hospitals and are owned by private equity firms,
physician groups, or payers. The remainder of the facilities are affiliated with hospitals. UCCs offer patients basic medical services and basic procedures. X-ray and lab services are a part of their standard business model. However, they do not offer higher complexity imaging and lab services. UCCs, on average, serve a large share of commercially insured patients and a low share of Medicare patients. Use of UCCs by Medicare beneficiaries is low, but the growth has been rapid in this service. In 2017, beneficiaries had roughly 3 million visits to UCCs, and this is about 1 percent of all physician E&M claims. However, from 2013 to 2017, use of these facilities for E&M services increased 73 percent per beneficiary. This is faster than any other type of provider for this service. The most common conditions beneficiaries were treated for at UCCs in 2017 included upper respiratory infection, bronchitis, and other relatively low-complexity conditions. Medicare pays UCCs differently, depending on the hospital affiliation. In general, independent UCCs receive
only physician payments, and hospital-affiliated UCCs receive both a physician payment and a facility payment. To illustrate the difference between Medicare's basic payments rates to EDs and UCCs, we will compare the 2018 payment rates for a level 4 ED visit at a hospital ED to the payment for an equivalent case at the two types of UCCs.

On the left, you can see that a level 4 ED visit generates a combined physician payment and facility payment of $476. By contrast, the same beneficiary treated at a hospital-affiliated UCC would generate a total payment of $246. Then on the far right is the payment rate for the same beneficiary treated at an independent UCC, which generates only a physician payment of $167.

There are two dynamics to consider with this. First, in all three settings, the beneficiaries are responsible for 20 percent cost sharing, so their liability is higher in the ED than in the urgent care center. And, second, the dollar values on the slide reflect the physician and the facility payment rates the providers
would receive, but it does not include the ancillary services that typically occur with visits to the EDs and UCCs, such as MRIs and x-rays and lab services.

In our mailing materials, we explained that when you factor in spending on ancillary services, ED spending per encounter is on average 5 to 35 times higher than at UCCs. So the ancillary services tend to enhance the payment differences in these two settings.

So I’ve just told you about UCCs and how Medicare pays them relative to EDs. So I will now turn to our comparison of hospital ED and the UCC.

In general, we see overlap in the types of conditions treated at these two types of providers. Among the 20 most common conditions provided to Medicare beneficiaries at both EDs and UCCs, they had 8 conditions in common and 12 that were not in common.

With this in mind, it was necessary to create a common sample of conditions to compare these provider types. To do so, we used a method developed by researchers at Dartmouth to identify what they call non-urgent care. As a part of this method, non-urgent care is defined as any claim containing one of seven conditions as the principal
diagnosis. Using this method, within the 2017 physician
claims, we identified 15 million claims involving non-
urgent care. Most of these claims occurred at physician
offices, but a significant number occurred at EDs and UCCs.
Also, from 2013 to 2017, the number of claims for
non-urgent care per beneficiaries at UCCs increased 72
percent, significantly faster than at EDs.
In 2017, as I said, there were approximately 1.5
million claims at EDs involving non-urgent care, and this
represent 7 percent of all physician ED claims.
The beneficiaries receiving non-urgent care at
EDs in 2017 appeared more complex than beneficiaries
receiving non-urgent care at UCCs.
As you can see in the table above, for the
beneficiaries receiving non-urgent care, the average
beneficiary risk score was higher at the ED. Beneficiaries
treated at EDs also had a higher average number of chronic
conditions, and a larger share of these beneficiaries were
75 years or older.
So given the apparent higher complexity of the
claims for non-urgent care at EDs, it seemed reasonable
that only a subset of the 1.5 million claims occurring at
1 EDs might be appropriate for treatment at a UCC.
2 To specifically identify how many of these 1.5
3 million ED claims might be appropriately treated in a UCC,
4 we identified those claims for non-urgent care at EDs where
5 the beneficiary had a relatively low risk score and few
6 chronic conditions. Therefore, these were beneficiaries
7 treated at EDs that looked a lot like beneficiaries treated
8 in UCCs.
9 As a result, we identified roughly 500,000 claims
10 at EDs which may be appropriated treated at a UCC, which
11 represents 33 percent of claims for non-urgent care at EDs
12 and 2 percent of all physician ED claims.
13 Using this estimate and our estimate of the
14 average spending per non-urgent care encounter, we estimate
15 that Medicare paid between 1- and $2 billion more per year
16 because these beneficiaries were treated at a hospital ED,
17 rather than an urgent care center.
18 Commercial insurers have responded to the high
19 costs of ED services with retrospective claims audits and
20 patient education efforts. The public and the media have
21 reacted negatively to the auditing approach.
22 It is also worth mentioning that a recent study
1 using data for Aetna members found a decrease in the use of
2 EDs for non-urgent care and an increase in the use of UCCs.
3 Because Aetna was not one of the insurers to use
4 the auditing approach and because we do not think it is
5 reasonable to penalize beneficiaries when they are trying
6 to get care immediately, we suggest the Commission consider
7 a softer policy approach, softer than retrospective audits.
8 For example, the Commission might consider initiating a
9 Medicare beneficiary education campaign, expanding quality
10 measurement to include variables like avoidable or
11 preventable ED visits, or encouraging EDs to better
12 coordinate with primary care physicians.
13 So, with that, I'm going to hand this off to Dan
14 to discuss the second topic.
15 DR. ZABINSKI: Okay. When a Medicare beneficiary
16 receives care in a hospital emergency department, the
17 hospital codes the visit into one of five levels, and each
18 level reflects a different level of expected resource use
19 to treat the patient. Therefore, the payments for ED
20 visits increase with the level that's coded.
21 An odd feature of the codes for ED visits is that
22 national guidelines aren't used. Instead, CMS has directed
hospitals use their own internal guidelines, which gives
hospitals much discretion over how they code ED patients.
We found that the coding of ED visits has
steadily shifted from more levels to higher levels. In
this diagram, the yellow columns show that in 2005, ED
visits approximated a normal distribution across the five
levels, and CMS at that time said that this is a desirable
outcome because it indicates that hospitals were billing
the full range of codes in an appropriate manner.
But the red columns indicate that by 2016, ED
visits had become much more skewed towards the high levels
and the longer approximated normal distribution. For
example, the share of ED visits coded at level 5 increased
from 11 percent in 2005 to 28.3 percent in 2016.
This shift has important implications for the
Medicare program. For example, if the distribution of ED
visits in 2016 was approximately the same as a normal
distribution that they had in 2005, combined program
spending and beneficiary cost sharing would have been
nearly $1 billion lower.
The shift of coding ED visits from lower levels
to the higher levels could occur for two reasons. One is
that the clinical attributes of ED patients may have
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3 have more conditions requiring substantial hospital
4 resources, or the conditions might not have changed much,
5 but the severity of the conditions might have. The other
6 possibility is that hospitals are upcoding by coding
7 patients with similar clinical attributes to higher levels.
8 We've examined the change in conditions treated
9 in EDs and the severity of ED patients, and the results do
10 suggest that some upcoding has occurred. In particular, we
11 found that there's been little change in the conditions
12 treated in EDs, and it's unlikely that patient severity has
13 changed enough to explain the change in ED coding.
14 To examine the change in conditions treated in
15 EDs, we examined ED claims from 2011 and identified the 210
16 most frequently coded principal diagnoses. These principal
17 diagnoses were on about 75 percent of the ED claims in
18 2011. Moreover, these principal diagnoses were also on
19 about 75 percent of ED claims in 2016.
20 We found that for each of these 210 principal
21 diagnoses, the share of all ED visits that had a particular
22 diagnosis code was usually very similar in 2011 and 2016.
For example, the most common principal diagnosis in both years was unspecified chest pain. This condition was the principal diagnosis on 3.3 percent of all ED claims in both 2011 and 2016, and this similarity across the years in terms of the share for each code was consistent for both 2011 and 2016.

This result indicates little change in the conditions treated in EDs from 2011 to 2016, even though the share of ED visits coded as level 5 increased from 21 percent in 2011 to 28 percent in 2016.

Moreover, for 97 percent of these principal diagnoses that we evaluated, the share of ED claims that was coded at level 5 increased from 2011 to 2016.

To determine whether patient severity could explain the shift of ED codes to higher levels, we started with the idea that the most likely way for patient severity to increase among ED patients is that low severity cases migrated to other settings.

And by far, the largest growth in alternative settings to emergency departments is the urgent care centers that Zach discussed, with an increase of 1 million UCC visits from 2013 to 2016.
But we found that even if all of that growth in UCC visits was from migration of low-severity ED patients, the growth in the UCCs has not been large enough to explain the increase in coding of ED visits to level 5.

To the extent that upcoding has occurred, one way to address it is to create new ED codes. One alternative to the current codes is a single code for all ED visits. So there would be no levels.

Another alternative is to continue to use multiple levels but create national guidelines for coding, with attention to reducing incentives for upcoding. National guidelines for ED coding currently don't exist. As I said earlier, hospitals use their own internal guidelines. But having national guidelines would provide a consistent basis for assessing coding patterns, in contrast to internal codes where hospitals have discretion over their own guidelines.

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

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

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

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

I turn things back to the Commission.

DR. CHRISTIANSON: So clarifying questions. Jon?

DR. PERLIN: Well, thanks, Jon. And, Dan and Zach, thanks for a terrific and thoughtful presentation.
I have two clarifying questions, one on the first topic, the distribution of care between emergency departments and urgent care centers, and the second on the coding.

It's fascinating that there is incredible overlap of the types of conditions seen in both the urgent care and the emergency department, and you pointed out some stratification, patients with higher risk and greater complexity, and that makes sense. But might there also be some other systematic factors -- there are probably too many mics on -- that drive the distribution ultimately of the patient's decision to go to one of the two places?

I would just note that you pointed out some of the ownership of the urgent care centers, but many of the urgent care centers are not 24/7. That might change. And so given their locations also, which would be in areas of higher socioeconomic status, that may systematically preclude who's able to go to a different facility.

So if you corrected for that and the fact that they're not simply available in all markets as ubiquitously as emergency departments, do we have any sense of how those numbers would change of those who might be construed as
MR. GAUMER: It's hard to say. There have been a couple of studies out there on this. You know, within our own data, we haven't done any kind of stratification on, you know, market. We've looked at some of the states, and there are some states that have more urgent care centers than others. And we see, you know, in some of the states the use of urgent care for non-urgent care conditions, if they go up in urgent care, they go down in the ED. We see a little bit of that. But we haven't done a detailed analysis of the different markets.

The other research that's out there has done some more sophisticated statistical work to control for risk adjustment and that kind of thing, and they're finding similar things.

DR. PERLIN: I'd just commend to consider, you know, looking at the differences in hours of operation, the differences in geographic access, and the difference in some of their models, some of those urgent care centers do not actually, you know, accept government payers. They accept commercial insurance only. So there may be some systematic variables that drive differences, and I'd
1 absolutely -- I think we need further discussion about the
2 patient's sort of choice with respect to those risk
3 factors.
4
5 Just to give you a sort of concrete example, take
6 two 80-year-olds who have some respiratory symptoms. One
7 is your individual 3.1, other comorbidities, the other a
8 2.0 comorbidities. Let's for the sake of argument say that
9 the 80-year-old with the two comorbidities has some
10 arthritis and something else, and the other actually has
11 diabetes and heart failure. You know, that individual is
12 wondering: Is this heart failure or is this a cold? That
13 may drive choice.
14
15 Let me flip over to the second question, which is
16 the effect on coding and distribution. I'd be interested
17 in how your research has -- or any comments on the
18 systematic effect of ACEP. I know CMS chose not to
19 incorporate the guidelines, but, you know, when this
20 discussion was going on with CMS, I think people were
21 looking for a reference point, and the American College of
22 Emergency Physicians offered some guidance on that and did
23 that exert a systematic influence on the coding?
24
25 The second is I wonder if your research
contemplates the effect of the EHR capturing work that would not have been systematically captured over that period of time, because obviously in this past decade, there has been an exceptional increase in the use of electronic health records systematically capturing things that may not have been scribbled, in fact, probably prompting for capture of elements of procedures and physical examination.

And then the third is even though you note that the constellation of diagnoses is the same, I wonder if it contemplates how the therapy has changed. So if I had a stroke and showed up in an emergency room a decade ago, I'd be given an aspirin and observed. Today, you know, you're seeking a door-to-needle time for either a thrombolytic or mechanical thrombectomy in less than an hour, and so the intensity of the response to the nominally same diagnosis with the same degree of comorbidity or risk is very different. So I'd just appreciate any comments on those other aspects of comparison.

DR. ZABINSKI: All right. I'll tackle the first one. Then you're going to have to remind me of the other two because I can never remember.
DR. PERLIN: Okay.

DR. ZABINSKI: After answering one question, I can never remember the follow-ups.

The first one was on the ACEP guideline.

DR. PERLIN: Yeah, did it impose a systematic influence despite not being a CMS-sponsored guideline?

DR. ZABINSKI: I'm not sure. It might have. I think that's something to think about. I do know, you know, CMS did not spend a lot of time talking about the various internal guidelines that hospitals might use, but they did make it clear that there's some variation in the approaches that different hospitals take. But they didn't really say -- you know, there's just a couple sentences in one of their regulations, and I also know that there was some discussion that, you know, the ACEP approach was sort of the gold standard and the way to go, but also when the AMA and the -- sorry, yeah, the AHA came up with their approach that that was also considered quite a good one, and then some hospitals I know developed their own.

So it's probably the case that the ACEP approach had some influence. I'm not sure the extent to which it did, though.
DR. PERLIN: Yeah, but I think your point is well taken there. The gold standard, it probably influenced -- even though they're independent nominally, you know, guidelines that institutions implemented, they didn't sort of pull it out of the air. They kind of out of safety, frankly, likely went to a reference -- it may be worth surveying.

Let me go back to the second, and that was the systematic effect of the electronic health record in terms of capturing workload.

DR. ZABINSKI: Yeah, probably -- you know, the electronic health record, I think what you're getting at is there's more complete information about patients or --

DR. PERLIN: The more complete capture, I mean, so any of us using the electronic health record, you know, it will take you through and it prompted you, Did you do this? What were the elements of your physical? And, you know, we know from our other E&M coding activities in other parts of an institution, three elements of this, four elements of this, so, you know, you can actually -- they prompt with templates for this, that, or the other to get a complete history, physical, and capture of procedures. So
things that may not have been captured as workload are more systematically captured as workload.

I just think it's worth an assessment. I'd be happy offline to discuss with you ways to capture that.

DR. ZABINSKI: My thought on that is, you know, it's a definition possibility, but this shift to the higher levels of coding has been going on for quite a long time, probably back to a period that preceded the use of EHRs. We'll go back all the way to 2005, and there's been -- there was a movement toward the higher levels. So I'm not sure.

DR. MATHEWS: Hey, Dan, let me try and get in here for a second. So, Jonathan, if I understand what you are saying, one of the policy options that we're proposing here is a more definitive refinement of the five levels of coding that are used to classify patients in the ED. And what you are suggesting is that data on level of effort and work that is now captured in the electronic health record could be a source of information to help with that refinement. Is that what --

DR. PERLIN: I think that's a great comment, and I think that change may also reflect the increased capture
over the period of time. And I conceded that, you know, if
you draw the beginning to 2005, that may have been adoption
before the thrust of the meaningful use high tech which
really came, you know, full bore in 2009. But there seems
to be an increase in capture of that sort of workload.

The last is the intensity of treatment for the
same diagnosis, which would co-vary with the other --
because the biggest clusters, as you said, are chest pain -
chest pain, stroke, those things that are the common ED
big-ticket items -- have changed significantly.

DR. ZABINSKI: That's definitely an angle I've
considered and thought about, and I would say -- there are
approaches to national guidelines that I think would help
capture that sort of issue. You know, one of them is the -
there's sort of a point system where you assign a certain
number of points to each intervention, and you add up the
points and whatever the number of points you get, that's
what level you fall into. And I think changes like, you
know, in methods of treating something would be captured in
that.

DR. PERLIN: Well, I'll look forward to
discussion of some of the approaches in Round 2, but thanks
for those clarifying answers.

DR. CROSSON: Okay. All right. Let's start with Pat and go down that way.

MS. WANG: Zach, you said something that I want to make sure that I caught correctly, because of the sort of geographic lumpiness of the distribution of UCCs in certain markets and not others, the study that you performed to test whether or not the increase in UCC visits could explain part of the increase in the prevalence of Level 4 and 5 ED coding because the lower-intensity visits were being decanted to UCCs, and you didn't really find a correlation. It's just a question. Does it make sense -- because that's on a national scale. Does it make sense to further test that correlation or lack thereof in a geography that has, you know, a density of urgent care centers that Medicare beneficiaries use compared to the ED utilization and the Level 4 and 5 coding in the hospital emergency department? Because I think -- I guess I just wondered. It feels like it's very peanut butter to cross the whole country, and there are not UCCs everywhere, so maybe the correlation is too small.

MR. GAUMER: So I think there are two things
going on here. The second part about the coding is
something Dan looked into, so he should address that. But
in terms of looking on the market level, I think that's
something that we can do the next time you see this, and we
can talk about the characteristics of the patients going
into UCCs and their risk scores and that kind of thing to
see if there are big differences. But I think the
correlation between the coding is Dan's department.

DR. ZABINSKI: Handoff, okay. The question
again, what was it exactly?

MS. WANG: Just not to make extra work for you,
but whether you think it would be worth validating the sort
of conclusion or observation that the increase in UCC
visits is not explaining the increase in Level 4 an 5
coding.

DR. ZABINSKI: Uh-huh.

MS. WANG: Whether you think it would be worth it
to take a look at a geographic area that has a prevalence
of UCCs and hospital EDs and just look within that smaller
area whether that phenomenon is borne out.

DR. ZABINSKI: That's a reasonable -- yeah,
actually I like that idea.
MS. WANG: Okay. The second question that I had has to do with the coding phenomenon. On Slide 4 you mentioned that when you showed the difference in payment across these different settings, it doesn't include sort of all of the ancillary and other services that are provided. Have you looked at in the hospital ED setting in particular for Level 4 and 5 whether there is -- what the total cost is for the 4 and 5 levels and whether there's consistency there? I guess, you know, it's not just the 500 bucks for the facility and the physician fee. It's everything else that goes along with it. And as you mentioned, Zach, it's a multiple. And I just wondered whether there was anything of merit to observe about the bundle of cost or services that are delivered around 4 and 5 visits. That's a question. And where that leads me is just to wonder whether, as you're looking at 4 and 5, because Slide 11 was kind of fascinating to me. Regardless of the reason for the change in coding -- and it might be better information capture; it might be actual patient acuity, maybe not -- you know, you see the shift in the bell-shaped curve from the original -- I have black and white here -- from 2005 to 2016. Is it crazy to think that one would simply just
rebase and shift the curve over to achieve some budget 
neutrality in the amount that is being spent? That's what 
that slide kind of cries out to me.

And the second sort of separate thing and the 
reason I was asking about the bundle of cost is whether you 
think it might be appropriate to look at a different type 
of payment for emergency department visits that accounts 
for the additional spending to the extent that it's 
predictably related to that level of coding.

DR. ZABINSKI: Let's see. On the first part, as 
far as, you know, the shift -- shifting the whole thing 
over, that's an issue that I think is important to think 
about. Even if there is not upcoding, the fact that you 
have such a high share at the high level tells you that the 
codes probably need some sort of massaging or changing in 
some way to get it to look more normal. As I said, in 2005 
CMS' response to that distribution was that this is 
comforting because it shows that hospitals are coding 
completely and, you know, in a way that we're looking for. 
And it doesn't exist anymore. So, yeah, just changing the 
codes for the sake of getting them to be more normally 
distributed I think is a reasonable idea to pursue.
And, once again, you're going to have to remind me of the second question.

MS. WANG: This probably doesn't make sense, but I just was curious about if there is a bundle of cost that is predictably related to a Level 4 --

DR. ZABINSKI: Oh, yeah --

MS. WANG: -- coding, whether there's any utility in your mind of exploring a different type of payment for an ED visit.

DR. ZABINSKI: I'm not sure, but I would say this: CMS over the last five years has really been pushing towards greater bundles in the outpatient payment system, so that, you know, fits in well with where they're heading. Maybe they'll get there without even any prompting. Maybe it's in their plan, I don't know, but I think that's a reasonable approach. You know, they have these comprehensive APCs where for the more advanced type procedures like implanting a defibrillator, everything on a claim gets packaged together. It doesn't matter what it is. That's fairly new, and perhaps they'll head that direction for ED visits. They're already doing it for observation care. So it's an idea.
DR. CROSSON: Okay. Brian.

DR. DeBUSK: Two questions. First of all, when I was doing the reading, I was wondering: Is there any evidence that UCCs induce utilization? I know there's some work in ASCs where it looks like you could look at, say, use per 1,000 beneficiaries, you add an ASC, and you watch it spike up.

MR. GAUMER: So our own research and the current research out there doesn't speak to the inducement issue, but, you know, this might be something to explore. When you look at growth rates on a per beneficiary basis, use of all these settings that do E&M services are going up. So there could be some inducement there if a new facility popped into a neighborhood that had never been there before. There could be. But we haven't really looked at it yet, and there's no clear evidence that it's happening.

DR. SAFRAN: One way or the other, okay. So there's nothing in the literature.

Then a question for both of you. Has any site-neutral work been done here looking at UCCs and EDs?

MR. GAUMER: I think with UCCs specifically in mind, no, but the site-neutral policy, Section 603 that Dan
has worked -- I won't go into that description, but it does affect these facilities. And so as you saw in the reading material, there's great complexity with how these facilities get paid, whether they began after November 2, 2015, or before that date. So the Section 603 site-neutral policy does affect UCCs.

DR. DeBUSK: But between EDs and UCCs, they're explicitly exempted through 603, right?

MR. GAUMER: EDs are exempted from this, yeah.

DR. DeBUSK: Okay. But back to just because it's exempted, Dan, is there any site-neutral work that you've done in this area?

DR. ZABINSKI: No, there's not. But I think it's something to strongly consider. How about that?

DR. CROSSON: Brian, I just want to be clear. When you talk about inducement, do you mean just the simple existence, new existence, or purposeful inducement or both?

DR. DeBUSK: Just simply the existence. I've read a paper that looked at ASCs. They looked at regions where they added an ASC, and it looked like claims per 1,000 beneficiaries actually spiked up. I wondered if anyone had looked at something similar for UCCs, because I
wondered if they were additive to the overall volume of
claims or if they were somehow, you know -- all this
squeezing a balloon.

DR. CROSSON: Are these both on this point? Dana
first, and then Pat.

DR. SAFRAN: Yeah, on this point. So we have
looked at this in our commercial and both from our data and
from what our members say when we talk to them, and we do
see that there is new utilization happening where UCCs come
into place. And when we talk to members to understand if
you hadn't sought care at this UCC, what would you have
done? A very small percent seem to be substituting UCC for
emergency room. Most seem to be going to a UCC rather
than, you know, the wait-and-see attitude just because it's
convenient, it's there, it's a low co-pay.

And just while I have the mic, it seems to me
that similar to Pat's point, you could leverage geography
here to look at that question in the data. It would be
very instructive.

DR. CROSSON: Pat.

MS. WANG: Just on this point, is it possible
from the data that you have to see where a UCC visit was
followed by an ED visit? Because this definitely happens, and this happens in my -- and it's a great caution. We really like to have UCCs in the network because it provides additional access, but the thing that we try to really pay attention to is is it really addictive or is it substitutive.

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

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

DR. CROSSON: Okay. Amy and Paul.

MS. BRICKER: I have three questions.

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

DR. ZABINSKI: Well, it was very brief. It's in the comment letter to the 2014 ASC OPPS proposed rule, and we didn't say a lot. Just our opposition at that time was
that it could be unfair to hospitals that have a lot of high-acuity patients. You're paying the same rate for everybody, but if a hospital happens to get a very sick population in, they're going to, on average, get underpaid. As far as reintroducing it, it's the case of just trying to be complete with possibilities in terms of how to approach this issue. This is just one way to approach it. I guess that's about it.

MS. BRICKER: Okay, fair enough.

So the costs that you showed in one of the graphs around the independent versus hospital-owned, UCC versus ED, is there also ability to look at the quality associated with each of those venues?

Instinctively, you had suggested education, and maybe that's what we need to do is educate beneficiaries, that there are lower-cost alternatives. I agree with that, so long as the outcomes are the same. So have you looked at that?

MR. GAUMER: We thought a little bit about this, but there are a couple of pieces of literature that are out there that talk about it. And we can include that the next time we come back to you.
MS. BRICKER: Okay.

MR. GAUMER: But, generally, what they say is that the quality of care at urgent care centers is similar to the quality of care for these non-urgent care cases, but we need to dive in a little bit deeper to see more about who conducted the studies and who's paying for them and that kind of thing.

MS. BRICKER: Perfect.

Lastly, we've done work previously on standalone EDs, and if we might consider putting that work -- tying that back into future work here. We talked about whether folks end up going to a standalone ED over a lower-cost UCC. The cost impact, when you put ED up, is it connected to a hospital versus standalone? All of that is rolled up together?

MR. GAUMER: Yeah. When we did our estimate of the 1- to $2 billion in extra payments, is that what you're referring to?

MS. BRICKER: So you represent EDs. Is that traditional ED as well as standalone ED?

MR. GAUMER: Yeah. We're thinking of them together, and when we did our calculations, we considered
all EDs kind of as type A EDs, the higher-paid EDs, and it
would include your standalone EDs as well.

MS. BRICKER: So if I recall, those standalone
EDs saw low-acuity patients. I don't know if it was you or
Dan that did that study. We talked about how ambulances
pass the standalone EDs and go to the traditional EDs.
They act more like urgent cares and not EDs. So I think
just to refresh, maybe the Commission on that work might be
helpful here.

MR. GAUMER: Okay, okay. Sure.

MS. BRICKER: Thanks.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: This is for Dan.

Dan, the coding process, what role does the ED
physician play in that?

DR. ZABINSKI: My understanding is not much. The
physician codes for themselves, and then the hospital codes
for the hospital.

DR. PAUL GINSBURG: Okay. So the code doesn't
have to be the same?

DR. ZABINSKI: Oh, no. It is often different.
The other thing I'd notice is that if you count
the number of ED visits that show up on physician claims versus the number of facility claims, there's more physician. My guess is that because you have a patient comes in and more than one physician sees them.

DR. PAUL GINSBURG: More than one physician, yeah.

DR. ZABINSKI: Yeah. There's a definite difference between the physician coding and the hospital coding.

DR. PAUL GINSBURG: Yeah. I think it might be instructive to compare the trends in the mix of levels for the physician claims versus the ED facility claim to see if they're lining up.

In the ED physician worlds, there's been a very rapid transition to corporate staffing models, which it would be an obvious opportunity for coaching physicians to code more aggressively. This may be a part of the picture. It may be a distinct picture that perhaps we should bring into the analysis and not restrict ourselves to what's happening on the facility coding.

DR. CROSSON: On this point, Jon?
DR. PERLIN: Thanks.

I think that is a really good point, Paul, because the other thing that occurred over this period of time, just the implementation of observation status, that may also have some bearing on the trend.

By the way, just back to that point in 2005 versus 2009, we're looking at 2005. It may be useful to actually look at 2009 versus 2015 or whatever the out date was on those charts.

Thanks.

DR. CROSSON: Jaewon, on this point as well?

DR. RYU: Yeah. I think Paul raises a good point. It would be good to match up the physician coding aspect.

The other question is, On the facility component, does length of stay in the ED play a role at all into how that gets coded? Because I believe it does, and ED boarding has also increased during the same time period. So it may be a function of just longer length of stay in the ED.

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

DR. CROSSON: Okay. I just want to interject a second. We're now almost an hour into the discussion, and we're still on clarifying questions. And we've only gotten halfway through the Commission.

We have got lots of time. We could stay here, but I do want to suggest that we get through the questions so that we can actually provide some advice in terms of the options that have been presented to us.

So, with that prolog, can I see hands for questions?

[Show of hands.]

DR. CROSSON: All right. Let's start this way, Bruce, and go down.

DR. PYENSON: Thank you.

A question on Slide 11. The emergency room is often the gateway to an inpatient admission, and a question on whether there's sufficient -- whether the reduction in inpatient admissions that we've seen, especially for medical cases, could account for some of the increase in
severity.

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

DR. ZABINSKI: I don't.

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

DR. CROSSON: Sue.

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

When you talked about strategies used to simply work to reduce utilization, whether it be retrospective audits or trying to education the patients or the beneficiaries, and you called out from a commercial insurance side that they had decreased -- Aetna had decreased use of the EDs for non-urgent care. Do you know
what about any strategy they used that actually reduced?

Was it education to the beneficiaries? Was it plan design, increased out-of-pocket? What do we know about that?

MR. GAUMER: So I only know --

MS. THOMPSON: And then how would you think about that in the Medicare context?

MR. GAUMER: I only know a little bit about what's been happening in the commercial world. We spent a little bit of time doing it, but we haven't done any interviews with insurers to dive deeper into it.

A lot of what we've learned has come from the literature, studies done with commercial data and whatnot.

There are two large commercial insurers that have taken the retrospective audit approach, and they've been well published and gotten a lot of heat for it.

Just looking at the other large commercial insurers out there on their websites and what they are talking about, there are extensive patient education pages, videos that are trying to reach out to patients to say, "Here's what you do. When you're having this big question of where to go, these are the 20 conditions we think you should take to the UCC, and these are the other things."
And they're very well done, and obviously, they've spent a lot of time thinking about this. But we have not interviewed representatives of these insurers yet.

DR. CROSSON: Thank you.

Jaewon.

DR. RYU: Two questions. One is getting back to the scenario Pat mentioned where you have a beneficiary. They go to the urgent care, and then they go to the ED because the capabilities are beyond -- or the needs are beyond the capabilities of the urgent care. Does that beneficiary get hit with two different cost shares, 20 percent for both encounters?

So I think in the commercial payer world, this has been one of the tools that have been used just to de-risk that scenario for patients because otherwise they will always choose -- or not always, but frequently, they'll choose the higher-level service thinking that, "Well, if I go to the urgent care, there's a chance I may get sent to the ED." And that doesn't need to happen often for that to shift their behavior.

So it might be helpful just to look at that transition and how often that actually occurs and
strategies around how we might de-risk that.

The second question for you all is -- and I don't know if there's any way to access this other than clinical data, but it would be helpful if there was a way to identify what the patient presented for, so the chief complaint that they entered the ED for as opposed to the discharge diagnosis, which is what we have on the claim.

And, again, don't know the feasibility of that, but that was my question to you is, Do we have access to anything along those lines?

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

The second question about the chief complaint, that one kind of bounces off my forehead, and I think I'm not aware of how that would work. I think we only have the
principal diagnosis code on the claim, but maybe --

DR. ZABINSKI: No. I am not aware of any way that we can find that out, but we can definitely take a look. That would be really a helpful piece of information, I think.

DR. CROSSON: Karen.

DR. DeSALVO: So building on that, first of all, what John said about the potential for there to be more accurate coding, more detailed coding in the electronic health record area, there is some data from both the inpatient side and I believe the outpatient side, so we can talk about that offline. I'll see if I can help track it down.

I wondered if it is possible to access some of that clinical data now for purposes that you're thinking of helping to understand complexity in the ER, but also maybe this chief complaint. And the place where we could think about going wouldn't necessarily be the institutions, but perhaps some of the stronger regional health information exchanges in places like Cincinnati or Tulsa where they have a pretty good master patient index and might be willing to make that available.
The second thing I wanted to raise that's come up in some of the conversation from Pat and Amy and others is this struck me as this work was starting with a very heavy focus on the cost implications, which is obviously important, but there is a balance perspective here also of the impact on the beneficiaries of the quality of care they receive, where they're going.

Maybe you all can tell me where we are in trying to understand it's not just about less cost, but it's the right care at the right time.

Which brings me to my third, which is really the question I have, and that is -- unless you can answer the second -- when I read this, I was also thinking about our discussion yesterday about primary care access, and some of these codes that you all describe seem very appropriate for the primary care environment. I don't know if this work that you cite on page 5 by Corwin has looked at whether some of these codes are appropriate in the primary care environment and maybe thinking about this as an entire continuity, not just a tradeoff between UCC and ER, but also bringing and thinking about primary care access.

MR. GAUMER: Okay. So going in reverse order of
your questions here, so the access to primary care issue, a lot of the studies we've seen do include the physician office in their analysis to see where these non-urgent cases are bouncing around. So we can include more information on that.

We also looked at that but for your benefit tried to whittle down this thing to ED and urgent care. But we have some information that shows generally that the growth of non-urgent cases -- or all cases, even, in physician offices has stayed pretty constant. Most of the non-urgents go to the physician office. That's the bulk of them, 77 percent or something, and that has stayed pretty constant.

It seems as though there has been some shifting from the physician office to the UCC and also from the hospital ED to the UCCs, and also retail clinics are involved in this as well. They've grown rapidly within Medicare. So we can look into it is my point.

In terms of the quality, I think the only thing I can offer at this point is kind of the same thing that I said to Amy, which is we've only looked at it superficially, and we can dive into it a little bit more.
But it looks like so far, the overall message is quality is still good at urgent care centers, but we need to better understand how they make those determinations.

DR. DeSALVO: Yeah. This was mentioned, but is it possible to track beneficiaries within seven days of a visit to a UCC to see if they also went to an ER and/or had an inpatient admission, something like that?

MR. GAUMER: Yes.

DR. DeSALVO: Thank you.

DR. CROSSON: Okay. Thank you.

So we have two issues on the table, the issue of non-urgent care being seen in emergency rooms, and I guess it's a cost issue as well as a question of whether that's the best place for continuity of care for folks, and then the question of ER upcoding and what would be the best approach to dealing with that problem. So I think those are the two issues, and you can find the setup for those on pages 8 and 15, respectively.

We'll start the discussion with Paul.

DR. PAUL GINSBURG: Thanks. This is a very stimulating paper that you prepared, really well done, obviously generated very rich clarifying question rounds,
which I think is why it took so long. There was a lot in it.

I find your evidence convincing that, you know, increasing UCC visits don't explain the coding change, probably don't explain -- also don't explain the volume change you would have expected if a substitute for emergency departments, that ED visits would be going down. But, of course, they've gone up quite substantially. I guess there were suggestions of ways to be more sophisticated in the analysis that probably are worth doing because establishing the point before we wade into the coding discussion is very important, saying, no, this isn't just the easy patients being siphoned off.

When it comes to coding, I was thinking about the single code idea and that, you know, the obvious problem is hospitals in areas where the population has a lot more in the way of problems, et cetera, you might expect higher acuity ED visits, but there's something else that could balance it, that EDs do a lot of primary care in those areas. I don't know how that comes through, but I was thinking that the Commission has been, I think, successfully grappling with a lot of situations where
efficiency or quality is influenced by the environment that a hospital is in. We've done the groupings. I'm wondering whether that approach could work here in the ED thing so that you actually do analysis of this by area, by socioeconomic areas surrounding a hospital, and perhaps come up with adjustments that could be used if you went to a single code.

The other thought I had is that, again, in DRGs and I think in some other areas, Medicare when it has perceived upcoding, does an upcoding adjustment. It seems to be accepted by the field. They don't like it but, you know, CMS is going to do it.

What about the possibility of, in the course of considering improvements in coding, whether there should be a CMS upcoding adjustment to the rates paid to EDs? I'd like to put that on the table as another option.

DR. CROSSON: Thank you, Paul.

Further discussion of the options on the table?

Kathy.

MS. BUTO: Okay. I've been trying to get my mind around UCCs, and I can't decide whether we think UCCs are a good idea or a bad idea. I know they're out there. They
are maybe not as good for an individual patient as her own physician because that person has more continuity. They serve a useful purpose because they are there where minor problems occur, and it might be difficult to get an appointment.

Then I thought, along the lines Paul was talking about, that maybe this is a future opportunity to generate another site of primary care and for patients who don't have a regular doctor, potentially more of a bundled payment approach to primary care management.

So I think there are possibilities here, but I have to say I think right now, if we thought they were saving money, I think they're probably costing money to the system. There's additional usage. Much of it is needed. But I don't believe in the substitution effect here where there are fewer encounters with -- necessarily related to this UCC existence, use of EDs.

As I was looking at the paper, it occurred to me that we are beginning our thinking already about things like site-neutral payment. There are a number of comments about the comparison of ED costs to UCC costs. I think we have to be careful there for the reasons that Pat has
already raised, which are -- and others have picked up on, which is until we look at the data on referrals from the UCC to EDs and actually back to physician offices, I think it's hard to say whether site-neutral payment in, say, the ED setting to a UCC is making the difference where it counts. In other words, it may turn out to be the greater cost is in the fact that the urgent care center cannot provide all the necessary follow-up, and so there are a lot of other services that could be generated as a result. So I think we should proceed cautiously and do a lot more analysis of referral out of the UCC before we make any judgments about this is a $1 to $2 billion saving if we could just pay the ED at the UCC rate.

Thanks.

DR. CROSSON: Bruce.

MR. PYENSON: I wanted to talk a little bit about the single-code issue, and I know in the past MedPAC has not supported the single code, and in commentary last month, we did not support CMS' proposed consolidation of E&M codes.

I'm wondering if this is a different situation for the emergency departments. One of the reasons not to
support consolidation of E&M codes is that physicians might avoid more complex patients. That is perhaps not possible in an emergency room because of some of the other regulations. There's certainly things to consider about fairness and regional distribution or the behavior of physicians' billing and their activity with respect to choosing to admit a patient or not.

But I think this might be a very different kind of situation than with respect to E&M codes. And I think it might also be possible to use some form of risk adjustment to reflect the different environments of hospitals, but to use a single code.

One thing that would accomplish is also have a relatively higher cost sharing for low acuity and relatively lower for high acuity. So I think that would perhaps be a good policy to have to avoid the lower -- encourage avoiding the lower-acuity visits.

Finally, this is all Part B, right, the emergency room and urgent care centers. And I'd welcome some insight into whether this matters, whether in the budget and projections and the annual updates of reimbursement, whether that process is budget-neutral or indifferent to
shifting the money around. I hope it's not, but I'd
welcome clarity on that. For sure, better equity in
reimbursement is a good thing even if it doesn't have an
effect on spending.

Thank you.

DR. CROSSON: Thank you, Bruce. Sue.

MS. THOMPSON: Well, I think by my question I'm
interested in work that will help us create a system where
patients are cared for at the right place at the right time
with the right amount of services. I think we need to
understand and learn from the commercial payers about how
to work with the beneficiaries, if necessary to self-select
into that right category.

I really, until we spend more time on this, which
I understand we will be, struggle with thinking about one
code and would go on record saying that at this point in
time, that seems very problematic to me. But I am quite
intrigued looking across this continuum, because we tend to
look at each of these sites of service in a silo. And I
think what we need to think about is how do we think about
this pre-acute care, whether it's primary care, urgent
care, emergency services in a more cross-continuum way,
but, again, working with the beneficiary to choose the right point of service.

So those would be my comments, and I think we do have a lot to learn if we could interview some of the commercial payers in this space.

DR. CROSSON: Jaewon.

DR. RYU: Yeah, I think the single code, I think it's intriguing on several levels, but I think it would be a very tortuous path at this point until we have the additional analysis that many have talked about.

You know, yesterday we spent a lot of time on inpatient psych, and 80 percent of the cases there were psychosis. And we said even with that, there's difficulty unpacking within that because there's some heterogeneity within what gets classified as psychosis.

The ED I think is the hallmark of heterogeneity in health care. It is where the spillover effects between primary care, inpatient, outpatient, and everything in between hits in that one spot. So to manage that kind of variety through a single code seems really, really tough and gets us back to the guiding principle of trying to match payment with resource use and cost. I think that

Dr. DeSalvo: I think the idea of pressing on the emergency departments through something like a single code won't necessarily solve the problem, at least until we understand more maybe from the data, because to me one of the key inputs here is the primary care system and access to appropriate care there. And one set of mechanisms could be to help steer beneficiaries, as Sue was talking about, through shifts in co-pay, et cetera. The other is when they go to that door of primary care, if it's appropriate for their level of acuity, they make sure the door is open. And that just sort of brings you to a whole world of either differential payments for primary care access after hours in a way that Massachusetts Medicaid did years ago to try to steer the open door so that there was a place to go aside from the ER, or the broader opportunities that come with some of the value-based payment models, whether that's a patient-centered medical home or some other kind of accountable entity, because in those worlds where there's more financial and other risks, when there's shared, aligned incentives, there's more innovation for telehealth
or after-hours care or other ways that people can access services that might help get them to the right place at the right time.

So I'd like us to think a little more broadly about how to align the incentives but not just focus on the ER and closing that door, but really thinking about making sure we're opening other doors and getting people to want to go towards them.

DR. CROSSON: Thank you. Warner.

MR. THOMAS: So I would concur with everyone else. I think the single code for ED for all the reasons that have been mentioned just does not make a lot of sense, and I think, again, you have a lot of entities, and I think you'd have patients that would be harmed kind of going through that process. I just think it's complicated.

On the urgent care, I just would come back to -- I agree with Dana's point that I think that some of this is out of convenience, that, you know, people, instead of just waiting to see, go to urgent care, so there is some increased utilization there.

But I think the other thing, I think we ought to continue to challenge ourselves, that this is a replacement
for lack of access to primary care. And if we had an
amazing access to primary care, you probably wouldn't see
as big of a demand for urgent care. My guess is if you had
urgent care for psychiatry and mental health services, it
would be busy like all day.
So, you know, I think we just have to understand
that this is a substitute for the lack of access in primary
care, and it's probably going to be increasing not
decreasing going forward.
Now, with that being said, I think there's -- I
still think we're better off having urgent care versus
having people go to lower-acuity ER visits, and we may not
-- you know, it would be even better if they could go to
office-based primary care. But if we don't have that
access, I think that's going to be problematic.
So those are just -- I think we need to look at
that continuum of primary care and E&M, and I know you said
you didn't really see a downtick in E&M codes, and you may
not because there's probably, as we see in the aging of the
population, going to be a need for more of those types of
visits going forward, not less. So just another viewpoint.
DR. CROSSON: Thank you.
Okay. Coming over here, we'll start with Dana.

DR. SAFRAN: I'll be really brief. So picking up exactly where Warner was and, you know, triggered a little bit by, Kathy, your comments, I was pulling back a lens thinking, you know, there's a lot not to like about urgent care. You know, we're pretty convinced it's raising costs. It's certainly fragmenting care, disrupting, you know, longitudinal relationships. And it's also tying us to a bricks-and-mortar mentality about health care.

So it has made me wonder whether there's more we could be doing with respect to payment to primary care that would motivate more use of telehealth and virtual care to solve the access problem that the UCCs are solving. So that was one thought.

And the other was I know that oftentimes some of the non-urgent care that's seen in the ED, we know from commercial patients anyway, there's this sense of comfort and security for some reason going to a hospital, being in a hospital. And so that I think is going to be a kind of intractable mind-set for a lot of consumers. And I wondered whether our hospital incentive model that does use total cost of care as one of the incentives might be
leveraged to try to start to have hospitals understand that

a way to succeed on that is to create on-site urgent care

so that a patient who comes into the ED door who doesn't

need an energy room level visit can be triaged to urgent

care, seen at a lower cost, they win, the system wins, you

know, the beneficiary wins.

So those are my two thoughts on this -- oh, and I

also agree with all the points made about the single code.

I'm not in favor of that.

DR. CROSSON: Thank you. Jon.

DR. PERLIN: Thanks. Again, thank you for just

really a thought analysis. I want to add one more concern

with the single code that extends beyond socioeconomic

status. It extends to the characteristics of the services

that a particular facility offers. You know, you might

have a facility that actually happens to be the trauma

center or the stroke center, the heart center, the sepsis

center, you know, cancer center, et cetera. It may not be

in a disadvantaged area, but it has an extraordinarily

complex set of patients there, and I think that would be

problematic. I could actually see some shifting of

workload, you know, to elsewhere if there were a single
payer, and so I worry about adverse incentives there.

I do want to come back to the unspoken. The problem with no standards is that there is no standard, and you heard my theory and my question that I think the ACEP has offered a bit of an implicit standard, but not an explicit standard. You know, if there's heterogeneity, that is a soluble problem. I just would suggest that it not be overly onerous, you know, that it not lend itself a recapitulation of the sort of MAC level interpretation and the RAC level adjudication as has been seen in prior.

To really get to understand this, though, I'd also commend us to do the further research that's been suggested and just to consolidate that around urgent care centers. I think Pat's and others' comments on the market-by-market analysis really lets us unpack those questions of, you know, the geographic maldistribution of UCCs, whether they're good, bad, or otherwise, they happen to exist in higher socioeconomic status areas. Many don't accept government payers. They have limited hours. They may, in fact, not be a substitute for ED but, as Karen suggested, for primary care.

I think these data are really tricky around
primary care because you may -- I may say I didn't really
have a problem getting -- finding a new doctor, but maybe,
you know, if you've got something that's sort of middling,
it's just awkward or difficult to get seen or get seen
timely. Urgent care solves that, and I totally agree with
Dana that the extension of it, certainly with the newer
generation of Medicare beneficiaries, increasingly will
rely on virtual tools for solving certain problems. And so
we should make sure that our policy is future-looking, not
retrospective.

With respect to the hospital emergency
departments, I would also agree with my colleagues that, in
terms of unpacking this toward our best policy
recommendations, we need to specifically evaluate the
effect of observation status, the effect of the EHR, and
the effect of changes in therapy as they relate to even the
same nominal diagnosis.

Thanks.

DR. CROSSON: Thank you. Pat.

MS. WANG: On your specific question around
guidance on national guidelines, it seems like it could
make sense, given that there aren't any, and it's unusual
in the Medicare payment system for organizations to have
their own coding guidelines. So just in the interest of
standardization, it seems to make sense as long as it's not
too onerous.

But to Paul's point, if the main issue around
guidelines for coding is the belief that there is upcoding
without fundamental underlying change in the condition, I
think Paul's suggestion might be like the most direct to
either rebase the rates or have some sort of coding
adjustment. With DRG creep, there's no underlying kind of
sort of deep dive into are these the right coding
guidelines. It's just something that CMS does. So that
might be the more straightforward approach.

Dana raised an important point about shouldn't
hospitals be urged to have urgent care centers on-site. I
do want to know. A lot of hospitals, at least in my
market, have either open urgent care centers or have
developed close relationships with nearby urgent care
centers to try very much to head off folks that can be seen
there versus going into the hospital and was pretty
explicit.

In my area, anyway, the urgent care centers are,
if anything, increasing the specialization of the types of services they provide and try to move away from the sort of more primary care types of services because they are not a substitute for PCP. They are not a substitute for primary care. They are emergency room light. It's transactional. It's a one-shot. There's no evaluation of somebody who walks in and whether they might have an underlying metabolic condition, and they don't pretend to. They don't want to.

The ones that we deal with are very clear about that. We have no intention of displacing PCPs. It's a one-shot, decant the emergency room. That's why we're here. But it's a dilemma. So I think that the issues that people have raised about PCP are a much bigger issue.

I also have to say this is -- and I'm not suggesting. This might be chasing too much down a rabbit hole, but the overall observation that the increase in urgent care visits has not affected the overall level of primary care visits is again subject to this large market versus small market phenomenon. In my market, anecdotally, PCPs, it's like cabdrivers' reactions to Uber. They're getting put out of business. Some of them don't have the
office visit volume anymore. Their patients have been
decanted. Anecdotally, it's had an impact on them.

So I would again caution about making
observations from a national database where the supply is
really lumpy.

DR. CROSSON: Can I just ask a question here?

Pat, you brought this up, and Dana as well, of the process
of kind of triaging certain patients from ER to urgent care
centers.

It seems to me in the past and in my previous
life, we ran into EMTALA issues there. Is that generally
the case? I just think if that's a direction that we think
is a good direction -- and, personally, I do -- there may
be some need to take a look at EMTALA.

Sue, has that been your experience as well?

MS. THOMPSON: That's been our experience because
we do have an urgent care just probably 20 yards down the
hallway from the emergency department, but if the patient
self-selects to go to the emergency room, despite the
medical screening exam and stabilization and all the
component parts of meeting EMTALA regulations, they have
chosen to be an emergency patient.
But is there an opportunity there to rethink that component of EMTALA? I don't know, but we definitely have experienced that.

MS. BUTO: I don't think EMTALA would preclude you once you got a stabilized patient from allowing that handoff. You'd have to look at it, but you're saying you think --

DR. CROSSON: We absolutely had that problem, yeah.

MS. BUTO: Because you can hand off a patient to another facility after they've been stabilized, period, another hospital.

DR. CROSSON: Yeah. I mean, I can't remember. I don't want to distract you. I can't remember the level of stabilization, but I --

MS. BUTO: That's the whole point of EMTALA.

DR. CROSSON: Yeah.

DR. SAFRAN: But I think your point is an important one, Jay, in that in order to encourage this, there has to be clarity on whether it is or isn't on the wrong side of EMTALA.

DR. CROSSON: Right.
MS. WANG: I also think that there are things that people can do short of that thing of somebody has walked through the emergency room doors and they need to get triaged and telling them go down the hall. I think in the relationships that exist, the urgent care centers will probably display that they are affiliated with XYZ hospital, and there's a patient education component of it as well as "This is available to you, if you want to get seen more quickly than waiting for a couple of hours."

DR. SAFRAN: Would it be a lower copay?

MS. WANG: I don't know about that. Yeah, it would be a lower copay. It would be a lower copay.

And I think the ones that I'm familiar with are the ones who frankly are moving more in a straightforward way towards a population health ACO risk-based model. I mean, they are trying to sort of sort their patients, decant their emergency rooms which are crowded, and create a better experience. That's an experiment that there might be some interesting information about in the coming years.

DR. CROSSON: Brian.

DR. DeBUSK: Again, a great chapter. It's nice to see us work on this. I do think we should work on
establishing national guidelines. I think there's something there.

The other thing, obviously, from my question, I'm a huge proponent of site-neutral policy there.

The other question I had, though, if you had a -- and I'm on a limb here -- if you had a national guideline that called for certain coding standards and that guideline called for certain would-be E&M visits or would-be emergency visits to be recoded at E&M visits, so just to say you must code it this way, does that sidestep the 603 exemption that they would have to site-neutral policy? Because they're the ones coding it under those guidelines. It's not like we're imposing a site-neutral payment on them.

DR. ZABINSKI: I'm not -- sidestep. I'm not sure. I don't feel comfortable answering that off the cuff. I can think about it and get back to you.

DR. DeBUSK: It just might be a nice way to sidestep the whole issue of their 603 exemption.

DR. ZABINSKI: Yeah.

DR. CROSSON: Okay. Seeing no further discussants, I think we have opened up a good set of issues
here and look forward to future work.

Zach, Dan, thank you for the presentations.

That concludes our October meeting.

We now have time for public comment. If there are any members of our audience who would like to make a comment, now is the time to come up to the microphone, so we can see who you are.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until our November meeting, which I believe begins on the 1st of November.

[Whereupon, at 11:05 a.m., the meeting was adjourned.]