# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C. 20004

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9:40 a.m.

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P R O C E E D I N G S

[9:40 a.m.]

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

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

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

First, some background about the topic. Part B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

countries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In terms of disadvantages, there would be

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

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

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

In terms of next steps, it would be helpful to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Jon, Pat, David.

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

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

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

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

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

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

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

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

Pat?

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

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

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

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

DR. CROSSON: David.

DR. GRABOWSKI: Thanks.

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

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

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

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

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

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

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

MS. WANG: Thank you.

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

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

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

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

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

trigger.

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

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

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

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

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

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

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

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

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

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

DR. GRABOWSKI: Correct.

DR. CROSSON: All right. Sorry. Kathy.

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

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

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

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

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

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

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

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

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

Bruce?

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

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

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

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

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

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

MR. PYENSON: Thank you.

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

MS. BUTO: [Comment off microphone.]

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

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

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

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

MS. BUTO: Right.

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

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

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

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

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

MS. BUTO: Okay.

MS. RAY: Potentially.

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

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

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

MS. RAY: Right.

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

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

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

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

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

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

DR. CROSSON: Thank you, Kathy. Karen.

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

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

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

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

DR. CROSSON: Okay. Jaewon.

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

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

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

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

MS. RAY: Yes.

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

MS. RAY: That is correct. Now there would be – the process envisions some sort of medical exception process.

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

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

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

DR. CROSSON: Dana and then Jonathan.

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

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

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

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

DR. SAFRAN: Yeah.

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

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

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

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

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

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

factors.

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

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

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

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

per se. Would that be included?

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

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

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

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

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

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

DR. CROSSON: Warner.

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

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

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

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

DR. CROSSON: Jon.

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

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

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

DR. CROSSON: Pat.

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

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

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

MS. WANG: Okay.

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

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

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

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

MS. WANG: Okay.

MS. RAY: Okay.

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

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

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

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

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

MS. THOMPSON: Yeah.

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

additional costs.

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

MS. BUTO: Right.

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

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

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

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

MS. BUTO: Right.

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

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

MS. RAY: Yes.

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

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

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

MS. RAY: No.

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

MS. RAY: That's correct.

MS. BUTO: Potentially the least costly alternative.

MS. RAY: That's correct.

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

MS. RAY: Yes.

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

DR. PAUL GINSBURG: Okay.

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

Paul?

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Paul.

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

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

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

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

DR. CROSSON: Karen.

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

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

Thank you.

DR. CROSSON: Jaewon.

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

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

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

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

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

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

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

DR. CROSSON: Dana.

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

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

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

DR. CROSSON: Warner.

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

I think building on Jaewon's comment of the

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

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

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

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

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

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

DR. CROSSON: Thank you, Warner.

Okay. So we'll start with Jon.

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

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

DR. CROSSON: Thank you. Kathy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you. Brian.

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

presentation.

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

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

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

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

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

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

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

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

DR. CROSSON: David.

DR. GRABOWSKI: Thanks for this chapter and

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

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

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

DR. CROSSON: Jon.

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Warner. Last comment.

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

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

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

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

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

With that we will move on to the next presentation.

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We've validated the MA encounter data files to

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

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

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

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

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

Our validation found three categories of encounter data issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

information about each instance of missing encounter data.

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

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

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

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

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

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

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

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

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

without any processing.

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

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

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

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

organizations' submitted data and provide robust feedback.

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

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

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

The recommendation would not have any direct effect on beneficiaries.

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

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

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

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

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

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

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

plan's spending.

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

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

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

Thank you. I'll turn it back.

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

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

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

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

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

DR. JOHNSON: Right.

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

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

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

DR. DeBUSK: I got you.

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

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

DR. JOHNSON: Correct.

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

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

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

- to determine the benchmark, and that seemed circulate.

DR. JOHNSON: Right.

DR. DeBUSK: Thank you.

DR. CHRISTIANSON: Okay. David and then Pat.

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

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

The -- actually, I forgot your second question.

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

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

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

DR. CHRISTIANSON: Pat.

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

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

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

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

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

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

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

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

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

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

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

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

MS. WANG: I see.

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

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

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

MS. WANG: Okay. Interesting.

DR. CROSSON: Dana.

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

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

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

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

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

DR. SAFRAN: So --

DR. CROSSON: Okay. Go ahead.

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

these programs to be comparable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SAFRAN: Oh, I'm sorry.

MS. PODULKA: I'm sorry.

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

DR. CROSSON: Yes.

MS. PODULKA: Okay.

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

DR. CROSSON: Yeah. Right.

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

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

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

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

Pat, you wanted to comment on this?

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

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

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

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

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

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

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

MS. PODULKA: Yeah.

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

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

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

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

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

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

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

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

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

DR. JOHNSON: Yes.

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

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

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

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

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

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

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

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

DR. CROSSON: David.

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

DR. CROSSON: Sometimes that is a consideration.

Not in this particular case.

[Laughter.]

DR. CROSSON: Pat and then Jon and Marge.

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

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

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

actually to the recommendation or just repeat it.

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

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

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

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

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

that are important.

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

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

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

MA plan was even close to hitting the mark?

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

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

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

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

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

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

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

DR. CROSSON: Thank you. Okay. Jon.

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

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

DR. CROSSON: Marge.

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

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

DR. CROSSON: Okay. Thank you.

Other comments? I see Dana and Bruce.

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

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

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

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

DR. CROSSON: Okay. Yes, Bruce.

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

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

DR. CROSSON: Okay. Thank you, Bruce.

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

[Laughter.]

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

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

[Laughter.]

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

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

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

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

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

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

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

[No response.]

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

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

AFTERNOON SESSION

[1:47 p.m.]

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

This is the beginning of the afternoon session. We have three items before us for the remainder of the day, and the first one is going to be a discussion of options to try to slow the growth of Medicare expenditures in emergency departments. We have Carolyn, Zach, and Dan. Carolyn, it looks like you are going to begin.

MS. SAN SOUCIE: Good afternoon. In this presentation, we will revisit our discussion of options for slowing the growth of Medicare fee-for-service spending for emergency department services. In October, Zach and Dan presented information on the provision of non-urgent care and emergency departments and hospital ED coding practices. Today, we have several updates for you, as well as policy considerations for the two topics.

As a bit of context, in the past Commissioners have expressed concern about the rapid growth in Medicare ED spending. To get you started with the discussion, I have updated you requested on urgent care centers as an alternative to EDs. Next, we will address the overall

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

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

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

Additionally, payment to UCCs is much less than

to emergency departments for the treatment of similar patients..

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

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

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

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

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

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

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

departments.

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

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

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

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

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

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

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

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

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

Policymakers could also consider expanding

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

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

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

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

result.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We will turn it back to Jay.

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

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

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

DR. JAFFERY: Okay. Great. Thanks.

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

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

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

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

DR. JAFFERY: Okay.

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

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

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

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

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

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

DR. ZABINSKI: Correct. Yes.

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

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

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

[Laughter.]

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

DR. CROSSON: All right. Jon.

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

DR. CROSSON: Are you going to answer that?

[Laughter.]

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

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

DR. ZABINSKI: Yeah.

DR. MATHEWS: Yeah.

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

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

DR. CROSSON: Okay. Where am I?

DR. JAFFERY: [Off microphone].

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

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

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

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

DR. CROSSON: Karen.

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

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

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

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

DR. CROSSON: Jaewon.

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Where are we? Dana.

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

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

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

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

DR. CROSSON: Sue.

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

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

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

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

as what we know, not much right now.

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

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

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

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

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

MS. THOMPSON: Consumed.

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

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

DR. ZABINSKI: Yeah, that -- yes.

DR. CROSSON: More than somewhat defined. Sorry.

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

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

DR. CROSSON: On this point, Brian?

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

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

DR. DeBUSK: Agreed [off microphone].

DR. CROSSON: Okay. Warner?

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

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

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

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

DR. ZABINSKI: Correct.

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

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

MR. THOMAS: Great. Thanks.

DR. CROSSON: On this point, Dana?

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

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

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

DR. CROSSON: Okay. Marge.

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

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

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

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

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

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

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

MS. MARJORIE GINSBURG: [off microphone].

DR. CROSSON: Pat.

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

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

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

DR. GRABOWSKI: To follow on --

DR. CROSSON: Yeah.

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

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

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

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

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

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

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

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

DR. CROSSON: Brian.

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

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

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

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

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

DR. ZABINSKI: Okay.

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

DR. ZABINSKI: Okay.

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

DR. ZABINSKI: Okay. Got it.

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

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

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

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

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

DR. CROSSON: Kathy.

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

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

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

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

MS. BUTO: Thank you.

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

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

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

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

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

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

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

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

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

'15, 4.0, 4.1.

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

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

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

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

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

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

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

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

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

may be driving some of that progressively over the time.

Let me come to this concept of the distribution. I don't know that it should look like a normal distribution unless you, in fact, want to incentivize lower acuity in the emergency department. Perhaps it should be skewed to the right because the emergency department is the place for higher acuity. And so there probably is some distribution, but we need to align that distribution with what we think the care should look like.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Support? Lack of support? Marge.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: You're worried about induced

demand?

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

DR. CROSSON: Got it.

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

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

MS. WANG: Yeah, I guess --

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

MS. WANG: I can wait until the end.

DR. CROSSON: Go ahead.

MS. WANG: Just a quick one on beneficiary

education.

DR. CROSSON: Yes.

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

DR. CROSSON: Bruce.

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

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

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

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

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

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

So those are my comments.

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

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

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

So these are generally good tools. I just think

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

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

DR. SAFRAN: [Sneezes.]

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

DR. SAFRAN: [Sneezes.]

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

[Laughter.]

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

[Simultaneous conversation off microphone.]

DR. CHRISTIANSON: You can get a CT scan.

DR. CROSSON: Listen, you've got three

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

DR. DeSALVO: Come on to primary care.

[Laughter.]

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

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

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

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

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

DR. CROSSON: Thank you Karen. Jonathan.

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

[Laughter.]

DR. JAFFERY: And then in terms of the

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

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

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

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

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

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

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

DR. CROSSON: Okay. Go ahead.

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

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

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

[Laughter.]

DR. SAFRAN: Okay.

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

DR. CROSSON: Thank you. Sue.

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

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

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

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

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

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

DR. CROSSON: Thank you, Sue. Warner.

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

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

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

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

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

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

But I would concur with the recommendation.

DR. CROSSON: Thank you, Warner.

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

[Laughter.]

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

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

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

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

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

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

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

Can I have the next slide please?

[Pause.]

DR. CROSSON: I guess we're done.

[Laughter.]

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

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

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

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

Jon, do you want to comment?

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

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

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

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

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

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

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

Let me give you an example. When the quality

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

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

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

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

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

to Medicare patients.

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

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

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

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

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

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

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

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

DR. CROSSON: No, absolutely.

DR. GRABOWSKI: I don't think this is a magic bullet, so to speak.

DR. CROSSON: To me, this is the first step on the staircase.

DR. GRABOWSKI: Got it. Maybe just suggesting that.

DR. CROSSON: For all of the reasons people to discuss, it doesn't take away upcoding or any of the other manipulative behavior that can exist.

But to me, this is a sine qua non. I mean, how can you even start unless you have a basis; right? Okay?

Done. Okay. Zach, thank you, Dan, Carolyn. Nice job.

[Pause.]

DR. CROSSON: Okay. We've fallen a little bit

behind, but once again, it was an important discussion. And now we have another important discussion. Ariel is going to take us through an additional consideration -- this is years of work that we have been doing -- an additional consideration about how we may approach the potential pipeline problem for adult primary care physicians.

MR. WINTER: Okay.

DR. CROSSON: And, Ariel, I just want to start out by thanking you. I thought this chapter was exquisitely researched and written, and I learned an enormous amount reading it. So you've got the stage.

MR. WINTER: Thank you very much.

Good afternoon. As Jay said, I'll be talking about Medicare's role in the supply of primary care physicians. I want to first thank Emma Achola and Alison Binkowski for their help with this work.

So this is a follow-up presentation to our October meeting. I've addressed your comments and questions from that meeting in the paper. The paper has been substantially expanded, which is why we're coming back to you today.

So for today's discussion, I'll start with some background information; describe the future pipeline of primary care physicians; talk about federal scholarship, loan repayment, and debt forgiveness programs for physicians and other clinicians; discuss an idea for a scholarship and loan repayment program for physicians who commit to providing primary care to Medicare beneficiaries; and then talk about next steps.

High-quality primary care is essential for creating a coordinated health care system. The Commission has made several previous recommendations to increase Medicare payments for primary care clinicians, such as establishing a per beneficiary payment.

In our June report last year, we described an approach that would shift fee schedule spending from procedures, tests, and imaging to the kinds of services commonly done by primary care physicians -- ambulatory E&M visits.

Commissioners have also expressed interest in exploring approaches that could have a bigger impact on the supply of primary care physicians, which is the focus of today's session.

According to a beneficiary survey and beneficiary focus groups that we conducted last year, most beneficiaries reported that they are able to obtain clinician care when needed. Their access to care is comparable with (or in some cases, 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 number of beneficiaries who are seeking a new doctor. We monitor this situation closely every year when we do our survey.

A well-functioning, coordinated delivery system needs an appropriate balance of primary care physicians and specialists. But the mix of future physicians is tilting towards specialists, as we will see on the next slide.

In addition, minority, low-income, and rural students are underrepresented in medical schools. This is an important issue because many studies show that a diverse

health care workforce is associated with better access to care for underserved populations and higher patient satisfaction. And students from rural areas and from ethnic and racial minorities are more likely to choose primary care careers and to practice in underserved areas.

Between the 2013-2014 academic year and the 2017-2018 academic year, the number of active residents in family medicine and internal medicine increased faster than the total number of active residents.

In the 2017-2018 academic year, about 20 percent of all residents were in internal medicine and 9 percent were in family medicine. Although almost all family medicine residents end up practicing as generalists, most internal medicine residents enter subspecialties, such as cardiology or gastroenterology.

According to a survey of third-year internal medicine residents conducted between 2009 and 2011, only 21.5 percent of them planned careers in general internal medicine. The remainder planned to enter subspecialties or hospital medicine or were undecided. And there is evidence from other studies that the share of internal medicine residents who become generalists has been declining over

time.

In the paper, we review the literature on the key factors that influence physicians' choice of specialty. The findings vary based on the time period studied, the group studied, and the analytic methods.

Several non-financial issues are important factors. They are shown here on the slide and are described in more detail in your paper.

In terms of financial factors, there is evidence that income expectations play an important role, and we have noted previously that substantial compensation disparities between primary care physicians and specialists may discourage medical students from choosing primary care.

The evidence that educational debt affects specialty choice is mixed. Some studies show no relationship between debt and career choices, but other studies find that debt is modestly related to career decisions.

Medicare is not in a position to address most of the non-financial factors that affect specialty choice, which is why we're focusing on the financial factors.

It is important to recognize that medical

education debt has grown steeply in recent years, so debt could be a bigger factor in the future. Median medical school debt among medical school graduates grew from almost $165,000 in 2010 to $180,000 in 2016, in inflation-adjusted dollars.

Meanwhile, the share of medical school graduates planning to participate in debt reduction programs increased from 40 percent in 2014 to 46 percent in 2018, according to a survey by AAMC.

Of those who planned to participate in a program in 2018, about three-quarters indicated that they were going to participate in the Public Service Loan Forgiveness program, which we'll discuss on the next slide. Smaller shares of students were planning to participate in state programs, the National Health Service Corps, and military programs.

The Public Service Loan Forgiveness program, which is run by the Department of Education, provides loan forgiveness to borrowers who work in a public service position for 10 years and make at least 10 years of loan payments while working in a public service job.

Public service employers include federal, state,

and local governments; the military; and tax-exempt organizations, such as nonprofit hospitals.

This program is not limited to health professionals. The AAMC estimates that physicians who take out large loans for medical school can receive a substantial amount of loan forgiveness through this program. But in a recent report, GAO found several problems with the Department of Education's management of this program.

As of April 2018, the department had processed applications from about 17,000 borrowers for loan forgiveness but had approved only 55. The high number of denials suggests that many borrowers are confused about the program's requirements.

In addition, GAO found that the department does not provide sufficient guidance and instructions to the contractor that operates the program.

HRSA runs two programs that are designed to increase the supply of primary care clinicians: the National Health Service Corps and the Primary Care Loan program.

The NHSC provides scholarships and loan repayment

for primary care clinicians; it will receive $300 million in funding in FY 2019. Recipients must commit to practicing in a health professional shortage area, in a site approved by HRSA, for at least two or three 3 years.

As of 2018, there were 10,900 NHSC clinicians who provided care to 11.4 million people. The largest group of participating clinicians is mental and behavioral health professionals, followed by nurse practitioners and primary care physicians.

Sixty-three percent of clinicians serve in federally qualified health centers; other approved sites include rural health clinics and community mental health centers.

Minorities account for a higher share of NHSC clinicians than they do of the national health care workforce. For example, in 2016, African Americans represented 17 percent of NHSC physicians, compared with 4 percent of the national physician workforce.

The Primary Care Loan program provides low-interest loans to medical students who commit to practicing primary care. Recipients must practice primary care for ten years, which includes their residency, or until the

loan is paid off, whichever comes first. Unlike the NHSC, there is no requirement to work in an underserved area. In FY 2016, there were about 2,600 active borrowers who owed a total of $18 million.

The program is funded through a revolving fund that was established with a federal contribution and matching contributions from medical schools. There is no annual appropriation.

Participating medical schools must contribute one-ninth of the loan amounts received by their students. Only 9 percent of the program's borrowers practice in a medically underserved area, less than 2 percent practice in a rural area, and less than 3 percent are African American.

These HRSA programs might serve as a model for a Medicare-specific scholarship or loan repayment program. But the goals of these programs would be quite different.

A Medicare program would have a specific objective: to encourage more physicians to enter primary care and provide primary care to beneficiaries. By reducing educational debt, a Medicare-specific program would provide a financial incentive for physicians to choose primary care.

However, given the mixed evidence from the literature on whether debt affects specialty choice, it's difficult to predict how physicians would respond if they were offered debt reduction in exchange for a commitment to practice primary care. This incentive may convince some medical students to choose primary care instead of another specialty, thus representing a net increase in the number of primary care physicians.

But some number of students who participate in the program would probably have chosen primary care anyway. Nevertheless, policymakers could consider such a program as one option to address concerns about the future pipeline of primary care physicians.

In thinking about a Medicare-specific program, there are some important design issues to consider. The first is the size of the program in terms of dollars and the number of physicians. As one reference point, the NHSC has received about $300 million per year in funding since 2011, and it had 10,900 clinicians in 2018.

A second issue is how to finance a Medicare-specific program. One option is to fund it with savings from the Commission's recommendation to eliminate MIPS, the

Merit-based Incentive Payment System. MIPS provides $500 million per year for exceptional clinician performance from 2019 through 2024, for a total of $3 billion. When we recommended eliminating MIPS, our intent was not to produce budget savings but to consider policies that would reinvest these funds in clinician payment.

Another financing option is to require medical schools with students who participate in this program to provide matching funds, as is required under the Primary Care Loan program.

A third issue is whether the program should offer scholarships, loan repayments, or both. Scholarships could attract low-income students who might be less likely to apply to medical school because of its high cost. But loan repayments are targeted to students who are closer to graduation and, therefore, have a stronger idea of whether they're interested in primary care.

Fourth, the size and complexity of the program would have implications for program operations. As the program gets larger and more complex, it would require more resources to administer, both in terms of staff and dollars.

The next set of issues relates to eligibility for the program and the rules for participation. Which specialties should be eligible? Based on our previous work, you could think about including the following specialties as primary care: family medicine, geriatric medicine, general internal medicine, and pediatrics. The program could also include behavioral and mental health clinicians.

Another issue is ensuring that clinicians in the program provide primary care to beneficiaries. The program could require that clinicians treat a minimum number of beneficiaries, which is a measure that could be validated with Medicare claims data.

It would also be important to require that primary care services account for a significant share of a participant's Medicare fee schedule revenue. For example, under the Primary Care Incentive Payment program, primary care visits had to account for at least 60 percent of a primary care clinician's fee schedule revenue.

Another issue is the length of the service commitment, which could vary based on the amount of the scholarship or loan repayment received. Because there are

multiple design choices for a Medicare-specific program, and it is difficult to predict the impact of such a program on physicians' career choices, it might make sense to start with a small-scale pilot program.

A pilot program could test the impact of different design choices on program operations, physician participation, and career choices. Policymakers could use the results to improve the program and decide whether to expand it.

So for next steps, the work I presented today will be packaged together with our prior work on APRNs and PAs into a chapter in the upcoming June report. This summer, we are planning site visits to medical schools that emphasize primary care and that graduate a high share of primary care physicians.

For today's discussion, we would like your feedback on whether you're interested in further developing the idea of a Medicare-specific scholarship and loan repayment program for primary care physicians. We would also welcome your comments on the design questions we've raised.

This concludes the presentation. I'd be happy to

take any questions.

DR. CROSSON: Thank you. Ariel, just to be clear, when you're talking about the June report, the assumption here -- correct me if I'm wrong here -- is that it would contain the analytic information that you've presented but not necessarily a proposal for this program because we're going to investigate that into the next term. Is that correct?

MR. WINTER: That's correct, unless you come to some consensus today around a proposal.

DR. CROSSON: Oh. Well.

[Laughter.]

DR. CROSSON: That should work out okay.

MR. WINTER: Absent that, we can lay out the design choices like we've done in the draft paper.

DR. CROSSON: All right. Clarifying questions. We'll start with Karen.

DR. DeSALVO: Fantastic chapter and great edition. Thank you so much. I wondered about the pipeline question about the number of graduates in internal medicine that plan to go into general internal medicine and if you're able to further break that down into those that are

choosing to be a hospitalist compared with the outpatient physician. As I understand it, that's also a startling number, that there's a dramatic increase, making the shortage look even worse potentially than it is. And I can share some data with you if you haven't had a chance to see it.

MR. WINTER: Right. So the paper I cited by, I think, West and Dupras did break it down by the choices. And so 64 percent of them plan to enter subspecialties; 9 percent, hospital medicine; and 4 percent were undecided. And that relates to the third bullet on this slide, the 21.5 percent who intended to practice general internal medicine.

DR. CROSSON: Jaewon.

DR. RYU: Yeah, thanks. I, too, really enjoyed this chapter. You started the chapter with some discussion about the fee schedule and the devaluing of primary care services over time. And then it kind of led into a discussion about various loan forgiveness programs. I guess my question was: Which of those two levers would be more impactful? And do we have any evidence to suggest that one would be more influential in shaping the

decisionmaking of graduating medical students versus the other? Or is it both?

MR. WINTER: So I don't have a direct answer to that question, but this kind of follows up from the work we did last cycle that resulted in the June chapter from last year looking at options for redressing the passive devaluation of ambulatory E&M services, and the approach that we discussed and that we modeled in the June report was to increase payment rates for all ambulatory E&M service by 10 percent and in a budget-neutral manner, which would reduce payment rates for all other services by about 3 percent. And that would transfer something over $2 billion to those types of services.

The Commission felt strongly that that increase should apply to all ambulatory E&M services regardless of the specialty that provided it. And many of these services, as you know, are billed by non-primary care clinicians.

And so there was also a lot of discussion at the time about what are more direct ways, direct approaches, options that we could pursue that would have an impact, direct impact on choice of specialty, and several

Commissioners suggested that we take a look at loan forgiveness or debt reduction kind of programs as a potential option. So that's why we pursued this work. In terms of which option would have more of an impact? I don't have the evidence to say.

DR. MATHEWS: Right, but just to amplify what Ariel said, our prior work dealt with things like identifying overvalued services within the physician fee schedule and plowing those RVUs back into the fee schedule more generally. And correct me if I'm wrong, but even when we talked about modeling a per beneficiary per month payment, we were talking very small dollar amounts at the initial stages, $2.40 a month, something like that. And the question was: Are these kind of incremental revenue changes going to be sufficient to influence someone who is making a decision primary care versus orthopedic surgery, as much as a more direct approach, here's $100,000 worth of loan forgiveness to help start you out on your career.

But it was, as Ariel said, in direct response to Commissioner interest in pursuing something more immediately impactful.

DR. CROSSON: Paul, do you want to comment on

that?

DR. PAUL GINSBURG: I want to add to that. I think the Commission believes that fixing the fee schedule is, you know, the best way to proceed, but that either -- this could either, you know, expedite the change in response to that, or, you know, we realize we may not get the fee schedule fixed, and this could be a second-best alternative to pursue.

DR. CROSSON: I agree with that.

DR. DeSALVO: Can I add on to that?

DR. CROSSON: Yeah, Karen.

DR. DeSALVO: Yes, though I -- you see this in some of the data that you have in this chapter. Financial drivers aren't the only or even perhaps the most important decisionmaking, and I keep going back to it's also about intangibles like the practice environment, the amount of time you're able to spend with patients, and how you have continuity and the team that you can assemble based on not just how much you're paid but how you are paid.

So I think that in addition to the rebalancing of the fee schedule, this gets back again to moving to value-based care arrangements like, you know, patient-centered

medical home and other intangibles, like the retention for National Service Corps, I think the number is 55 percent of National Service Corps are retained. Some of those communities, particularly smaller ones, provide other benefits to those physicians once they arrive there, like mortgage or housing or, you know, other supports that help keep them in those communities that are somewhat financial but also relate to things outside of the fee schedule.

DR. CROSSON: Thank you. Jonathan.

DR. JAFFERY: Yes. You said a little bit about the Public Service Loan Forgiveness program that spoke to maybe an existing program that's not fully maximized, or optimized, I should say. Do we have any data? Do you know, are the other programs that currently exist being fully utilized?

MR. WINTER: That is a very good question. With regards to the military program, it seems like they are -- I mean, their funding has been pretty stable, as I recall, and it seems like they're filling their slots. And I'm referring here to the health professional scholarship program, which is run by DoD, and has about 3,000 physicians right now who are participating in that.

With regards to the NHSC it's hard to say, because their numbers, as we talk about in the paper, have gone up from about 3,000 clinicians to almost 11,000 clinicians in the last decade or so, and funding has gone up as well. But there are also about 4,600 or so, 4,500 or so unfilled slots at sites that have been approved by HRSA, for NHSC clinicians, and it is unclear whether there's not enough money to fund all the people who are applying or there's not enough people applying to fill those slots. And we've asked HRSA for that information and have not heard back yet.

With regards to the Primary Care Loan program, there's been a decline in borrowers, from about 4,500 or 4,600 to -- where is it today? -- 2,600 borrowers. And I think that's due to -- it seems like that's due to several factors, the fact that it's a fairly long time frame to participate in the program. You've got to participate for 10 years, you have to practice a specific specialty, and also there's been development of more attractive programs, like the Public Service Loan Forgiveness program or the NHSC. And if you participate in the PCL you cannot be in the NHSC. So that's another factor perhaps driving

reduction.

So that's sort of the best evidence we have right now.

DR. GRABOWSKI: A follow-up to Jonathan's question?

DR. CROSSON: Yeah.

DR. GRABOWSKI: Jonathan, I think, was asking about uptake of these programs, but has anyone actually evaluated your issue around, are these attracting new individuals into primary or is this just individuals who otherwise would have entered primary care? That's kind of a different issue, but related to whether these programs are actually effective, not just whether folks are signing up.

MR. WINTER: Yeah, I wish there were evidence about that. I've not seen any attempt to evaluate that question in my review of the literature. There have been some evaluations of the NHSC that have focused, really, on retention rates within the HPSA or within the HPSA generally, within 1 year or 10 years after, but have not attempted to address that question. And that would be really -- that's obviously a very important question to

address.

DR. CROSSON: Okay. So let's move this way. Jon.

DR. CHRISTIANSON: So if I understand right we are concerned about the Medicare beneficiaries will have access to primary care. We do this annual survey that says right now, on average, their access is better than people in private insurance, but we know, around the average, there's a lot of variation so there may be a lot of areas in the country where their access is not good at all.

So the question I have -- so I would think we would want to tie a loan program to physicians who practiced in areas where Medicare beneficiaries don't have adequate access. But my question is, I don't -- is there a source of data that would tell us that? I don't think our survey is scaled to tell us, at any kind of a local level or a smaller level, whether somebody -- whether Medicare beneficiaries have adequate access or not.

So how do we -- what data are available to help us link a program to where we really think the benefit would be?

MR. WINTER: Right. So you're correct that our

survey is not adequately powered to look at specific geographic areas where we think there are problems, although I think generally folks in rural areas report more trouble accessing -- no? Okay. It's the same. Okay. Rural and urban are the same.

But to address your question, I think one option could be to look at health professional shortage areas, which are areas defined by HRSA, where there is a shortage of primary care clinicians, generally -- not just Medicare beneficiaries but generally -- and that's, as far as I know, the best source of data we have for -- if you wanted to target a loan program or a debt reduction program to shortage areas. I'm not aware of any off-the-shelf system that identifies area where there's a problem -- where there's a shortage of clinicians for Medicare beneficiaries specifically. I'm not sure how you would do that.

DR. CHRISTIANSON: So it's not so much whether the ratio is lower in one area or another but basically whether Medicare beneficiaries are having trouble accessing primary care.

MR. WINTER: We don't have a metric for that.

DR. CHRISTIANSON: Right. And a lot of your

comments here are around clinicians, not physicians per se. So when you talk about clinicians available that are taking advantage of these programs that's not the same thing as physicians, which we seem to talk about. We talk about physicians, primary care physicians.

MR. WINTER: Right. So we were asked to investigate a program that would be targeted to physicians specifically. As you correctly point out, the Public Service Loan Forgiveness program, well, that's for everybody, you know, not just health professionals. NHSC is for many types of clinicians and physicians are only 20 percent of the total. The Primary Care Loan program is targeted to physicians, and that's the one program that we talk about. And the military program is targeted for clinicians and other -- sorry, for physicians and other clinicians as well. So the PCL is really the only one that's targeted to physicians.

DR. CROSSON: You know, I just want to make a comment on this. As I said earlier, we've been working on this issue of primary care physician pipeline for a long time. I'm not sure how long -- 10 years, perhaps, at this Commission. And I can remember my predecessor Chairman,

who came from central Oregon, when we would present the data about appointment access for primary care, scratching his head and saying, "Well, that may be the case but that's not the situation in central Oregon."

So, you know, it may be that in the aggregate rural and nonrural are equal, but I have a strong suspicion that there are areas of the country where it's very different than that.

Okay. Kathy.

MS. BUTO: Sort of a related point. Nurse practitioners and physician assistants are not included in the proposal. I understand that we know there's growth in those areas but I also remember, I think the last go-around, Ariel, you might have pointed out that increasingly nurse practitioners are beginning to subspecialize and get out of primary care.

So I wonder whether we ought to think about including that group. Is that -- did you leave them out for a reason, just because we were focusing on physicians, or what exactly were you thinking?

MR. WINTER: So the direction that I got, based on comments from Commissioners last cycle was to focus on

physicians, and part of that could be driven by the rapid increase in the number of NPs and PAs, which has basically doubled, I think, since 2010 -- yeah, which has doubled between 2010 and 2017. And so there seemed to be less concern about people choosing that -- choosing to become NPs and PAs than about choosing to become primary care physicians. But it's certainly something you could discuss, is whether to include NPs and PAs in the kind of program we're discussing.

MS. BUTO: I think, to turn the tide a little bit back to primary care, we might want to consider if not a full comparable program to bring them into something that's maybe a little less than that.

The other thing I wondered about is pediatrics is included in the list of physicians. I mean, with all due respect to a pediatrician here, I guess I'm wondering why would we include pediatrics in a program for Medicare?

MR. WINTER: Right. So in our prior work, for example, the recommendation that led to the Primary Care Incentive Payment program, we included pediatrics in the list of clinicians that should be eligible for a bonus or a payment adjustment. And there are some, when we look at

the number each year of physicians who treat 15 or more Medicare beneficiaries, there are about 1,000 or so physicians who are self-reported to be pediatricians, you know, in that number. And so you could leave them out if you wanted to, but including those is not going to make a huge difference because there are not so many treating Medicare to begin with.

DR. CROSSON: And, Kathy, it was in the context of a per-beneficiary payment, in which case it was de minimus.

MS. BUTO: But if this program is designed to actually --

DR. CROSSON: Different policy.

MS. BUTO: -- get people to sort of gravitate toward Medicare primary care --

DR. CROSSON: So adult primary care.

MS. BUTO: -- I don't see that.

DR. CROSSON: I would agree that this is different.

MS. BUTO: Yeah.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, thank you for a really

great chapter on a very, very important topic. My question, in the reading materials I look at page 17 and I look at page 18, and there's this stark contrast between these two pages, because you talk about evidence of a relationship between the characteristics of students and their specialty decisions, that these things are correlated with the choice of family medicine, that demographic characteristics best predict choice of practice, about even the characteristics of the schools that they use, community hospitals, you know. I mean, it's just full of evidence in that this causes that.

And then, on page 18, the one sentence that stood out, "Evidence that educational debt affects specialty choice is mixed." So, see, a page of this causes that, and a sea of this is page of mixed. My question is this -- have you contemplated that some programs that are aimed at the levers that you describe on page 17, or are we jumping straight to page 18 in our design considerations?

MR. WINTER: So that is a very fair question, and I -- the assumption -- my assumption has been that we were -- we wanted to focus on things that factors of Medicare had more control over, and Medicare doesn't have very much

control over lifestyle and the design of medical school curricula, although maybe it should -- that's a separate question, I think -- and much control over demographics and control over work hours and things like that. But it has, perhaps, more control over the income gap, because the fee schedule comes from Medicare and many private payers use Medicare as RVU uses as the basis for their payments. And in terms of debt, the evidence is mixed but, you know, we were asked to look at whether a debt reduction program might have some impact on specialty choice.

And one other point I'll make is that in terms of the student characteristics, so there is evidence showing that students from rural backgrounds, lower SES, from minority backgrounds are more likely to choose primary care, and you do see a disproportionately high share of minorities in the NHSC program, which does provide, obviously, a financial incentive, but the people who are choosing that, self-selecting into that, tend to be people with characteristics that make them more likely to choose primary care.

DR. DeBUSK: Thank you.

DR. CROSSON: Pat.

MS. WANG: So I also am struck by a couple of things, and Brian mentioned one of those and you summarized it at the bottom of Slide 7, that the evidence of the effect of student debt is mixed, like from zero effect to modest effect. And so it makes me want to sort of step back for a second from the idea of creating a new loan forgiveness program as opposed to maybe fixing the ones that are out there, making them work better.

I guess my question is -- and this is infamous also by another -- I think I have mentioned this -- I am so struck by the member of a conversation with a colleague who is geriatrician, who described how, in the course of his residency, as it went along, you know, his supervising physicians would say, "You're so talented. You're so smart. Specialize." Like he had to resist and buck the pressure that if you are talented, you specialize.

And I just wonder whether there is any literature or otherwise -- this is payment policy, I understand -- that is along the lines of behavioral economics. Because we're talking about a -- forget student debt and all of the rest; that exists -- but that would suggest that there might be other ways to use the tools at Medicare's

disposal, money, to -- you know, there's the fee schedule, obviously, but whether there are other ways to change the valuation, I guess, or the status of certain primary care specialties. And I picked geriatricians, you know, for a reason, because, to me, they are the ultimate Medicare physician, you know. A primary care doctor who can only afford to see you for 15 minutes at a time is fine, that's one thing, but a geriatrician is going to set his practice up so that he or she can spend that kind of time with you. So to me it's a little bit a gold standard, whether it's a geriatrician or a, you know, internist with whatever.

So these are wacky ideas but I just wondered if there's literature that would suggest that there are other ways, if there is to be new money, to, short of a fee schedule, structure a program to incentivize people, regardless of whether they have debt or not, because loan forgiveness is sort of a special thing. You need to have debt. You need to have help paying off your debt. You know, it doesn't apply equally to everybody, perhaps. That even if you were going to forgive debt in the amount of $100,000, structuring it as a bonus payment instead, regardless of whether you have debt, whether, you know,

Medicare should think about setting up malpractice insurance subsidization for people who choose primary care for older people. You know, something that kind of just elevates the status of people who pick this very important pathway.

DR. CROSSON: So let me just -- I want to comment on a little bit of Pat, because I think you are hitting on something here, which is both important and delicate at the same time. And it has to do with another payment stream from Medicare and that is for graduate medical education.

So we took a run, as a Commission, I think, in 2010, for not exactly this reason, that is primary care, but more from the perspective of whether or not, in a more general sense, the residents who were coming out of training had the mindset, the level of knowledge, expertise that was needed for modern physicians, and whether or not some of the Medicare payment for graduate medical education could be not taken away but redirected to create incentives for training programs.

Now that didn't go over well at the time. But I do still think that there's something in here, and Jim reminded me that we're still working on this, in terms of

how that money is provided, and specifically, not to be the reductionist here but just to give an example, you could imagine creating incentives for programs to distribute the training of physicians more broadly than is currently done in, you know, the mother ship, such that, you know, physicians -- incentives within the GMA payment program to provide physicians, particularly physicians, you know, contemplating primary care, or, for example, physicians contemplating internal medicine, to have a broader experience in their training so that they see health care as it is delivered in the community, and get comfortable with that, as opposed to just simply experiencing, in their training program, primarily inpatient care services.

So again, I don't necessarily want to revisit the whole issue of GME and its uses, but I do think that there may be something -- and I'm not sure you were saying that exactly but you were close to it -- there may be something in there for us to look at.

MS. WANG: Just to be clear, I think that what you're saying is very relevant and very important, but short of even touching the GME system, whether there is something -- again, I use the term behavioral economics --

that changes the status of primary care in the eyes of other physicians, including the attendings who are training you, that, you know, geriatrics is like, well, it's pretty cool, you're going to pay your malpractice for the rest of your life as long as you stay treating, you know, Medicare beneficiaries. You know, that just kind of would help people sort of stick to that as a profession.

DR. CROSSON: And I heard that, and I can sort of give you examples from my own training. And, you know, we had -- when I was a resident training in a large institution in Boston, as a pediatrician, we had some rather derogatory names for the physicians practicing in the community who would refer their patients in, because all we ever saw were the really sick ones, and occasionally patients who had not been treated properly, right.

Subsequent, you know, during later years of my residency I actually moved out of Boston myself into a suburban community, and for reasons I can't remember, decided to work more at night, actually covering multiple practices, and got an entirely different viewpoint of what the community practice of general pediatrics was like.

So that's sort of what I'm saying. I think part

of that mindset that the physician has, in terms of, in some instances, not everywhere, but in some instances, part of that mindset about what is a desirable role for me as a doctor, what is something which is ego-enhancing, even to put it that way, can be, in fact, and is, affected by the environment in which the individual trains and the peers that the individual experiences. And that was what I was trying to get at, along the lines I think that you were thinking.

MR. WINTER: And, Pat, I did look for anything in the literature that tried to evaluate the influence of status, the kinds of things you're talking about, or prestige. I couldn't find anything that directly assessed that, but every year the AAMC does a survey of its medical school graduates and asks them what factors played the biggest role in influencing their choice of specialty, and number three on the list was role model influence, which was reported by about 50 percent of the graduates. And that could be kind of a proxy for, you know, if the person you're training with, learning from influences you or directs you towards one direction or another, that could be related to what you're talking about.

DR. CROSSON: Where are we? Still on Round 1. On that point?

MS. BUTO: On that point. Yeah, I totally agree with Pat, and I came at it from the standpoint that -- and I realize this is a Round 2 comment, but that status would be related to having more control. So physicians often feel like they don't have control in Medicare, that they're required to do a lot of things, and that they are subject to the fee schedule. If there were some way to grant more autonomy, control, and convey status that way, whether it has to do with greater flexibility in whatever, payment models and so on, but only if you're a primary care practice, that's where I think you can begin to shift the status within Medicare of primary care. I don't think it's about paying each fee more money. I really have never thought that.

Loan forgiveness is one thing, but I really think it's about being looked to as some sort of an entity to be reckoned with within the program, and I don't think we have that now.

DR. CROSSON: And, Karen, I think you've made the same point a couple of times, today even.

Okay. So I've lost track. We're still on Round 1, right?

[Laughter.]

DR. CROSSON: Okay. Any more questions for Ariel? Dana and Bruce, and then we'll get on.

DR. SAFRAN: So in the chapter and in the presentation, you make a point that a couple time periods recently, '13 to '14 and '17 to '18, there was a growth in internal medicine residents, and that's new. We've been seeing declines, right? Growth relative to other specialties. And my question is: I know anecdotally in Massachusetts that with our payment reform work and how broadly that got adopted, we were hearing that primary care was now in such demand that, you know, primary care physicians were coming into Massachusetts from other states.

And so that got me to wondering whether you see these time periods and this shift as something related to the payment reform work that CMS is doing, because as it is, then that's just something important for us to note, too, that by continuing to pursue that path, CMS is helping to enhance the primary care workforce and the attraction

into that workforce.

MR. WINTER: Yeah, that could be on -- as we noted from earlier-on studies preceding this time period, you know, about 80 percent or so of internal medicine residents end up subspecializing. So it's unclear what percent of the residents, today's internals medicine residents, also specialize. Maybe it will be less. And maybe there could be some influence from the greater attention towards new payment models.

The other point I just want to make -- and I will include this in the chapter -- is at the same time we're seeing, you know, higher than average growth of internal medicine and family medicine residents, we're also seeing very, very slow growth of geriatric medicine residents. It grew by about -- I think it grew by about 2 percent over that five-year time frame. So I'll include that to add some balance to the picture.

DR. CROSSON: Bruce.

MR. PYENSON: Pass [off microphone].

DR. CROSSON: Pass. Okay. So we're going -- I'm sorry. I didn't see Warner.

MR. THOMAS: Just real briefly, and I think, Jay,

this goes back to a comment you were making earlier. I do think the idea of thinking about would it make sense to have additional funding in GME slots if, in fact, they were targeted to this area or to community care, you know, kind of off the campuses, you know, kind of off the tertiary campuses. I mean, we've done this in our program, it's been very successful. It's going to grow that pipeline, and it may just be another tool here, because ultimately it is about how many people we can train, and this is attracting people to go into those slots. But we ultimately need more slots for people that kind of go into the primary care world. And I just would put that out as another tool to potentially consider. I know it's more dollars, but if they were specifically targeted to these types of careers, I think that would be attractive to academic medical centers and attractive to people that were interested in those paths.

DR. CROSSON: I think that's fair. I was actually talking about expanding the number of slots, but I think that's fair to put on the table, and it would cost money, but so would a loan forgiveness program, to be frank.

Okay. So we don't have a discussant, so I thought I'd start a little bit. I think we need to decide, you know, whether or not this issue of -- and I'll use the term "loan forgiveness program," but that's kind of generic. It's essentially a program to provide money to new physicians to enter and pursue a career in adult primary care so that they're available to beneficiaries who want to have a physician perform that function. And I think Ariel has done a wonderful job giving us sort of the baseline, the status of where things are, both in terms of the need and in terms of what's available.

The question on the table is: Do we think that adding a program, however designed -- and there are multiple design elements -- would substantially improve the situation we have now? And, you know, I've heard the comment already: Or would it just be duplicative? Should we instead invest in improving the existing programs through HRSA or someplace else?

I think it is true that what we're contemplating here is a little different from the design or the intent even of any of the existing programs. So there's that point to be made.

So I'm sort of functioning here as the discussant, so I'll just give a few thoughts of my own, because I've had some experience kind of tangentially related to this, and that had to do, you know, with my prior career in Kaiser Permanente and wrestling with the problem not about what specialty an individual chose but the ability to attract physicians in adult primary care into a system in Northern California which had very diverse geography, places that were wonderful to live by most people's standards with nice weather and the bay and beaches and all that stuff, and then other parts of California which were on average less desirable, the Central Valley, for example. And yet we needed physicians in primary care but also other physicians in those areas as well.

And what we found over a period of time was that, in fact, providing financial assistance up front did work. It has to be substantial, and it also in order to work needed to be associated with a significant time commitment, the notion being that if you provided to physicians a substantial amount of money up front but then, you know, made the forgiveness of that money contingent on -- and it

was a ten-year period of time, what you ended up with was people -- and it was often individuals who came from backgrounds where they had less money themselves to bring to bear -- choosing those sites to work in, and then after a period of time becoming very much a part of those communities, something that in many cases doesn't occur in a very short period of time. Two or three years, from my perspective and my experience, doesn't work very well. But a significant period of time does, and a significant amount of money does seem to work.

The question -- and I'm not framing the debate in this way right now as the Chairman. I'm just throwing out my own ideas. The question is: Do we think it's worthwhile over the next year or so to have the staff and then the Commission pursue some idea in this direction? Or should we be devoting our efforts somewhere else?

Jon first, and then we go down here.

DR. CHRISTIANSON: Yeah, so we're talking about spending Medicare money to improve access for Medicare beneficiaries so that, as I brought up before, for me the issue of targeting that expenditure is important. And I think it's really difficult to do geographically because we

compute these ratios over fairly broad geographic areas and populations. But I kind of like the ideas that Pat and Warner were talking about.

Maybe we could distinguish whatever program we come up with, whether it's loan forgiveness or whether it's funding of slots, maybe we could distinguish our program from other options out there by focusing in on geriatricians and on palliative care specialists who, I think we would all agree, are specialties that are underrepresented and serve the Medicare population. And I would like you to think about and explore options along those lines, because I just would feel better about the efficiency of the expenditure of the Medicare funds if we could think that through a little bit.

DR. PAUL GINSBURG: Yeah, actually, before I get to my other comments, I really like this emphasis that Jon suggested about geriatrics, because we know the visits are longer, that, you know, we just wonder why do people go into this because it's so challenging economically to do it.

What I was going to talk about -- and Jay was really getting into this -- is we need to talk more about

the ratio of the additional primary care or geriatric physicians we get compared to the ones that were going to do that anyway and collect the money. And I don't have a magic answer to that yet, but I think that's what we should be thinking about coming up with ideas. And that's what really Kaiser did with the very long commitments, figuring that that's the way to have people commit to the Central Valley for ten years, that these really might be people that you wouldn't have gotten otherwise because of the money.

A couple of other comments. One is that it's -- you know, I can see the type of thinking how the PCL program requires some contribution from medical schools and what Ariel wrote was medical school matching funds. But to me those are perverse incentives for the medical school. You know, the state medical schools have long been under pressure to produce a high percentage of graduates headed for primary care. And here we're saying, oh, if you succeed, we're going to clobber you because you're going to have to pay some of the loans, loan forgiveness these students get. So I think we should really get away from having the medical schools contribute to the success that

they may have achieved by steering the students.

I'll stop there.

DR. CROSSON: Thank you. Kathy.

MS. BUTO: I'll make this very brief. I had written down "start with geriatrics." I really think if it's loan forgiveness, then we have people who have already incurred debt. And if it's targeted at geriatrics, the only thing I'd add is we ought to consider nurse practitioners or PAs who are also willing to make a geriatric specialty commitment.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, I think the geriatrics idea is fantastic. I had not considered that, and that's an easy idea to get behind.

I think this is a really important area, and I think any progress is progress. So if we do wind up with some type of loan forgiveness program, it's better than nothing. And I think it is something that the Commission should definitely take up, and I think this is time well spent.

One of the things that was very encouraging, I saw in the presentation when you said you were planning to

go to some of these medical schools that specialize in producing primary care physicians, I would encourage you to do site visits there because those are very, very different places. They don't feel like ordinary medical schools. And it's a different culture. You know, no one's going to tell them they're being foolish choosing primary care because everyone -- well, I say everyone -- most want primary care. Again, culturally it's very different.

On the site visit I would ask you please ask them, Where would you spend the money? If you had access to some type of funding mechanism, would you spend it on loan forgiveness? Or, for example, would you spend it on buying more clinical rotation spots in community hospitals? Which, by the way, I mean, for the primary care schools, virtually every clinical rotation spot now runs between $1,000 and $2,000 per student per month in years three and four. They've monetized clinical rotations now.

But ask them what they would spend the money on, because I think you would get some really good ideas, and I think you would see to these schools -- and I would contend the majority of the decision to go into primary care has already been made by the time the school sends the

acceptance letter out to the student. I would argue that the die is cast. And, again, you'll never see me stand against a loan forgiveness program because any progress is progress. But I think you're using a very expensive dollar there, and I think if you go visit these focused factories and ask them how they would spend that money, I'm not sure their go-to would be loan forgiveness. It might be on recruiting. It might be on other forms of -- and then the final thing, just if you do decide to use some of these levers on page 17 -- which I do agree when you answered my question, you know, Medicare doesn't normally engage in those levers. When you do engage those schools, the one thing to consider a hope in the design, I'd be interested in some type of grant program where you hold the school accountable for producing an increment, don't you dare pay them for the students they already produce but some increment in primary care physicians, and then leave it up to them. Maybe they do it with a class size enrollment. Maybe they shift their curriculum. But I would leave it up to them and hold them accountable so that those grants become repayable loans that they don't deliver on the primary care students that we, Medicare, feel like we're

buying. So good luck this fall.

[Laughter.]

DR. CROSSON: Jon I think wanted to make a comment.

DR. CHRISTIANSON: Yeah, as an amendment to your suggestions, would you suggest they have a mix of osteopathic schools in there as well in terms of starting out with the notion that you are interested in primary care?

DR. DeBUSK: Well, the osteopathic schools obviously have led the way in producing primary care physicians. Since you raised the subject, the one thing I would caution, I do think osteopathic schools have been a little bit of a pressure relief valve over the last probably decade for the primary care shortage. Now that the residencies have been harmonized with the ACGME so that the MDs and the DOs are following the same path, what you will notice is that the osteopaths are starting to specialize now at allopathic rates. So you are losing that pressure relief valve, and I think it's going to be surprising how quickly we lose it.

DR. CROSSON: That's a good point. David.

DR. GRABOWSKI: Great, thanks. Let me also get on board on Jon's suggestion about geriatrics. I think that's a really great idea.

I wanted to go also to Paul's point about not wanting to pay individuals for something they would have done otherwise. I think that's why we really need a pilot here. That was the last bullet on the prior slide, on Slide 14. I think that's really important. And I'd love for it to be a meaningful pilot where we get to test some of these design features and actually see what works and what doesn't work. I think we could learn a lot there.

I'm really glad you're going to talk to -- do these site visits to medical schools that emphasize primary care. I work at a medical school that doesn't emphasize primary care, but --

[Laughter.]

DR. GRABOWSKI: We have made a concerted effort to take on more students interested in primary care, and it's actually been a lot more about who we admit than what we do once they're there, and that really fits, Brian, with the point you just made. I wonder a lot about whether this is selection versus steering. And we've certainly had the

problem, Pat, you described of losing some students who said they were interested in primary care and then find other interests once they arrive. But I do think selection is really important, and so, Ariel, when you're talking to these medical schools, I really think it will be important to learn a little bit more about who they recruit and what they do once those students are on campus.

Thanks.

DR. CROSSON: Pat.

MS. WANG: So I'm in sync with what folks have said here. I am a little bit sort of not as enthusiastic about continuing to explore additional loan forgiveness programs, at least not before the ones that exist sort of are working in tip-top shape, because it sounds like there's more efficiency and more access to be granted with the programs that exist. And I'm not sure based on, you know, what you included in your paper, which was tremendous, that we can actually show the relationship between loan forgiveness and the goal that we're describing here, which is to encourage more people.

As you sort of pursue these pathways that have been described, I'd encourage you also to do that kind of

qualitative research maybe by talking to individual practicing geriatricians or palliative care physicians, or whatever the subset is, to see if they can give you more insight into what they think might be important, because I suspect that the more we can understand about sort of the -- things that have dollar signs attached that create a different environment for folks who choose this pathway, both in terms of status but also maybe some perks that go along with, you know, practicing geriatrics, because that clearly is for older people. You know, I had mentioned malpractice before. Maybe there are other parts of some of the rules that apply to clinician payment that -- you know, I mean, we just talked about -- we just eliminated kind of "incident to" billing. Maybe if you're a geriatrician, you could be allowed to retain "incident to" billing because you have a workforce of NPs who are kind of supporting your practice. Those sort of additional perks that would take some dollars but that would change the status of the specialty that you've chosen.

DR. CROSSON: Thank you, Pat. Jon.

DR. PERLIN: Yeah, this really follows from the sequence of comments, but the question is whether our

target is correct. Forgetting incremental benefit from the investment in the individuals, there's general agreement and the literature would support that certain institutions have higher turnout of primary care. Maybe the target should be the institution. The privilege of being a board member at Meharry Medical College, one of our historically black graduate medical institutions, it turns out 80 percent of primary care. The limitation is actually the resources for additional seats and funding them. You know, if you just think this through, if you know that's your pathway and it delivers, maybe in contrast the programs that already exist -- and I have a good deal of experience with it from my VA days -- maybe another approach is, in fact, direct investment in that, and that's our pilot.

Thanks.

DR. SAFRAN: Can I make a comment on that [off microphone]?

DR. CROSSON: On that point, yeah.

DR. SAFRAN: I was just going the same place in my thinking, and I think prompted a little bit by something that you said, Brian, but definitely, David, listening to you and remembering, you know, my own teaching at Harvard

Medical School, literally would have the experience of talking to first-years, asking them, "How many of you think you're going into primary care?" And almost every hand would go up -- like three-quarters of the room. And then teaching third-years and, you know, you'd be lucky if you'd see a couple of hands in a very big auditorium.

And so I just started thinking the same thing, and the question I have is: Do we go with what Brian was talking about, which is for the schools that are already doing a lot of primary care, reward them for an increment there, versus do we try to reward the schools like you and I have taught in that aren't really focusing there and try to reward them?

I'm not sure. I could make the case for either one, but I do think that this idea of focusing on the institution is one we should play with a little bit.

DR. CROSSON: Warner.

MR. THOMAS: I would just confirm, you know, Jonathan's comment about -- I think the loan repayment and everything I think is interesting. But I think direct financial support to institutions that can expand this pipeline is probably a more -- a quicker way that we're

going to have the impact, and I think a more direct way. So I would just encourage us to really look at that as an option, because I think the impact will be much quicker and much more direct, frankly.

DR. CROSSON: Okay. Sue.

MS. THOMPSON: I want to go back to comments that Kathy made in Round 1 where she was asking about the nurse practitioners and their role in filling this void of, I think, the problem we're trying to solve, which is to have a more adequate supply of primary care. And I am not absolutely resolved on my thought here, but I do think as a Commission we need to be careful because I remember last month, as we were making the recommendation about eliminating "incident to," we were reminded the Commission has held Medicare should pay similar rates for similar care. And I think we left that sort of hanging. And then I think the question was raised today: What about nurse practitioners? And yet the statement is, nevertheless, it's important to maintain an adequate supply of primary care physicians to ensure beneficiaries have the choice of receiving primary care services from a physician.

So we're not -- we're teetering here on a bit of

an issue that we could slide into unknowingly, or not, and then kind of get caught, you know, but what is our position on the role of the nurse practitioner or PA in filling this void and providing primary care? Because there's parts of the country -- I live in one -- where nurse practitioners play a key role in the face of primary care.

DR. CROSSON: Yeah, go ahead.

DR. PERLIN: As someone who came out of VA experience where it's very much team-based care and practiced at the highest level of skills, I absolutely agree in principle. The challenge right now is that, to my understanding, there's a pretty substantial surplus of nurse practitioners at the moment, and many are actually underemployed. My own institution, you know, a substantial number are working in RN roles because they've not been able to.

So, on contrast, I think both are eminently capable and patients should have the choice. I think there is a deficit that's reported and a surplus that's reported, and that may be the distinction I'd just draw.

DR. CROSSON: Let me just add to that. I think if there's a principle buried in there, it's somewhere in

that sentence, and it's kind of like, well, we don't want the Medicare payment program that applies to physicians to be a mechanism that so depletes the supply of primary care physicians in the country that Medicare beneficiaries, no matter where they live, who want to see a physician for primary care services cannot because there aren't any. And that's to say nothing -- I mean, that's completely consistent with robust support for the role of nurse practitioners, who are, in fact, probably keeping us going right now, as you say. Is that helpful? Do you think we're still teetering on the edge of heresy?

MS. THOMPSON: Maybe it's just me, but I feel like we're teetering a bit on that. But it may just be me.

DR. CROSSON: Okay.

MS. BUTO: And I thought we made -- somebody made the point last time that nurse practitioners increasingly are specializing. They're not going into primary care. So we obviously have to keep our eye on that. Even if there is an oversupply, we don't want to disincent nurse practitioners from pursuing primary --

DR. CROSSON: Right, so that's another issue, a tangential issue, but it's still -- I still think, you

know, the Medicare program pays physicians. The Medicare program has developed over time a way of paying physicians. We have evidence that, over time, unlike what Bill Hsiao and the others who developed the RBRVS program initially intended, it was intended to -- if you read the work at that time, it was intended as a payment system which would have the net effect of increasing availability of primary care physicians for Medicare beneficiaries. And the evidence is that it did just the -- it and other elements of -- thank you, Karen -- other elements inherent in the practice of primary care, which has become much more arduous and complicated over time, those --

MS. THOMPSON: And, again, I'm not completely resolved on this question.

DR. CROSSON: Okay.

MS. THOMPSON: I just think we need to spend more time thinking about it.

DR. CROSSON: Okay. All right. Sorry.

MS. THOMPSON: That would be my -- and, secondly, in order to think more about it, I do believe we need to be watching quality scores as it relates to the work of nurse practitioners and PAs versus MDs, DOs doing the same work.

DR. CROSSON: I agree. Okay. Jonathan? Jon? Paul?

DR. PAUL GINSBURG: [off microphone] something you said, because there is evidence that the Medicare fee schedule caused a major shift in money that went to primary care and away from procedural specialties. It's just that it didn't law.

DR. CROSSON: Oh, okay. All right. So net-net, over time --

DR. PAUL GINSBURG: Over time.

DR. CROSSON: But -- okay.

[Comment off microphone.]

[Laughter.]

DR. CROSSON: Sorry. Were you on the work group? Oh, you both were? Okay.

MS. BUTO: PPRC.

DR. PAUL GINSBURG: PPRC developed -- made the recommendations to do that.

DR. CROSSON: Okay. I'll extract my feet from whatever they're currently --

[Laughter.]

DR. CROSSON: Jonathan.

DR. JAFFERY: So I agree with that stream. I wouldn't want to lose the long-term goal of trying to decrease the disparities in payments between primary care and specialists. But I think, you know, Pat, you brought up this idea of getting at the behavioral economics of this, and I think there's a real opportunity there or a need. I'm not sure that status is necessarily the thing, but, I mean, the preponderance of stuff that we've talked about today seems to suggest that maybe the financial piece isn't the most important. And even Jay's example of success was maybe less about people choosing to do primary care and geography and convince somebody to live somewhere. But they were doing what they wanted to do.

And so, you know, going back to some things that Karen said a few times today already, understanding what makes it appealing to be a primary care physician for people, and there may be a number of things that are less tangible than making more money, and being able to get support for team-based care and relieving the burden of documentation and being able to associate -- tie in your work with social determinants of health. You know, I think getting -- the behavioral economics piece is getting at

that and understanding what are those drivers, and then we can think about how do we invest in them. And then in terms of these pipelines, understanding where are the most important pipelines. Is it med school? Is it residency? Is it both? I actually started residency in a primary care track, and so, you know, things changed in that place, too. And that was not between first and third year of medical school.

The GME point is a great one, I think, to think about how do we direct whether it's primary care overall, whether it's geriatrics, and I wouldn't want to lose the palliative care piece that Jon brought up initially either.

You know, we give all of the money -- GME money goes to hospitals, so we shouldn't really be shocked that people come out wanting to do things that happen in hospitals. So maybe we can -- maybe that scenario with the pilot program where we actually start to do more in the communities, and actually -- I mean, there have been some small things through HRSA, I think, already that we could maybe even build on.

DR. CROSSON: Okay. I think we've got Karen, and that's it. Right? Karen.

DR. DeSALVO: So to this point about the many opportunities that CMS might have to improve access to primary care physicians, just being focused on that, over time I would like to see us look at all the potential options -- and some of them have been raised, so I'll underscore some of it -- is about payment, which not only influences or affects salary but also a practice's ability to have a team and infrastructure to be supportive of the beneficiaries.

The second would be around training, so some significant opportunities, I think, in graduate medical education funding. And then also an opportunity around the encouragement component for folks who might engage in a scholarship or loan repayment program, so encouraging them to be a part -- requiring them to be a part of an alternative payment model, whether that's a medical home of some version or something broader like an ACO, and to, I think reduce some barriers, I think this is a great idea Kathy has about lifting some of the regulatory barriers.

So specifically on a couple of your points, on this second one in particular, rather than think about the primary care visits have to be 60 percent of the revenue

from Medicare, that smells to me a little bit like fee-for-service. And you could generate a lot of revenue without necessarily a lot of good outcomes. So one other way to think about it is either a population management, so the number of beneficiaries and/or, again, to require that folks are, you know, as a condition involved in alternative payment models going forward.

I do want to swap out pediatrics for palliative care in the thinking, though I wouldn't only make it geriatrics and palliative care, though I appreciate the concept, only just because of the pipeline issue. I think that if we really wanted to see access to care improve significantly, we couldn't only do it on the backs of geriatrics and palliative care. And they probably wouldn't want to because geriatricians do an extra fellowship to take care of a certain subset of seniors, and so I think perhaps thinking more broadly.

Just a suggestion and then a final point. The suggestion is that when you do your visits, in addition medical school, undergraduate medical education that focuses on primary care there, I think it's implied, but I want to be clear for you that the residency programs, the

schools that specialize in residency programs, that's a really important decisionmaking time.

And my final point then is about where the money should flow. Let's see. I'm obviously supportive of the concept of providing an added support to individuals that want to do primary care, whether that's scholarship or loan repayment, and we should explore it, not necessarily create a program but make sure the ones in existence work and/or fund them more or encourage people to go work in certain geographies or certain practices. So there's that component to it.

But I also think it's but one of many opportunities we have to make improvements using the Medicare program, but the institutional piece that I would be concerned about is it doesn't necessarily directly touch the individual. So they might want to do primary care, but if they're going to on balance make less money longitudinally or have a more difficult work environment, et cetera, why does it -- why would we want to not offer them a scholarship? I was using Harvard as an example. People are going to go to Harvard probably if they get a scholarship or not, but you kind of want to encourage the

best of the best, so you give them a scholarship, right? So I would sort of see this in that same vein. Even if you're going to do primary care, I'm not sure it really hurts.

But the institution piece is this. There are probably legislatures around the country that could tell you that they created medical schools to create primary care physicians, and it didn't really work out the way they thought, and they put the money in institutions. So maybe learn a little more about where that has already been tried and think about whether that's been successful or not.

Thanks.

DR. CROSSON: Okay. Jon, on that point. And then Marge and then we have to stop.

DR. CHRISTIANSON: I just wanted to say that it doesn't have to be either/or. You could have specialized programs targeted at geriatricians, palliative care. At the same time you could be pursuing thinking about a general primary care loan forgiveness program.

DR. DeSALVO: Yeah.

DR. CROSSON: Marge, close it out.

MS. MARJORIE GINSBURG: Yeah, I just wanted to

support the comment I think, Pat, that you made earlier, reluctance to put any additional money in at this time or urge any additional money for this purpose.

I also question whether we should be using our phenomenal influence with Congress right now to work in that arena, but instead to do much more about learning from the medical schools, from the residency programs, how do we create more primary care docs, what's working to increase that, and use that as our basic premise for how we move forward next. It's really a -- it's perhaps even a doctoral paper from somebody in your shop, Ariel. But I think that's the missing piece right now. We really don't know all the pieces of what encourages doctors to go into primary care and stay in primary care.

DR. CROSSON: Okay. This has really been a good session. As I said earlier, Ariel did a very good job building us a base that we could work off of. We've got a lot of ideas. They're not all the same ideas. But each one of them I think has merit, and so, Ariel, your job, should you choose to accept it --

MR. WINTER: Do I have a choice?

PARTICIPANT: No.

[Laughter.]

DR. CROSSON: -- will be to take this and begin to build on it, and I think you are already intending to go out into the field and try to, you know, actually get some information from people who would execute on whatever ideas we come up with. And I think that's going to be very valuable to us the next time we take this up. So thanks very much.

Kathy?

MS. BUTO: Just a very quick point. This may not lend itself to a June chapter. Maybe we could tee it up? I guess what I'm hearing, I've heard so much today that I'm thinking there's no reason why we couldn't take more time, right?

DR. CROSSON: Oh, no. Let me go back to what I said in the beginning of the session, the question, anyway, I put to Ariel, because I think we are going to have a June chapter. But I think, you know, based on this discussion, it will not include the solution. It will include the analysis, the excellent work that has been done to analyze the problem and perhaps describe the current state of affairs. You could also potentially, you know -- I'm not

telling you how to write it, but potentially set up in the chapter the fact that this additional work is going to go and maybe a little bit about some areas that we're going to explore. Does that make sense, people?

Okay. Thanks very much, Ariel.

[Pause.]

DR. CROSSON: Okay. Let's move forward here. I think we are at the end of the day, and Kate's going to take us through our final look at the mandated report on clinician payment. This is, as you may remember, a request that we look at least some provisions of MACRA as it might affect physician income to date or physician income going forward. And I think we're about ready to complete this work, so, Kate, take us galloping through your presentation.

MS. BLONIARZ: The last session today, as Jay mentioned, returns to a mandated report on Medicare clinician payment that I last talked about in September.

So today I'll cover the mandate, give an overview on Medicare payment for clinician services, consider some longer-term trends in payment adequacy indicators, and give an early look at a new analysis showing how shifts in the

site of service affect fee schedule volume and spending. And I want to thank Kevin Hayes and Brian O'Donnell and Emma Achola for their help with the work.

I'm looking for your feedback on the draft chapter as we finalize it in our June report to the Congress.

So as part of the Medicare Access and CHIP Reauthorization Act of 2015, the Congress asked MedPAC to consider the effect of the statutory updates between 2015 and 2019 in four areas -- efficiency and economy of care, supply, access, and quality -- and asks us to consider any future updates necessary to ensure beneficiary access.

Because I don't have data for the entire time frame, I also report some of the measures over the past decade when the statutory updates were generally consistent to those between 2015 and 2019.

This slide has background on Medicare's payment system. The program pays for clinician services in all settings using a fee schedule of more than 7,000 codes. CMS updates the payment amounts each year and applies any yearly update to the fee schedule conversion factor.

The fee schedule updates over the past decade

have generally been in the range of no update to 1 percent per year. Under current law, there is no statutory update between 2020 and 2025, but there is an incentive payment.

Payment rates for each service can also vary by a number of other factors -- geography, clinician type, and setting.

When I covered the mandate in the fall, I reviewed our payment adequacy framework and what our measures looked like over a longer time frame than I usually do in our yearly update. All that detail is covered in this mailing materials and summarized here.

In general, we find that access to clinician services for Medicare beneficiaries has been stable and as good as or slightly better than access for individuals with private insurance.

The number of clinicians billing fee-for-service Medicare grew, led by significant growth in NP and PA billing. Volume growth varied over time and by type of service. And quality is indeterminate.

Medicare's payments for clinician services were about 75 percent of private PPO rates, and that's a slight decline over the past five years.

Overall, our payment adequacy indicators have been notably stable in the context of updates of between 0 and 1 percent each year. and we'll continue to monitor the indicators in the future.

When we see concerning trends in these payment adequacy indicators, we consider whether Medicare payment is implicated, if a change to the overall payment rate is necessary, or if other Medicare policy changes are called for.

There are three examples on the slide of the last one. As Ariel just covered, income differences by specialty has motivated some of our work on ensuring an adequate supply of primary care services. Due to growth in advanced imaging, MedPAC made recommendations for changing the payment rates for some of those services. And due to shifts that we perceived in the site of service from low-cost to high-cost settings, MedPAC made recommendations in 2012 and 2014 to set site-neutral payment rates for certain services.

One thing I wanted to do as part of the mandate is to give a little color to some of the indicators, and so we did a deeper dive on volume trends in the context of

site-of-service shifts.

Services may shift across settings due to changes in safety profiles, clinical practice, or payment differences.

Our measure of volume captures both units of service and intensity, as measured as RVUs. And when services shift settings, these RVUs can change. So fee schedule spending and volume growth is sensitive to site-of-service shifts.

In our March reports, we have generally given a few selected examples of services we see shifting. This is the next step, a more comprehensive analysis of how site-of-service shifts affect volume and spending.

This slide shows the illustration of an evaluation and management visit provided in the office or outpatient, shifting from the physician office to an on-campus hospital outpatient department.

When the service is provided in the physician office, on the left, the total RVUs for the service are just over 2. When the service is provided in the hospital outpatient department, the total RVUs drop to 1.45. That's because the fee schedule practice expense declines and

there's an additional payment through the OPPS.

But just from the fee schedule perspective, it looks like the RVUs decline by about 0.5 when the service shifts from the physician office to the outpatient department. It looks like these RVUs disappear.

So if there is a trend in services shifting from the physician office to the OPD, this dynamic will artificially dampen volume growth, because recall that our measure of volume incorporates RVUs to capture intensity.

This table has our preliminary findings of fee schedule volume growth if we held the share of services provided in each setting constant over time. The first column is our traditional measure of volume growth, and the second column holds site of service constant over the entire time period. Another way to say it is that this is what volume growth would have been if the services had not shifted across settings.

Overall, volume growth would have been almost 40 percent higher -- 1.5 percent per year instead of 1.1 per year.

Imaging and tests would have grown at rates of 1.2 and 1.0 percent per year, respectively, instead of

generally flat growth for the unadjusted numbers.

You might note here that it appears that major procedures are shifting from the OPD back to the physician office because volume growth is higher for the unadjusted numbers. But what's actually happening is that there's a sharp decline in hospital-based cardiovascular procedures and a concurrent increase in physician office vascular procedures.

The last two slides covered RVUs and volume, but there's an associated effect on spending. So the services shifting from the physician offices to the OPD results in a decline in RVUs, and this causes fee schedule spending to decline. But total Medicare spending is significantly higher. That's because there's an additional payment through the outpatient prospective payment system, and that's the bar on the top right. For this E&M service, when it is provided in the physician office, Medicare pays $74.24. When it's provided in the OPD, Medicare's pays $168.11. So two things are happening. Fee schedule spending declines, and total Medicare spending goes up.

What this means for the volume analysis is that as services shift from one setting to another, it will

affect fee schedule volume, fee schedule spending, and total Medicare spending. And it can happen via changes to the number of RVUs for the service and also the units of services, which I didn't cover today but is in your mailing materials.

These changes have downstream effects on our measures of fee schedule volume and spending, and we plan to continue this work over the coming year and may incorporate some of it into the yearly payment adequacy assessment.

To go back to the mandate, over the time period that we reviewed, Medicare's yearly payment rates have been in the range of 0 to 1 percent. During this time frame, the payment adequacy indicators were mostly stable. Access to care was steady. Volume growth varied and can be sensitive to the site of service; quality is indeterminate; and Medicare's payment rates relative to private payment rates fell slightly because private payer growth outpaced Medicare's payment rates.

But despite this divergence in Medicare and private prices, it has not led to a divergence in reported access. In fact, Medicare still continues to be slightly

better on some measures.

I should note here that in the fall, Paul, you raised the idea that Medicare's low payment updates for clinician services might be a factor in the migration of services to the generally higher-paid hospital outpatient department. But there are other reasons those services may shift as well.

The mandate asks us to weigh in on any necessary future updates for clinician services needed to ensure access, and we believe we can best do so by considering the most up-to-date information each year through the payment adequacy assessment. And we just completed our 2019 payment adequacy assessment, finding generally consistent trends with what I just presented and making a recommendation for current law -- which is no update -- for 2020.

So this material will be finalized in a chapter in the June report to the Congress to meet our mandate deadline, and I welcome any suggested edits to the mailing materials.

I am happy to take comments and questions, and I look forward to your discussion.

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

Questions for Kate? Pat.

MS. WANG: Kate, can you just help me understand something? I just want to make sure I understand Slides 9 and 10. Is this saying that if services had not shifted from the physician office to the hospital setting, they would still have increased in volume? I mean, holding the site of service constant, because there was some masking with RVUs, I mean, what is this Table 9 telling us?

MS. BLONIARZ: So what this is trying to convey is we have always reported kind of physician volume, clinician volume as kind of one measure of access and, you know, a potential indicator of mispricing. But there's a problem where when services are provided in the hospital outpatient department, from the physician side part of the action is missing, and we just can't see it. So when services shift from one setting to another, it looks like it goes from, you know, a high RVU service to a low RVU service. But that's because there's all this other action over there that, because Medicare pays in silos, you know, I can't see it very well.

So what we were trying to do is say let's say

that shift didn't happen and everything was kind of static over time, what would volume growth actually look like?

MS. WANG: Right, okay.

MS. BLONIARZ: And it would have been higher than what we have been able to calculate and report.

MS. WANG: So then on Slide 10, which talks about the effect on spending, this is a combination of the higher sort of per service payment in a hospital OPD and the growth in volume. Is that correct?

MS. BLONIARZ: This is just for one service. This is only one service.

MS. WANG: Oh, okay. I'm sorry

MS. BLONIARZ: Yeah, and so the takeaway here is kind of that it appears the physician spending declined, and then total spending went up, and it's because, you know, part of the physician payment is kind of going away, and then there's this additional OPD payment.

MS. WANG: Okay. But there is sort of a net of the cost of the shift which takes out of the equation that volume has also increased. I see this price differential is -- it's a lot, but in total spending for these services, it's a combination of increases in volume as well as

increasing in price?

MS. BLONIARZ: Yes, and so one thing we did, when we did the work to put this table together, is we kind of accounted for the trend in volume for all of the services, you know, because we wanted to say, okay, if a service was being provided a great deal more over this time frame, we wanted to account for that. The only thing we were holding constant was where the service was provided.

MS. WANG: Thank you.

DR. CROSSON: Questions? Jaewon.

DR. RYU: I just want to make sure I'm understanding the shift dynamic correctly. If you go to Slide 8 and I think it shows up again on Slide 10, the practice expense component of the RVU calculation is what goes away when you go from an office visit to a hospital outpatient setting.

MS. BLONIARZ: It's part of the practice expense component. The idea is --

DR. RYU: I got it. But can you give some examples of what that would be? Because the expense clearly doesn't go away. It's just now bucketed under hospital outpatient. Is that right?

MS. BLONIARZ: Right [off microphone].

DR. RYU: So what would some of those things be?

MS. BLONIARZ: I believe that indirect practice expense -- Kevin?

MR. HAYES: Stays [off microphone].

MS. BLONIARZ: Stays -- indirect practice expense is paid through the physician fee schedule no matter where it occurs. But like OPD, the OPD payment could be rent and overhead -- is that right?

MR. HAYES: Supplies [off microphone].

MS. BLONIARZ: Supplies.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Thank you very much, Kate. Just a question in the calculation. Would you get the same results if you just looked at the work component over time?

MS. BLONIARZ: Sure. But let me make another distinction. One reason that -- when Kevin put kind of the work together to do the volume analysis about a decade to 15 years ago, you know, he wanted to account for intensity as well, right? And so what you might lose if you only did the work piece is if someone is -- if a higher PE service is substituting for a lower PE service, so like a service

is going from an X-ray to a CT scan, you might not pick that -- you might kind of be netting that out of the story if you only did the work thing. But I think it's a similar idea. It's kind of trying to get at the same answer.

MR. PYENSON: So thinking about how we use these numbers, you know, we say something like here's how much spending is going up in effect, and we perhaps think about that compared to inflation or other metrics. So I'm struggling to think of what's the right way -- I mean, the work component is kind of the -- think of that as what the physician keeps, kind of, you know, benefits and things of that sort. So help me think that through.

MS. BLONIARZ: Let me try, and you can tell me whether this is what you're thinking. You know, one story that we hear is, you know, volume growth really slowed down, right, in the physician fee schedule services. I think here it slowed down some, but not as much as it might appear, right? So that's kind of one takeaway.

I think there's a similar story with spending, which is, you know, physician spending has been relatively flat, but, you know, what's actually been happening is those services are just kind of being paid through another

payment system, and because of how packaging occurs in the OPD, I can't always pull it out and kind of give you, you know, a real number.

I do think it implicates how you might want to think about pricing, updating, and setting rates for services that are, you know, primarily work or, you know, mostly work versus services like some advanced imaging which are almost entirely practice expense. You know, those might be a little more like a commodity than a physician service.

MR. PYENSON: That's very helpful. Thank you.

Another approach might be to pull in the, you know, OPPS into that. That's different streams. But I'm wondering what that would be useful for.

MS. BLONIARZ: And that's definitely something we want to do. We've had to kind of just be a little smart about how we identify the site-of-service shifts that shows up at least three and we think probably four or five different ways in the fee schedule. And so once we have done that for RVUs, then we'd love to do it for spending and say, well, what is the net effect of all of this, you know, services shifting across settings?

DR. CROSSON: Okay. Let's proceed with the discussion. Kate has asked for input into the report as it exists in its semifinal version. Input for Kate in terms of the report before it's finalized? Bruce and then Jonathan.

MR. PYENSON: This is a really great report. Thank you very much. The only recommendation I would have is I would welcome at least a little more detail on the other two examples, maybe not the full-blown analysis that you did for E&M, but chemotherapy administration, you know, sort of -- I think that would show the whole physician piece going away for the administration and the CT. So I'd welcome those examples, at least at a high level.

DR. CROSSON: Jonathan.

DR. JAFFERY: Thanks, Kate. This is a great report. I think I've got much more clarity around sort of the mechanics of how payments are different in the two sites and actually how the whole volume issue gets perturbed in a different way. It's actually a little more complicated than I realized, which I think I could say about pretty much everything we talk about.

And I would echo, I think that would be helpful,

Bruce's suggestion would be helpful. I think, you know, not for this mandate or this report, but, you know, as we talk about these things on an ongoing basis, I think sort of to echo some of the things we talked about earlier today, you know, if we look at the updates, currently, the current state is that there are updates for multiple years in this sector, which is different than the other ones. And so, you know, I think that we should think about taking an opportunity to maybe suggest things that could move the program in a way that aligns with some of our other goals around maybe adjusting payments in a different way than they currently are for the differentials between advanced alternative payment models and not, for example -- which wouldn't sort of relieve us of our obligation on an annual basis to make sure that they're still adequate, just like we have now even another set for the foreseeable future.

DR. CROSSON: Sue.

MS. THOMPSON: A quick comment, Kate. As I read the chapter, you spent some time talking about the survey and about the fact that response rates are going down, and overall in general across the country, response rates are going down. And I was left wondering, do you still have

confidence? And while you resolve it by saying going forward we will continue to monitor, make sure it reconciles with other surveys, but I'm assuming other surveys are seeing corresponding reduction. So there's just a piece there that I was left feeling less than convinced you were convinced. So that would just be a comment I would make as you reread, to maybe strengthen your confidence in what we're looking at, if that makes sense.

DR. CROSSON: Brian and then Paul.

DR. DeBUSK: First of all, I really enjoyed reading the report. I think it clearly fulfilled the mandate that MACRA set forth, so congratulations. It looks great.

The one thing, to build on Bruce's point, it does, though, really underscore a vulnerability that we have in our analytics. I mean, I know I'm showing a firm grasp of the obvious, but here's my one part that I'd like to contribute. If I remember correctly, when we were doing the -- when we did the site-neutral adjustment, instead of just forcing the rate, didn't we do something like we took 40 percent off of the OPPS rate and added -- in the

balanced budget amendment, the way we first did that, there was a treatment there where we basically brought the fee schedules -- we implemented site-neutral payment, but we did it by taking a percentage of the OPPS and adding the PFS back in, something like that.

MS. BLONIARZ: I think that's right. So there's kind of three actions that have happened on site-neutral: what MedPAC recommended, what the Congress enacted, and then CMS has taken additional administrative action. One of them involves 40 percent.

DR. DeBUSK: Well, the reason -- I wasn't asking it to put you on the spot. I was just thinking, for initial direction -- because I was going to feel really badly if I said, "Hey, great report, and oh, by the way, figure this analytics thing out so our numbers are consistent."

I was just thinking about something along those lines. You guys may be able to come up with an adjustment on the OPPS side in aggregate that would allow us to normalize and see through the difference in site-of-service shifts, so that when we do look at trends over, say, the last decade, we can see through them because we've got a

normalization factor that's being applied to the OPPS component.

I know I botched that, but I think you understand what I'm saying.

MS. BLONIARZ: I totally understand the point, yeah.

DR. DeBUSK: Okay. Thank you.

DR. CROSSON: Paul?

DR. PAUL GINSBURG: My thing is editorial, and I can give it straight to Kate.

DR. CROSSON: Okay. Then Kathy and David.

MS. BUTO: My point is just that in listening to Kate, you know, the relationship between the site-of-service issue and the adequacy of clinician payment became a lot clearer to me. I was trying to understand that issue. And I would encourage you -- I went back and looked at the conclusion again -- to really highlight the fact that although the mandated report is supposed to address adequacy of clinician payment, it really -- in order to fully understand the adequacy, you've got to look at in this case the site-of-service shift to understand the full payment for sort of the underlying practice expenses. I'd

just be really explicit about that because I'm not sure that it comes through all that crisply the way you just described it. And I think that would help them understand why we think, you know, in a sense there's more than enough payment here.

DR. CROSSON: David and then Jon.

DR. GRABOWSKI: Great. I wanted to pick up on Sue's comment about the response rates. I also found that concerning, and this isn't headed in the right direction. I think that's pretty obvious. This is more of a big-picture comment or maybe sort of an idea for down the road. One approach that we've taken, obviously, is to survey beneficiaries about their access. There's a different style of study which is called an "audit study," where you actually call up physicians and ask about, you know, how long would it take me to get an American people, obviously with the vignette that I'm a Medicare patient or I'm a commercial patient. And that's a different strategy. It doesn't get at all the kind of questions that you have here, but that could be an alternate strategy down the road, and we can't get beneficiaries to pick up the phone. So an idea.

DR. CROSSON: Jon.

DR. PERLIN: Yeah, just to follow up on two things. One, the comment on the survey, you may recall earlier I made the recommendation that we should also survey on the physician side on how they divide their time. So if their practice is open, you know, are they blocking time for patients that are other than Medicare?

The larger issue is that I want to tie this together with our last discussion. In the last discussion, we were talking about the incentives or disincentives to go into primary care, and I couldn't agree more that the two-factor theory of motivation that there are things that are gratifying and there are social cues. There's another piece that is financial. And in that latter part, in terms of this, how are we thinking about the differences in terms of how the reimbursement actually gets to the providers?

So in the practice, at least traditionally, the physicians have either been self-employed or part of a practice; whereas, as the shift goes to hospital-based outpatient units, they may actually work for the hospital, and there may be less direct relationship between what Medicare is paying and how the physician is compensated,

which is more likely to be either through a hospital or perhaps a very large physician staffing group.

I'm just wondering how we deal with that in terms of thinking about how the incentives ultimately affect the physician choices in primary care and the ultimate ability to obtain access.

MS. BLONIARZ: So I would say, you know, about ten years ago we did look at physician compensation, and even at that point, I think we were a little surprised by how RVU-dependent it still was, despite, you know, interest in that time in salaries and other forms of compensation.

I think that as the physician sector has -- you know, now it's a greater share of physicians are owned or have some financial arrangement with the hospital or health system. I think that that might be a little less true, but I think we also, you know, in some of our focus groups and site visits, are still surprised at how much is RVU-based versus -- or it's a salary plus productivity, which is RVUs, even though the structure may be, you know, employment or a joint venture or something like that.

DR. PERLIN: I hear you and agree with what you say. The mandate here is examining the relationship of

Medicare's payments to clinicians and the supply and quality of care. I think not in this report but further down the road, somewhere we're going to have to figure out how to contemplate this relationship given that the reimbursement has changed from being more direct to the physician or per practice versus the current, which is through some probably very large intermediary with probably, to be sure, productivity expectations. But, you know, I think this issue of primary care adequacy is going to be one that will challenge us.

Thanks.

DR. CROSSON: Okay. Thank you, Kate. You got some good input here. Thank you so much for doing this work.

We are finished with the work of the day. We now have an opportunity for public comment. If there's any one of our guests -- and thank you, the ones who stuck it out this long. If any of you would like to come up to the microphone and make a comment, now is the time to do that.

[Pause.]

DR. CROSSON: Okay. So we have one individual coming to the microphone. I'd ask you in a minute to

identify yourself and any organization or institution you are affiliated with. Please make your comments and limit them to two minutes. And when this light comes back on, the two minutes will have expired.

MS. EMMER: Very good. I'm Sue Emmer, and I'm representing the Council of Academic Family Medicine.

First of all, I want to thank you for your report on primary care and issues raised beyond loan repayment are very important to us. We're really interested in how best to use GME to promote primary care access and training. And in this regard, we really want to raise two issues.

The first is the issue of THCs, teaching health centers. That's not something that came up today, but it's a model that we think you should look at. It's not something that's paid for right now under Medicare, but it does allow for payment to institutions, which is something you talked about. So we think if you look at that and maybe -- the real problem in that right now is lack of funding. So if you could look at that as a model under Medicare, we think that would be a great solution.

And there's also the need to remove the disincentives within GME for training in rural areas. So

we think if we could look further into that, it would promote greater access in that area.

Thank you.

DR. CROSSON: Thank you for your comments.

Seeing no one else at the microphone, we are adjourned until 9 o'clock tomorrow morning.

[Whereupon, at 5:20 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, March 8, 2019.]

# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, March 8, 2019
9:00 a.m.

COMMISSIONERS PRESENT:

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

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P R O C E E D I N G S

[9:00 a.m.]

DR. CROSSON: Okay. Let's see if we can begin the morning session. Welcome, everybody. I'd like to welcome our guests. This is the Friday morning session. Today we're going to be focusing on post-acute care topics.

The first one will be a discussion about the potential to use episode-based payments in post-acute care, and Carol is here to do the presentation.

DR. CARTER: Good morning, everyone. Today we'll continue our discussion of a unified payment system for post-acute care, and our began on this in 2015 and resulted in a mandated report in the June report of 2016. Since then, we've taken up variety of issues that I'll review in a minute.

I'll present information today that you requested on a design for a prospective payment system that would establish payments for an episode of post-acute care, and I want to thank Brian O'Donnell for his help with these materials.

Just a reminder of the post-acute care landscape. Spending across the four settings -- that is, home health

care, skilled nursing facilities, inpatient rehab facilities, and long-term-care hospitals -- totaled almost $60 billion in 2017. 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. And there is limited evidence to guide placement decisions, so it is not that surprising that Medicare spending per capita varies more for post-acute care than for any other Medicare service.

Further complicating the picture is that there are setting-specific assessments and outcome measures, so the patients treated and the outcomes of the 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 distorts the benchmarks for MA and ACOs.

For those of you who were not here in 2016, we completed a mandated report on the recommended design features of a unified payment system for post-acute care. The unit of service was a stay, and we'll talk about that in a minute.

Payments would be based on the average cost of stays and would be adjusted using patient and stay characteristics such as a patient's age and their comorbidities. There would need to be a large adjustment for home health stays to reflect the setting's much lower costs. The design should include short-stay and high-cost outlier policies.

Based on our analysis of 8.9 million PAC stays in 2013, the Commission concluded that a unified payment system design using administrative data was feasible and could accurately predict the cost of stays for most of the 40 or so patient groups that we evaluated.

In terms of impacts, compared to current policy, payments under a stay-based PAC PPS would be redistributed considerably across patient conditions and decrease for patients who receive rehabilitation care that appears to be unrelated to their clinical characteristics. Payments would become more equitable across different patient conditions compared with current policy because the differences in profitability would be more uniform.

As a result, providers would have less financial incentive to prefer to treat certain types of patients and

avoid others. Payments would be redistributed across providers based on the mix of patients they treat. Because payments would decrease for high-cost providers that treat patients who are similar to those treated in lower-cost settings, the payments for them would decrease.

Since 2016, the Commission has discussed several other issues. To begin to pave the way for a unified payment system, the Secretary could begin to redistribute payments within each setting before a PAC PPS is implemented by blending PAC PPS payments with setting-specific payments. This would increase the equity of payments across different conditions by directing payments towards medically complex care.

This past fall, you discussed the need to align regulatory requirements across the different settings, and that information will be included in this year's June report.

To keep payments aligned with the cost of care, the Commission recommended that the aggregate level of payments be lowered by 5 percent when the PPS is implemented, and that revisions and rebasing would become part of the regular maintenance of the PPS. Last year, we

looked at payments for back-to-back, or sequential, PAC stays, and that discussion led to a request to examine episode-based design.

In our discussion of sequential PAC stays, we noted that a stay-based payment system does little to dampen fee-for-service incentives for volume or encourage providers to offer a continuum of care that would cut down on the transitions that some beneficiaries experience in the course of their treatment.

In contrast, an episode-based payment system would encourage providers to deliver an efficient mix of PAC and would also encourage institutional providers to offer a continuum of care. This would benefit beneficiaries by reducing the number of transitions that a patient may experience over their course of care. Such transitions are often disruptive for beneficiaries and put them at risk for poor handoffs.

Let's look at how a stay-based and an episode-based design differ.

All of our work to date on a unified PPS considered each PAC stay as an independent event, shown in the first row. If there are two back-to-back stays, such

as when an IRF patient is seen in an IRF and then transitions to a home health agency, there are two separate payments that are made.

Yet about a third of PAC stays are part of a sequence of care, where patients transition from one setting to another or extend their care, such as in back-to-back home health stays. In an episode-based design, a single payment would be made for the combination of stays that make up the episode of post-acute care. Note that the episodes that we'll be exploring include only post-acute care, and other services, such hospital or physician services, would not be included in the bundle.

To conduct this work, we used the same approach that we've used before, designing a payment system that would establish payments based on patient and stay characteristics. We started by updating the stay-based model using 2017 data to reflect more current costs and utilization.

Like the stay-based design, the episode design would include a home health adjuster given this setting's much lower costs, and, again, we used separate models to establish payments for routine and therapy care and non-

therapy ancillary services, such as drugs, because the benefits differ slightly across the settings. We kept payments budget-neutral to the current level of aggregate spending in 2017.

This time around, we changed the way we estimated routine costs to use readily available cost report and claims information. Thus, the design no longer relies on any data from CMS' post-acute-care demonstration. The stay-based designs are very consistent with what we've previously reported and are included in the paper.

Then we constructed episodes from individual PAC stays that are within seven days of each other. To evaluate the feasibility of an episode-based design, we focused on solo and pairs of stays that made up a little over two-thirds of PAC stays. The idea was if the results looked promising, we could expand our analysis to include episodes that span over a longer period of time, such as four or five sequential PAC stays.

We want the PPS to reflect differences in the cost to treat beneficiaries. I've listed on the slide the various factors we used to risk-adjust payments. It includes a patient's age and disability status, the primary

reason to treat, their comorbidities and risk score, medical complexity, cognitive status, and other disabilities such as difficulty swallowing. Note there are multiple factors aimed at capturing patient complexity without relying on functional assessment data. All of these factors use readily available information from claims and other administrative data.

An episode-based PAC PPS would establish accurate payments for most of the almost 40 patient groups we examined and would also increase the equity of payments across conditions. And you can see this on this slide by comparing the numbers in the columns.

Under current policy, seen on the left, payments are 12 percent higher than costs, and that's the payment-to-cost ratio up at the top. The ratios centered on 1.12, and you can see that the current ratios range from 1.01 to 1.2, indicating why providers prefer to treat some patients over others.

In contrast, look to the right-hand column, you can see the overall average is the same, but the range in payment-to-cost ratios is much narrower. The episode-based approach would redistribute payments, again, from the types

of care that include rehabilitation therapy that's not predicted by patients' clinical characteristics and moves Medicare payments to episodes for medical complex care needs. With a much narrower range in profitability, providers would have less incentive to selectively admit certain types of patients and avoid others.

But the picture is a little more complicated. When we look at payments and costs for episodes of different lengths, even for just these episodes that included solos and pairs of stays, we see that there would be considerable over- and underpayment.

We grouped episodes into those that only include home health care, those that only include institutional care, and a mix into three lengths -- relatively short, medium, and long -- based on the distributions of lengths of stay or, in the case of home health care, the number of visits. Here I've shown the results for the episodes that include only home health care and only institutional PAC. But the mixed stays, episodes, are in the paper. On the left are ratio of payments to costs under current policy, and on the right are what payments would be under an episode-based PAC PPS.

Compared with current policy, the range in payment-to-cost ratios under an episode design would be much wider. This is because episode-based payments are based on the average costs across all episodes -- short, medium, and long -- whereas the current policy, multiple stays trigger separate payments for each stay.

In an episode-based design, payments for short episodes, those circled in green, would be more than double their cost. And, conversely, episodes that are long, those circled in yellow, payments would be about three-quarters of their cost, with payment-to-cost ratios of 0.72 and 0.76.

One way to dampen the effects of an episode design would be to create a single outlier pool instead of separate pools for institutional and home health episodes. With a single pool, home health episodes would be much less likely to qualify for an outlier payment because of their lower costs, and costly long institutional PAC episodes would be more likely to qualify for an episode payment.

We compared outlier policies that include separate pools for home health and institutional PAC with a single, combined pool. With separate pools, fewer home

health episodes, even long ones, would qualify for outlier payments.

Conversely, the share of institutional PAC episodes qualifying for outlier payments, especially long ones, increases. Yet payments would remain out of alignment with the costs of the care. Short episodes would remain highly profitable, and long episodes would be unprofitable. So the takeaway here is that a single outlier pool helps but doesn't correct the problems that we're seeing with over- and underpayment associated with short and long stays.

So far our analysis has indicated that an episode-based payment design would create incentives for providers to furnish shorter episodes over longer ones. But the differences in the payment-to-cost ratios for long and short episodes reflect, to some extent, the differences in the patient characteristics. That is, the patients included in the "short" group are likely to be different from the patients included in the "long" group. And so this next analysis estimates the profitability of episodes of different lengths holding patient risk constant.

This table shows the average profit or loss for

the patient of average risk for episodes that include only home health or only institutional PAC.

In the first column, we see that the home health agency furnishing a short episode for the average risk patient would make about $2,300, while furnishing a long episode would incur losses of about $2,000.

In the second column, you see an institutional PAC provider furnishing a short episode would make about $11,600, but long episodes would incur a loss of about the same magnitude.

If past industry behavior is any guide, the large differences in profitability could influence provider behavior. Providers would have strong financial incentives to keep episodes short. If current practices include unnecessarily long PAC stays, shorter PAC episodes may simply be more efficient PAC. But an episode-based design could result in premature discharges. Providers would also have a strong financial incentive to avoid patients who are likely to need extended care and to withhold costly care within the episode. The decision to transfer the patient or to extend care would be more complicated -- and we walked through an example in the paper -- but could be

driven by financial considerations rather than what's best for the beneficiary.

So let's review where we've been. The Commission explored a stay-based design and, given the incentives for unnecessary post-acute care, we examined an episode-based design. Both models could establish accurate payments for patients with different clinical conditions. However, an episode-based design would result in substantial overpayment for short stays and underpayments for long ones. This could increase PAC efficiency, but it also might lead to patient selection and stinting on care for beneficiaries who require post-acute care for longer periods of time.

While fee-for-service in general encourages volume, we think that the risk of unnecessary episodes may be lower than the risk of unnecessary stays. Under either design, the decision to initiate PAC is not controlled by the PAC provider, but the decision to extend care is more under a provider's control. In a stay-based design, this could generate additional volume; whereas, in an episode-based design, this would be less true.

Compared with an episode-based design, a stay-

based one may result in more handoffs mostly between institutional providers, and this may expose beneficiaries to the risk of poorly coordinated care.

Both designs would streamline the current four separate payment systems into one and could lower CMS' administrative costs, but a stay-based design would be easier for CMS to implement and to administer.

Over the past four years, the Commission has evaluated stay-based and now episode-based designs, and both designs would establish more accurate and equitable payments compared with current policy, but each has its strengths and weaknesses. A stay-based design would continue to encourage unnecessary PAC services and may result in more handoffs between providers, but it would be less likely to result in patient selection and stinting on services.

Conversely, an episode-based approach has features that are, in theory, attractive -- like increasing PAC efficiency and lowering the number of transitions between PAC providers. But we're concerned that an episode-based design could result in unintended adverse consequences such as patient selection, withholding of

care, or decisions about whether to transfer the patient or to extend care being based on financial considerations rather than what's best for the beneficiary.

So we plan to include this information in the June chapter, and we look forward to your comments and suggestions. And we're particularly interested in gauging your preference for a stay-based versus an episode-based design.

DR. CROSSON: Thank you, Carol. Very excellent analysis and clear presentation. So we're open for clarifying questions. Brian.

DR. DeBUSK: First of all, great chapter and great work. I really like the analytic rigor. But I had a quick question, and this is really for my own clarification.

In the stay-based design, we have the dichotomous variable that made the adjustment for the fact that really home health isn't an institutional-based -- I mean, to me it's no different than the physician fee schedule, how you adjust for facility-based versus non-facility-based care.

When you went to the episode model, if I understand it correctly, instead of using the dichotomous

variable, what you really did was two adjusters -- one that would adjust to your taking it down if it's home health only, and then you were trying to do a blended -- like a dichotomous adjuster in case it was home health and an institutional blend. So it's sort of a -- it went from dichotomous to sort of a three-state variable. So that part I've got.

Was the issue -- and this is the clarifying question -- the fact that the transition -- you know, we were really trying to model something that was continuous as three steps? Because in theory, you know, the home health length could be relatively short, and then I could go to institution or I could be in home health for some time. Was that some of the analytic problems that we were trying to stretch something that is, at least in theory, continuous, you know, the handoff point, into three -- into basically three somewhat dichotomous variables?

DR. CARTER: We were really just trying to reflect the different levels of cost that would be included. If you have a mixed stay, you're going to have one -- one of those stays is going to be substantially lower cost than an institutional stay. And so if you don't

have an adjuster in there, those payments -- the predicted costs for those episodes is just going to be wildly off, and it's because part of that episode is home health care.

DR. DeBUSK: I think your approach was clever, insightful, and well executed. I was just curious if the challenge was the bucketing and the fact that -- I mean, there is no way to do a continuous variable there. I get it. You have to -- I think you did what had to be done. I was just curious if that's where the fit issues came up in the episode-based model.

DR. CARTER: I'd have to get back to you on that because I'm not sure I'm really following your question.

DR. DeBUSK: Okay.

DR. CARTER: I'm sorry.

DR. CROSSON: Okay. I have Paul and David and Kathy. Paul.

DR. PAUL GINSBURG: Yeah, you've done a really great job, Carol, in really dissecting what this is all about. And I think the big question that hangs over this is, you know, there's a fairly substantial degree of patient-to-patient variation here. And the question is always: Does that reflect different variation in patients'

needs? Or how much of it reflects the variation in efficiency of the providers of post-acute care? And I know there's not a simple answer, but your judgment on that would be very informative to me.

DR. CARTER: So our designs are relying on current practice, and so whatever effects you see are comparing to the incentives that are already built into the payment system.

There are a lot of back-to-back home health stays, and that's partly a reflection of the benefit. And so I don't know if that's unnecessary care. I wouldn't go that far. But it is what you see in the current practice.

If you move to an episode-based design, that might change. I think in skilled nursing, I mean, there's lots of evidence that those stays receive care that is not commensurate with patient need. And what we're seeing from the BPCI and CJR evaluations are the savings are because there's less PAC use, shorter SNF stays, and more patients shifting from SNF to home health. So I think there's some efficiencies there.

Did I say "efficiencies"? I mean "inefficiencies." Sorry.

DR. CROSSON: On this point, Jon? Oh, you just wanted -- okay. David.

DR. GRABOWSKI: Great. Thanks, Carol. This is great work, as always. I have two questions. The first one really builds off of Paul's question. Anytime you do an exercise like this, you just acknowledge it's really based on current practices, and so everything you're observing, the distributions of spending across the different sectors and utilization, it all goes back to the underlying incentives within these different systems.

And so I'm curious. SNFs are about to undergo this huge shift to the patient-driven payment model. How does that affect this kind of exercise where we're going from a very therapy-driven payment system with the RUGs right now to a much more condition-specific payment model, which is, by the way, very consistent with a lot of what you've advocated here. But I'm just curious. Would that change any of this, or how would this potentially change this kind of exercise?

DR. CARTER: So the home health is also staged to undergo a similar kind of transformation. I think some of the redirection of funds within each of those settings

towards medically complex care is going to be occurring with the changes in those payment systems. So when we see some -- some of the redistribution effects that we're seeing here with this kind of design will occur already with those designs, and so we're going to see smaller impacts.

And so you might say, well, so why bother? And I think the reason we would say you should still bother is we see similar patients treated in the different settings, and so we do want to align the payments across the settings when patients are the same treated in different settings. But some of the redistribution will occur because of the redesign -- and, you know, the LTCHs are undergoing transformation as well with their dual payment structure.

So all of that, when this goes to be implemented, some of the impacts I suspect are going to differ from what we show, and it's because whatever the current year that's used is sort of the baseline, we'll have incorporated some of those changes.

DR. GRABOWSKI: Great. My second question is around -- I really appreciated both the text that's summarized in Slide 14, just illustrating the tradeoffs

across the two approaches. And I think the big concern with the stay-based design is if you pay based on stays, you're going to get more stays, and the unnecessary volume. So I'm curious if you have thoughts about if you go to that model, how do we prevent those kind of continuous handoffs? And I don't think to date we've done a very good job with home health. You just suggested that. We've had a lot of these multiple home health episodes. How can we build in some checks? It seems like it's got to go beyond just certifying these additional stays. I don't know if you have thoughts there.

DR. CARTER: Yeah, I do. We've thought about this. And so one thing I think you could do is include a measure of spending in a value-based purchasing program so that when you are -- part of your performance is measured on your downstream spending that you've referred patients to next setting, for example, so that would be one thing, looking at Medicare spending as a performance measure.

I do wondering whether 2 percent is a big enough number given the margins in these sectors. I think you might want to take a larger value-based purchasing withhold and then reward performance based on that given the

financial performance.

We've had conversations here on how to improve the ACO program, so sort of a broader umbrella. How do you get entities to take responsibility and risk from broader definitions of care? This is just trying to improve efficiency of PAC, but we've got, you know, a bigger problem out there. And so kind of beefing up the ACO program would be another -- those are two ideas, anyway.

DR. CROSSON: Kathy.

MS. BUTO: So I was wondering, Carol -- and it may be in the paper but I didn't pick it up -- if you could say something about for the episodes with only home health care under your episode-based design and the episodes with only institutional -- the short, medium, and long stays, what's the distribution there? Did you in home health see much more short stay, medium? And institutional, were there more medium and long? I'm just curious about the distribution.

DR. CARTER: So we based those definitions on the distribution. We didn't say, oh, we think short means this and long means that, and so whatever it doesn't meet those criteria, the middle. We based short, medium, long on the

distributions. But the distributions were broad. I'm trying to remember, which is never a great idea, but I think the average number of visits in a home health short stay were like eight visits and then long were 45. So there's a big difference in the number of visits that are captured in a single episode. And that's just for these solos and pairs.

MS. BUTO: Right. And so you found that of the solos and pairs you looked at, there was a pretty even distribution of stays along that -- in those three categories? That's what I'm trying to get at there.

DR. CARTER: So we forced those definitions into those buckets.

MS. BUTO: Oh, okay.

DR. CARTER: If you're asking a different question of like, well, if you hadn't done that, what does the distribution look like --

MS. BUTO: What does it look like, right.

DR. CARTER: I'd have to get back to you on that.

MS. BUTO: And then the second question I had was -- because I like the idea of an episode-based payment for some of the reasons David mentioned. I'm wondering if

you've thought at all about are there some sort of acute-care discharges for, say, joint procedures or something like that where episode-based might make more sense. In other words, we might generally prefer stay-based, but that there are some conditions for which there are efficiencies and episode-based might make more sense. I don't know if you've gone that distance in thinking about it.

DR. CARTER: We haven't thought about that. I think mixing and matching would be pretty complicated to administer and maybe for a provider to know, oh, okay, this patient, I'm thinking about a stay, and then the next one an episode. But we haven't actually -- we haven't thought about that.

MS. BUTO: Yeah. I was thinking more about, you know, a provider for hip surgery or bypass surgery knowing that there's a bundle that includes post-acute versus their not knowing one way or the other. In other words, there would just be some surgeries, for example, that naturally included post-acute care in them rather than having a stay-based payment. But there may be so much variation in patients based on other factors that that's not really practical or fair.

DR. CARTER: Mm-hmm.

DR. CROSSON: Jon.

DR. PERLIN: Let me add to the kudos for a terrific chapter and really an exquisite presentation of it.

This is incredibly complex from a provider perspective. You know, this question is really about why certain inefficiencies occur. So there are multiple mechanisms of inefficiency you've identified that range from patient selection to more handoffs, more sites of care, to a higher level of care than is necessary.

What I'm really wondering is your perspective on how this will affect getting to the right level of care initially. And, you know, I say that from a very practical framework in the sense that sometimes the satisfying answer is what's available, not what's optimal.

Is there any way as you contemplate this that there would be design features that would help to accelerate really the optimal placement at the first of potentially multiple stays? Thanks.

DR. CARTER: I think that when we've talked about implementing this, we have talked about regulatory

alignment and moving towards patient-based regulations as opposed to what's the shingle on the door. So if you did that and let's say you were treating somebody who was on a vent or with high, really high therapy needs, not run-of-the-mill therapy needs, you would have to meet a different level of criteria in order to almost be licensed to provide that service. And if that were true, then if you were a patient in the hospital getting ready for discharge, you would have a list of providers that actually meet the conditions required to have almost the license to treat that type of patient. So I think actually think it could get better.

I also know that we've talked here about how to improve the discharge planning process and allowing discharge planners to not just provide a list but maybe make recommendations, but there's been disagreement about whether that's a good idea.

But I do think having sort of licensing by service -- and that sounds worse than what I mean, but just -- I mean, I see that as a way to make sure that the providers actually have the capability and skill mix to treat the patients that they're treating. So you all have

to meet some basic competence and equipment and staffing and training and all that stuff, but then if you go after patients with special care needs, you have to meet requirements that are specific to the capabilities needed to treat that patient.

DR. PERLIN: I think it's fundamentally a question of load balancing in some way. You know, what is the availability of a particular level of care on a particular day of discharge? It varies. So I think there's more work in just the vein you've identified of how you do the load balance to make sure that whatever capacities are available can actually be ratcheted up or ratcheted down to match appropriately with the clinical needs as opposed to sort of being forced into the peg of what happens to be available at the sort of window of discharge from acute settings.

DR. CARTER: Yeah, I do -- I mean, one of the advantages of a PAC, at least as we see it, is there is more flexibility across providers to be a broader range of what you want. So if you're an IRF but you actually want to treat more SNF-level patients, you would have that flexibility. And the converse would be true. High-end

SNFs could look and feel a lot like IRFs, but they're not licensed as IRFs right now, and they get different payments. If they wanted to go after a higher intensity patient mix, they could, as long as they met those criteria.

So it might be that the availability would actually get easier because there would be more flexibility. I don't know.

DR. CROSSON: Marge, are you on his point or separate?

MS. MARJORIE GINSBURG: I think I'm on his points [off microphone].

DR. CROSSON: Okay.

MS. MARJORIE GINSBURG: I want to back it up a little bit because I was very confused by the episode-based model. We've got four different vendors, and we assume they're not all being run by the same company. How do you divide the money? I can't figure out how, if we start off, it gets referred to a higher level of care to an IRF and then they need to go to home care after that. That's my first question, just what's the mechanism for sharing the pot?

And the second question is: Home health care, even though it's part of the continuum, is so much less expensive, the model is so different than institution-based. I had a hard time reconciling -- except for the stay-based, you know -- how that fits in with the others that are institution-based.

DR. CARTER: Well, your first questions, we've thought about that because it is complicated. You have a single episode. Now how are you going to divide up the payment? You could either -- CMS could apportion the payment based, let's say, on costs. So let's say there's a $10,000 episode, but the first provider really provided two-thirds of the cost of the care, and so they would get two-thirds of the payment, and CMS would do that in making payments, you know, in real time to the different providers, knowing that there's a max and it's the episode amount, so you could do that. You know, that's complicated. It's a back-office function CMS doesn't now have to do.

The other would be to pay the first provider and make that entity responsible. That one makes me nervous because we have a lot of small providers in this space, and

they don't have the ability to bear risk and really the administrative function to pull that off. So I'm not crazy about that idea.

MS. MARJORIE GINSBURG: Who's got control then [off microphone]?

DR. CROSSON: Marge?

MS. MARJORIE GINSBURG: Who's got control then of deciding that the patient needs to go from one PAC to another?

DR. CARTER: Well, I mean, that's true now, right? If you're a patient that's in a SNF or an IRF, and the patient no longer needs that level of care, then you refer a patient to home health care. And this wouldn't be different than what currently goes on when you no longer need -- I mean, most beneficiaries want to go home, and so it's trying to get patients strong enough to be able to maneuver at home. So I don't see that as really different than what's going on now.

DR. CROSSON: Dana, Jonathan, and Warner.

DR. SAFRAN: Beautiful piece of work, Carol. I have two questions.

One, it might be helpful to put back up Slide 14.

One of the things that you emphasize as a potential advantage is that this model would be less volume inducing than a stay-based model, and I just want to push on a couple of assumptions there.

One is with the information you've shared with us about how advantageous financially a shorter stay is. I just wonder whether you did any modeling or sensitivity analyses that would look at how -- whether if you're inducing short stay and then people are bouncing back, you know, I just wonder how you considered that.

And also with respect to the assumption about potentially less volume, I wonder about -- I'm not very knowledgeable about how much the PAC providers are affiliated with hospital providers, but since that's oftentimes going to be the source, I wondered whether, you know, having this model could, in fact, be volume producing because it's a separate stay from the hospital but the hospital has an interest and the PAC provider has an interest in the volume there.

So those two questions about the volume assumption, and then I have a question about the assumption on handoffs, care coordination.

DR. CARTER: Okay. So right now there's just as much incentive for volume as under any of these designs, right? So whatever financial arrangements are encouraging or discouraging or neutral about referring patients to PAC, that's the landscape we're in.

If one of the things you need to think about is with larger dollars at stake with an episode, does that induce volume, right? And right now we're just -- with a stay, it could be it's a smaller bundle and there are fewer dollars. Do you think that there would be more incentive with a larger pot of money, if you will? I don't know. I guess the only thing that I am thinking is right now there is no disincentive for encouraging patients to PAC.

We haven't done any sensitivity analysis, but I understand what you're asking about, but we didn't do that, just to see what might happen.

DR. SAFRAN: And then this is sort of related to that question, but I thought in the reading materials, on Table 2, the data were really interesting, the distribution of the solo and pairs, and I was surprised how much is solo, how much is just home health --

DR. CARTER: Oh, yeah.

DR. SAFRAN: And so getting close to two-thirds that are just solo, and so -- and if you add into that the one pair of home health/home health, you're up to 83 percent. So that made me wonder, too, about a point of sensitivity around the seven days, right? So the question was, again, because of this financial incentive for short stays, could we either end up with folks who say, well, you know, let me move this patient on to some other provider so that, you know, I have a shorter stay that's -- you know, that portion of the payment is more advantageous to me. And that might tape a little bit into Marge's question of how would CMS apportion the money across.

But it also made me think about how often a provider would say, well, seven days is not very long, and so if this patient is discharged soon and comes back in eight or more days, you know, I'm up for another episode.

DR. CARTER: Right.

DR. SAFRAN: So I just was curious about your thinking on those possibilities that could undercut the value that you rightly point to related to better coordination and better handoff.

DR. CARTER: Well, we picked seven days really

because of home health. If we were just looking at institutional, we would have made that a much narrower window, because most of those transfers happen the same day. But home health, you know, I was thinking, we were thinking somebody could be ready for discharge, but then it takes a while for a home health person to actually come to the patient's home. And so you might shorten the window, but you need to have, I think, some gap because those transfers don't have -- the patient goes home, but home health doesn't necessarily happen that same day. So you need some kind of gap in there. And it is true, if you had a smaller window, you'd see more stays, and you'd probably see more needing to glue together more things, more individual stays.

We didn't do any sensitivity analysis about what would this whole thing look like if we used three days or something like that, if that was part of your question.

DR. SAFRAN: [off microphone].

DR. CROSSON: Jonathan.

DR. JAFFERY: So thanks, Carol. This is great and I really appreciate the summaries, in particular, about the different maybe strengths and weaknesses or concerns.

So I think, you know, one of the things that you called out is in the episode-based design there may be some incentives or pushes for organizations to create more of a comprehensive approach to delivering PAC services across the spectrum and sort of developing, I guess, even new entities that would do all that. There's something about that that feels appealing to me, like it could create some benefits for beneficiaries and for the program.

I guess what I'm really struggling with is that we're not -- I'm trying to decide whether state-based or episode-based is better. We're not just dealing with trying to compare the pros and cons of each one but also so many unknowns about unintended consequences in each of them. And so it creates this matrix for me that's just hard to - not only can I not have to weigh what's going to be better if this happens but I don't even know if it's going to happen.

So my question is, have you thought about or conceived of, would it be feasible to think about testing a couple of different versions of payment systems in different parts of the country. I mean, I know you're probably, you know, groaning about the administrative

complexity that you talked about a minute ago. But, you know, there are so unknowns here.

DR. CARTER: Well, we sort of have that with BPCI and CJR, right. We have time-limited bundles. It's true that they're different than these. They're broader bundles. They include hospital care and physician care. And so we are testing that in different parts of the country.

You could go with a pilot. I mean, my worry about pilots is they sort of take a long time and you don't -- I guess I just worry about their value.

DR. JAFFERY: Yeah, I mean, there's no question that there's plenty of downsides to that. There are just so many unknowns that I'm --

DR. CARTER: Yeah, well, and that --

DR. JAFFERY: -- and then you add to that the --

DR. CARTER: -- in the end, leads me towards going with -- personally, if you woke me up in the middle of the night. You know, a stay-based design is more like what we have, and so there are fewer unknowns than going to an episode where you're asking for a whole different level of risk to be assumed.

DR. JAFFERY: So I guess that's sort of an add-on question, is if you went to a stay-based design and did that for a period of time would that preclude you from them having it be a transition towards an episode-based design later on, once we saw some of the impacts, and would that be an easier transition than going the other way around?

DR. CARTER: You know, it's funny. We talked about that last week, and yes, I mean, it would be a good transition. Providers would learn how to deal with a single payment, right, across the settings. I think a lot of what they would need to learn they would be encouraged to learn under a stay-based design. So you could move towards that. Then you do have the administrative complexities of who gets the money and how do you divide it. But, you know, those are things that we could figure out. But, yeah, you could start with one and move to the other.

DR. CROSSON: I've got Warner and then Jon and then Jaewon and Karen.

MR. THOMAS: Carol, thanks for the great work on the chapter. A couple of questions, I guess one going to an earlier comment where you're talking about, you know,

providers being able to recommend or direct patients. I mean, where does that fit into this model? I mean -- and would that be part of the recommendation of this model to be able to loosen some of those restrictions so that there would be more ability to direct to organizations that, you know, have known quality metrics, known utilization? Any thoughts on that?

DR. CARTER: So we did have a conversation about this, was it last year?

DR. MATHEWS: Yeah. Do you want to take this or do you want me to?

DR. CARTER: So, well, I'll start and then I'll probably not quite get it right.

So we had a conversation about whether discharge planners could recommend, and what would that mean, and what information would a hospital need to use in basing that decision. But there wasn't agreement around the table about whether that was good and what it would look like. And so we did have a chapter that sort of talked through how important this was but didn't land with a conclusion about, yep, we should do this.

I do think that licensing by -- I mean, keep

using that word and it isn't quite the right word, but if providers had to have licensure for different levels of service that would help, because if you were a hospital trying to place somebody you couldn't place them in a facility that wasn't licensed to treat that type of patient. So that might help.

And I guess that's all I -- do you want to --

DR. MATHEWS: Let me try and jump in here.

DR. CARTER: Yeah.

DR. MATHEWS: Everything Carol said is correct about our conversations about giving acute care hospitals the ability to direct patients to post-acute care settings that have a certain track record with respect to quality outcomes, that kind of thing. But all of the work that we have been doing over the last several years, with respect to the unified PAC PPS, is independent from and separable from that particular decision. So as we've been developing the most recent iteration of this work we have not contemplated the referral idea as an integral part of what we're talking about now.

MR. THOMAS: Okay. Thank you. We'll come back to that, I guess, in Round 2.

My second question is just around looking at ACO or certainly successful ACO entities and their data in post-acute versus the general. Are you seeing, you know, kind of any differential there that would lead you to different conclusions or a different approach of how you think about the unified PAC in this proposal, in general? I mean, it seems as though -- and I guess is there any difference in post-acute utilization in ACOs versus kind of the general Medicare population?

DR. CARTER: My understanding from the ACO results is that a lot of their savings are coming from post-acute care, either by shortening the SNF stays or by shifting patients from SNF to home health. And so if you were to move to this, some of those savings would be scooped up in the payment system. And so those two things can coexist but it is true that the savings would accrue differently.

MR. THOMAS: Okay. So I guess, do we have data kind of that's available that would help us consider this proposal as far as what the changes -- what the potential changes could be in post-acute care, especially in a more managed environment?

DR. CARTER: We can think about that. I mean, I think the ACO folks are actually looking at that as one of their projects, is specifically how do they use PAC differently. And I think that's something on, you know, a longer time frame. There's, you know, grinding through data issues at this point. But that is exactly one of the things we're asking ourselves.

MR. THOMAS: Okay. Thanks.

DR. CROSSON: Jon.

DR. CHRISTIANSON: So most of the time when we are talking about payment we talk about it in the value-based framework connected to quality indicators. This discussion is kind of divorced from that. If we introduced some sort of portion of the payment connected to quality-based indicators for post-acute care would that change the way that we would think about the plusses and minuses of these two approaches?

DR. CARTER: I don't think it would make me think about these differently. I think it's a way to incent thing and that would be irrespective of the design. We've talked, in the past, about a PAC value-based purchasing and needing to have the same one across the four settings, and

it should be not just one measure but multiple measures and a measure of resource use and quality measures like readmissions or admission, readmission measure and discharge to community, things like that.

I do think a VBP, as I said before, can dampen a volume incentive and that would apply to either design. If you wanted a measure of care coordination you could do things like how long did it take once you discharged the patient to actually see a physician. I mean, I think there are indicators of each of these where we could try to encourage providers to do -- have different behavior and create what we think of as the right incentives for providers, but they would affect either design.

DR. CHRISTIANSON: What about the concern about withholding of care under the episode-based model? Would that be less of a concern if we had a good value-based payment model?

DR. CARTER: Yes. And so do things like measures of readmission or potentially avoidable admissions or ED visits would tell me that providers -- those would be decent, I think, indicators. They're gross but they would be a good start towards looking at that.

DR. CHRISTIANSON: So that is one area where if we thought about this expanded the way we think about this, to think about it in a value-based design, we might weigh things a little differently between the two?

DR. CARTER: Oh, I see what you're saying. Yeah, they would affect both of the things, but it might incent -- more likely it might be qualified because you have a value-based purchasing policy on top of that. So even though one design might encourage or discourage something you at least are trying to tap that down or amp it up with a value-based purchasing policy.

DR. CHRISTIANSON: And would -- just the way you think about it, would you even think about either one of these two designs without some sort of a value-based component to it?

DR. CARTER: I think you need to do both at the same time.

DR. CROSSON: Jaewon.

DR. RYU: Yeah, I had a similar question, just on the volume incentive and how to dampen it, and I think Dave touched on it, as did Dana. But you had mentioned under the stay-based, you know, you could introduce something

like a measure of spending element to try to dampen that volume.

Any thought on almost like a readmission to any PAC setting, and maybe seven days isn't out far enough. Maybe it's within 30 days or something like that. I guess my question would be how feasible, and would that truly dampen, you know, either the handoffs or the volume aspect under the stay-based. And I think if it does, and I'd kind of go where Jon's going, where I think the plusses and minuses might weigh out differently.

DR. CARTER: I'm not quite sure -- I didn't catch your example of the seven day. That's a seven day for what?

DR. RYU: Yeah, I was just saying, you know, seven days may be too short of a window, but if you, yeah, like a --

DR. CARTER: Yeah.

DR. RYU: -- like a readmission into any PAC setting, 30 days out, let's say, if that was your quality measure it seems like that could help address the volume incentive.

DR. CARTER: Right, as long as there was enough

risk and reward for having a high performance, that's right. Yeah.

DR. RYU: But is that feasible to collect and would that be administratively pretty --

DR. CARTER: No, I think that's --

DR. RYU: -- is it heavy lifting? Is it --

DR. CARTER: -- straightforward.

DR. RYU: Okay.

DR. CARTER: Yeah.

DR. CROSSON: Karen.

DR. DeSALVO: Carol, can you share with me how the risk model accounts for some of the social drivers and social determinants? It may be embedded in some of the scores. But this seems like an area that's particularly sensitive to people's housing situation and social support, and so I would love to hear more about how you've already been able to incorporate that.

DR. CARTER: Right now our model doesn't look at those things. So if they're not picked up in comorbidities or impairments or disabilities we haven't captured that.

One thing we did look at, not this time around but back in '16, the IRF payment system has a kind of -- I

think of it as a DSH payment. It's called something different. And when we looked at whether you would continue to need that, you know, it wasn't a slam dunk but it looked like maybe. But we do think that you would want to have that policy for all the settings. It doesn't make sense to have it for one. You would want to do it for everything. And we didn't model that but that would be the one thing that we have looked at.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: Carol, the analysis you've presented was at the beneficiary level, so you showed with the two, three systems the impact for a beneficiary as to how much the provider would be paid compared to in different situations. Have you done this analysis at the facility level? So that, in a sense, where the patients were kind of randomly distributed and it would probably look, particularly for larger facilities, much more benign. But probably that's not random.

DR. CARTER: Oh, we have done the impacts by provider type and ownership and at least one of the tables -- I'm looking at Table 4 -- shows the provider type. And I can include in the -- in Table 3 -- it just was getting

really long. But we have its brother for the provider characteristics, and it moves money in the way that we've found before. It moves money from for-profits to nonprofits and from freestanding to hospital-based.

DR. PAUL GINSBURG: One other aspect. Just as the individual provider level, what kind of distribution you find as far as, you know, are these going to be gigantic gains and losses at the individual provider level or much less so?

DR. CARTER: So we didn't look at that this time but we did back in '16. We did a lot of -- or maybe it was '17. We looked at the distributional analysis because of providers and their provider, and some provider -- there was a wide distribution of impacts, which led the Commission to a recommended three-year transition as one way to soften that.

DR. MATHEWS: But we've also made a deliberate effort to focus more on the impacts by patient condition. We're trying to bring more rationality to the way Medicare pays for post-acute care and mitigate the incentives to select some patients and avoid others that are embedded in the current for-payment system. So we fully expect that

there will be some potentially significant impacts for any given individual provider, but the goal here is to make the system much more rational from the patient's perspective and from the program's perspective.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: Is the problem -- or maybe I should ask which is the larger of the issues -- that patients are being referred to PACs that are inappropriate for their needs or is the problem that where they end up is simply providing more care than is needed, and that's what's driving their profits?

DR. CARTER: We saw redistributions of both types. So when we look at, say, the impacts on IRFs, one of the reasons why their payments go down is a lot of their patients are similarly treated in SNFs, which add a much lower cost. So we did see that kind of distribution between setting, because lower-cost settings treat many of the -- not always, but many of the same types of patients. So you do see that.

We also saw redistributions more along the lines of what you were suggesting, which is, you know, for example, a lot of SNFs provide what look like unnecessary

therapy care. And so if you're a provider that's tended to have that kind of therapy practice you're going to see a reduction in your payments because we don't predict those costs -- the characteristics of those patients don't predict those kinds of payments. And so if you're a provider that's had that kind of therapy practice you're going to see larger impacts. So it's both.

MS. MARJORIE GINSBURG: So right now does CMS do retrospective chart reviews, if you will, to verify that the patient was appropriate for this level of care, that the care they got was absolutely necessary? Or how do you reconcile inappropriate care in a financially meaningful way that hopefully will dampen overuse in the future, or do you?

DR. CARTER: CMS does very little auditing. Some of the information that we've had actually comes from the Justice Department and OIG that have done extensive studies of -- I'm more familiar with the SNF space. There have been multiple cases settled because of inappropriate, unnecessary care that's been provided to beneficiaries. So it's more those arms as opposed to CMS. But you're right, it would take medical record review and that's expensive

and it doesn't happen very often.

DR. CROSSON: Jon.

DR. PERLIN: On this point, just a practical reality that really gets back to my earlier question of how these systems will help in terms of load balancing. If you have a patient who is in acute care and needs to go to a SNF, and really is not stable for home health, needs that sort of support, you can make the choice, if you can't find a SNF bed, to go to an IRF, because the patient would be safe there, but you can't say "I'm just going to send the patient to home health." And so there's just an inherent challenge there where the patients end up, frequently, at a level of care higher than is necessary because of the resources available.

And, you know, I would look -- and this is why, back to Jon and others' thread of questions on sort of quality metrics and this issue of load, what other mechanisms would help in either of the systems in terms of either doing the load balancing or amongst similar entrants in the same level of care, identifying those that had, you know, higher performance. You know, parenthetically. I mean, you could have a four-star in a lower-performing

market that actually is better than a two-star -- I'm sorry. Yeah, a four-star in a lower-performing market that is worse than a two-star in a higher-performing market. And, you know, just not an adequate sort of way to triage the patient. So got to figure that piece out on both load and performance.

DR. CROSSON: Okay. Carol, could you put up the last slide?

So we're going to have a discussion now, and I think it would be helpful to Carol and the rest of the staff to give us a direction here, which direction we want to go in. So I'm going to ask David to start, and then, you know, weigh in. It's complicated, but which direction do you think we should go?

DR. GRABOWSKI: Great. Thanks, Jay.

Once again, Carol, great work. I really appreciate this, although I don't know if I should be saying "thank you" or "I'm sorry." I was one of the Commissioners that really pushed you down this road toward modeling this.

[Laughter.]

DR. GRABOWSKI: I think I helped make a

complicated issue even more complicated. But I do think we learned a lot here, and in particular, I was very concerned, as I suggested earlier, about the volume effects, and that if we pay by stay, we're going to get lots more stays. And so that's what really led me to think about an episode-based payment.

You did a really nice job in the chapter and in the presentation illustrating why in theory the episode-based payment system makes a lot of sense in practice. It's a little bit more complicated than that. Jon, I don't think I can repeat the Yogi Berra quote from yesterday, so I won't try. But, you know, theory and practice don't always link up.

And so, Jay, to answer the question, I think I'm favoring the stay-based design largely because I think it guards against some of the unintended adverse consequences like patient selection, withholding of care, basing decisions to transfer extend care on financial considerations that Carol outlined on Slide 15. I think I come down on the side of protecting the beneficiary here.

I did want to make several points, however. If we go this stay-based route, I think two important checks

need to be built into the system. The first is that although we won't have this incentive to stint at the episode level, there's still this incentive to stint within each of the stays. And so, for example, we're changing how we pay skilled nursing facilities from a per diem to a stay-based payment. If you go that route, there will be some sort of threshold, I imagine, you know, do they have this incentive right after they get past that threshold to then discharge the patient home? I think we really -- we want to make certain that those quality measures, that accountability is built into the system such that there's not this kind of stinting within a particular stay.

Then the second issue that will be really important to address is just this incentive to continue to create stays to get additional payments, and it's related, obviously, to the first stinting in that I end the stay early and send you to the next site of care from a SNF, for example, to a home health agency.

You had some great ideas earlier about how to build in some quality measures like Medicare spending per beneficiary. How do we build in other checks? Because I don't think we've done a good job to date in addressing

some of the multiple, for example, home health episodes that occur under the current payment system. I think we need to do better under this system.

A final comment, and this came up in a lot of the Commissioners' questions, is around value-based payment. Jon Perlin asked a great question around, well, how do we think about that initial site of care and whether or not it's appropriate? And I really think that's something that value-based payment is doing a really good job of addressing right now, at least the ACOs and thinking about not just limiting post-acute care use, but also thinking about kind of selection into a particular post-acute care setting. So I think this site-neutral payment has to be part of a bigger value-based payment approach, and I think both fitting this into ACOs will be really important as a first comment.

Second -- and this goes to Jon Christianson's comments around quality -- we need to pair this with really strong quality measurements, regardless of whether we go to stay-based or episode-based. But under a stay-based approach, building in a lot of those quality metrics and really strengthening post-acute care measures that work

across the different settings, I think right now we have the SNF value-based purchasing program. That's pretty limited. It's a single measure of readmissions. I don't think we've really built this out the way we've built out some of the other value-based payment programs for hospitals and other sectors.

A final point there is that we need to fit this into existing value-based payment models like ACOs, and we need to build a richer set of quality measures.

Thank you.

DR. CROSSON: Okay. Comments? Kathy, Brian, Warner.

MS. BUTO: So I would support beginning with the stay-based design. However, I also recognize -- and I guess it was really emphasized in some of the comments -- that an episode-based approach has some real value in creating a different incentive in the system. And so what I would really like to say is -- and I think it was Jonathan who brought this up -- that although stay-based would be the initial step, I would really love to see some work be done on creating episode-based bundles that could be managed by the hospital for particular procedures that

are done frequently in Medicare where we think there are savings in the post-acute area, but the hospital has accountability for readmissions. So I think that's one source.

I actually think as we move to the ACO -- and I think somebody made the point. I think you made the point, Carol, that a lot of the savings ACOs have achieved are in the post-acute area. So, again, for selected services, again Round 1 or Phase 2, if the ACO could have more accountability for determining how to manage that episode-based payment, I think that might be a way to go. I don't think we're ready to do that, so I think stay-based makes a lot of sense with a lot of the parameters that David laid out.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, as always, thank you. Excellent work. I want to be the second to apologize, with David pushing episodes and I was pushing episodes as well. I'm sorry.

[Laughter.]

DR. DeBUSK: But what I want to focus on is specifically Slide 16. You know, there are really two

dimensions to this issue. There's this philosophical issue around stays versus episodes. And then there's the mathematical issue, and I'm going to focus on the latter.

Your treatment on page 34 -- I guess that was an appendix or a text box -- where you talked about your analytic methods, you know, I was curious on how you would handle things like the home health adjuster, and I think adding the second one for blended -- there was a lot of rigor and thoroughness, and it was a well-thought-out approach to how you did the episodes and how you did the stays. Again, I want to congratulate you on that.

I was convinced -- I mean, after looking at it, I don't think mathematically episodes are practical or achievable right now. That doesn't mean we couldn't do them in the future. I really liked in the text -- I think on page 4 you referred to episodes as "theoretically pleasing."

[Laughter.]

DR. DeBUSK: I really enjoyed that comment. So my one contribution to this work would probably be that they are theoretically pleasing and mathematically unavailable at this time.

[Laughter.]

DR. DeBUSK: So I will refrain from the philosophical argument because until the math demonstrates that it's even possible, I'm not sure that we can go that dimension in that direction, anyway.

Thank you.

DR. CROSSON: So I would sum that up as theoretically exciting. Does that make sense?

[Laughter.]

DR. CROSSON: And, by the way, no more sitting together. Warner.

MR. THOMAS: So I agree, I think we ought to just stay with the stay-based design. A couple of comments, though.

I do think we should take this concept of the direction of patients back up. I think it's an important concept. I think we need to, with the appropriate information, guide patients to organizations that have higher and better quality measures and have better integration to the overall system. So I would encourage us to take that up again, because I think that's an important concept.

I also want to build off of one of Jonathan's points on the level of care. I think the reason we see people that gravitate into a higher level of care is because the economic model in skilled nursing is not really that effective. I think that's something we ought to be looking at. I think if there was a different economic model there, I think you'd see people use skilled nursing more than you'd see more skilled nursing beds. I think, you know, you've seen a plethora of skilled nursing beds basically go away over the past decade. They may come back now with ACO models, but I think that's been a big challenge.

I also would encourage us to not focus as much time and energy on reconstructing the post-acute reimbursement and put more time and energy in constructing the ACO model and creating the right incentive for the delivery system to get the patients to the right level of care and to manage it more effectively. I think we've seen initial results from the ACO, that they've done a good job there in managing that area. I think just to continue to reconfigure the payment mechanisms and the various areas of post-acute, I think this is a good chapter. But I think it

also identified that this is complicated, and it's probably going to be hard to have a policy or an approach that's going to essentially legislate or policy the solution. I think the care delivery system needs to drive the solution based upon what's best for that patient and create the right incentives for the whole entire delivery system versus each individual component of post-acute care.

So I would encourage us to spend our time going down that road versus trying to reconfigure the different components of post-acute care.

Then going back to Jaewon's comment on readmission penalties, you know, there really is -- there are no penalties in the post-acute area if they're not doing a good job and people bounce back into the acute-care world. And I do think having some or more robust penalties around, you know, value-based incentives in that area are important to get them incented to work together and also get them incented to work more directly with the acute-care portion of the delivery system to do a better job of coordinating care across the whole continuum.

So I would encourage us to put more of our efforts in some of those areas versus in the episode-based

design.

DR. CROSSON: Bruce, I saw your hand, then Paul, then Dana.

MR. PYENSON: Thank you very much. I support the stay-based approach, and one area that I think we might -- after this area is closed, if we wanted to explore further, we might look into the practice pattern variations that lead to the regional variations in PAC use. What I've observed in Medicare data is that the regions with high inpatient utilization also have high SNF utilization and also high home health utilization. So the drivers of that seem to be a system of practice, and I think it's great to move to better and fairer and more equitable reimbursement structures. But to understand the drivers of our utilization as something that's not inherent in the walls of the SNF or in the home health agency, but something perhaps that's on a bigger, more comprehensive basis. I think if we do that we'll -- that's for the future. If we decide to do it, I would prefer going in that direction rather than trying to develop quality metrics, which I think other organizations are very capable of doing in -- very necessary, but there's a number of outstanding quality

organizations that could explore what should be measured and how to do it.

So, overall, thank you very much for that. I think in retrospect, I think one of the questions I have or thoughts I have about an episode-based system is that episodes should probably be based on patients rather than site, and especially if the patient has a condition or that's perhaps a more sound basis for an episode, than saying here's a patient with a condition and happens to find themselves in a particular site.

So I think that's perhaps the reason why the inpatient DRG system actually has worked well, because it's on a more patient condition kind of focus. So just some thoughts there. So I disagree with Brian. I don't think this is intellectually interesting.

[Laughter.]

DR. CROSSON: Okay. Paul?

DR. PAUL GINSBURG: Yes, I agree with the perspective that at this point we should be going with a stay-based model. I think we can say that, you know, the combination of the evidence of extensive overuse in post-acute care and high rates of profitability creates a very

favorable environment for moving in this direction.

I suggest that we also say that, you know, a long-term goal or aspiration would be moving to episode-based payments, and pointing out how the experience with using stay-based will put us in a better position to move forward down the road, and that we should be thinking about getting prepared to move to an episode-based approach down the road.

DR. CROSSON: Thank you, Paul. Dana.

DR. SAFRAN: So I similarly support moving in the direction in the near term of stay-based approach and really support the point that Jon highlighted for us about needing to pair this with a robust quality measure set that has incentives attached to it.

I really like the point about how ACOs figure in here, and I think we've talked now and we're clear about how they figure in with respect to tamping down what could have been an individual for unnecessary volume, because I think we've seen in the ACO program -- and it's been referenced a few times today -- how, you know, hospitals in particular have become much smarter purchasers of post-acute care. So I think they'll be looking for post-acute

care settings that are good partners, as they are today, and those that don't take advantage by driving up volume will be part of that.

I also think that could help us with tamping down the incentive around increased handoffs that you point to as a possible downside of the stays, because I think hospitals will be looking for that, too.

So I think all in all, you know, we have a good mechanism in place to manage the potential downsides of stay-based, and that's a good direction to go while still exploring episodes to see if they would have value.

The one other thing I'll just put out there as something to consider is potentially having something built into our hospital value-based incentive program on the next round that holds a hospital accountable for the quality and performance in general of the post-acute care settings that they use. We found that really effective in my work at Blue Cross where were holding physician organizations accountable for the quality of the hospitals that they used, and it really created some pretty interesting shifts in referral patterns. So I think a similar dynamic could get created if you create some accountability on the

hospital side for who they're referring to for post-acute care.

DR. CROSSON: I wonder -- I don't disagree with that. I wonder if that then is tied into the issue that Warner brought up about, you know, the flexibility that hospitals have in terms of how they direct patient, which is another issue I think we need to come back to.

DR. SAFRAN: Yeah.

DR. CROSSON: Okay. Sue.

MS. THOMPSON: I'll be quick. I just want to underscore the opportunity I think we have uniquely to build on what we're learning in the ACOs, because I think we have access to ACOs who have indeed done what you articulated, Carol, and that is to see a reduction not only in the PMPM but in the quality scores as a result of doing just what you are describing, Dana, and that is building a network of post-acute providers who do meet the quality measures and deliver care based upon the network criteria. So there's just a lot to learn there that I think really will help us take the next step in this discussion. But, Carol, thank you. Great work.

DR. CROSSON: Jonathan.

DR. JAFFERY: A very quick follow-up to that. I agree with everything that has been said so far, and just to add, as we start to look at that and learn -- see what we can learn about what current ACOs have done in terms of partnering with post-acute entities, maybe making sure that we also try and figure out how different organizations have done different kinds of gain-sharing with those organizations, how they fit into -- you know, allowed some of those post-acute care settings to get back some of the shared savings and whether or not that has been an effective thing.

DR. CROSSON: Okay. Thank you very much. Good discussion. I think we have a direction, and I think we've had some additional thoughts which will be very helpful in rounding out the material that's finally prepared.

Carol, thank you once again for excellent work.

[Pause.]

DR. CROSSON: Okay. I think we're ready to move on to our final presentation for the March meeting, and that is going to be, I think what will be a final presentation of material for our mandated report on the impact of the dual-payment rate structure for long-term

care hospitals. And we've got Stephanie and Emma here, and Emma is going to begin. Thank you.

MS. ACHOLA: Good morning, today we will present the penultimate draft of the Commission's response to the Congressional mandate on changes in post-acute care and hospice services following the implementation of the dual payment rate structure for long-term care hospitals. Our objective today is to receive any final comments you may have since we will be publishing this information as a chapter in our June 2019 report to the Congress.

As you recall, we have discussed this topic several times over the course of this work cycle. In September, we discussed background information on the LTCH sector and provided you with the context for the mandate. In November, we presented our initial findings for the report, and we also provided information regarding payment adequacy in the LTCH sector in December and January.

Given the extent that we have previously discussed this material, our plan for today is to briefly review the payment changes made under the Pathway for SGR Reform Act of 2013, provide an overview of the mandate, present updated analyses through 2017, and finalize the

report for inclusion in the June 2019 report. Additional details regarding background and context were included in your mailing materials.

As you'll recall, The Pathway for SGR Reform Act established a dual-payment rate structure and therefore established patient-level criteria that determine payment levels. Cases that meet these criteria are paid the standard long-term care hospital prospective payment system rate, while those that do not meet the criteria are paid a lower site-neutral rate. The criteria for the standard LTCH PPS rate are as follows: patients must have an immediately preceding acute care hospital discharge and either spent three or more days in the ICU of the referring acute care hospital or receive prolonged mechanical ventilation in the LTCH.

Given the extent of this payment change, the Congress mandated that MedPAC examine the effects of the dual-payment rate structure on the growth in Medicare spending for services in LTCHs, different types of long-term care hospitals, the quality of care provided in LTCHs, and the use of post-acute and hospice care. The mandate further requested that the Commission assess the continued

need to apply the 25 percent threshold rule. However, CMS eliminated this rule in fiscal year 2019.

Now I will walk you through our approach to meeting the Commission's mandate. As you'll recall, we conducted a multi-pronged approach including a quantitative analysis of administrative data using claims and cost report data, and the provider of services file. We augmented this administrative data with information collected from site visits and telephone calls with LTCHs, referring acute care hospitals and skilled nursing facilities. We conducted site visits at 19 facilities in six states. Finally, we are also conducted telephone interviews with acute care hospital representatives in three additional markets.

We faced several analytic challenges in carrying out this work. First, because the dual payment rate policy is being phased-in over a four-year period, the policy is still only 50 percent implemented and our analyses will reflect this partial policy phase-in. Next, LTCH spending, use, and margins began to decrease prior to the implementation of the dual-payment rate structure, so we compared the rate of change in the years prior to the

policy implementation and the years after.

Lastly, LTCHs have relatively low volume of cases compared with the close to 5 million PAC admissions and episodes and 1.4 million hospice users. Therefore, it will be difficult to detect changes in the use of other PAC providers in the aggregate.

For certain analyses we focus on certain acute care hospital diagnoses that are more likely to be discharged to an LTCH and certain market areas based on their historical use of LTCHs. However, we urge caution in interpreting the data to attribute such changes to the implementation of the dual-payment rate structure given the limited time frame of the available data.

So starting with our interviews and sites visits. Generally, all of the facilities we spoke with reported the need to make operational changes in response to the implementation of the dual-payment rate structure. The degree to which these changes occurred varied facility to facility. Facilities that stopped admitting patients not meeting the criteria explained that payments under the blended rate were not adequate to cover their costs, and that focusing on cases that met criteria provided clear

guidance to referral sources. Interviewees stated their facilities expanded their referral regions and educated physicians and case managers in the acute care hospital on the LTCHs capabilities.

In contrast, some LTCHs interviewed continued to admit cases that did not meet criteria. Facilities reported several reasons for taking this approach, including maintaining relationships with referring acute care hospitals, providing a service to the community, and the belief that cases with short lengths of stay could be profitable under the blended rate.

Across facilities we spoke with there was consensus regarding an increase in patient acuity. As a result, staff at facilities interviewed reported the increased skills necessary at each staff level. For example, nurses were expected to be able to provide ICU-level care and received additional training, including critical care training. Facilities also reported increasing their capabilities adding bariatric beds, ICU beds, and telemetry services.

However, even with these admission and operational changes, staff members at several LTCHs

referenced declining occupancy rates and closures. To mitigate these declines, some facilities reported planning to repurpose beds. Another facility stopped staffing an entire floor, closing those beds to patients, while another reported reducing the number of beds it leased from its host acute care hospital. And now I will turn it over to Stephanie.

MS. CAMERON: The closures mentioned during our site visits and interviews are supported by our data analysis. Since the start of the dual-payment rate structure, over 50 facilities have closed, representing more than 10 percent of the industry. Most of these closures occurred in areas with other LTCHs and the remaining closures occurred where the closest LTCH was within about a two-hour drive.

Further, for-profit facilities comprised about 85 percent of the closures. Facilities that closed tended to have a lower share of discharges that met the criteria, lower occupancy rates, lower Medicare margins, and higher standardized costs than facilities that remained open.

Associated with fewer LTCHs is reductions in volume and as you can see, the number of LTCH cases

declined starting in 2012. Starting with the blue portion of the bar chart, although difficult to discern, the volume of cases meeting the criteria decreased slightly from 2012 to 2015, but starting in 2016 the volume of cases meeting the criteria began to increase slightly. In contrast, cases not meeting the criteria, the gray portion of the bar chart, declined more rapidly from 2015 to 2017 compared with prior years, as expected by the implementation of the dual-payment rate structure.

As a result of these two opposing trends, the share of LTCH discharges meeting the criteria has ultimately increased since 2012. Just over half of LTCH cases met the criteria prior to the implementation of new dual-payment rate structure; however, this share increased to about 64 percent in 2017.

As you will recall from January, in 2017, the aggregate Medicare margin fell to -2.2 percent, down from 3.9 percent in 2016. However, the aggregate Medicare margin for LTCHs with more than 85 percent of Medicare cases meeting the criteria was 4.6 percent. This indicates that facilities with a high share of these cases can have positive financial performance under Medicare. Further, as

you'll recall, the margin for cases meeting the criteria based on a claims analysis remained higher at 5.8 percent in 2017.

Now quality. Not unexpectedly, given differences in patient severity, unadjusted rates of direct LTCH to acute care hospital readmissions, death in the LTCH, and death within 30 days of discharge from the LTCH varied, depending on whether or not the case met the criteria, but were generally stable over time. In 2017, for cases meeting the criteria, 10 percent were readmitted to the acute care hospital directly from the LTCH, 16 percent died in the LTCH, and another 13 percent died within 30 days of discharge from the LTCH. This means that, combined, close to 40 percent of LTCH cases meeting the criteria in 2017 were readmitted or died within 30 days of LTCH discharge. By comparison, cases not meeting the criteria have lower rates of readmission and mortality.

Our mandate requested that we also assess the use of hospice care and post-acute care settings since the implementation of the dual-payment rate structure, so now we turn to that, starting with spending and supply. Spending for PAC grew slightly from 2012 through 2017;

however, the supply of PAC providers has remained stable. In contrast, hospice spending increased since 2012 in tandem with the number of hospice providers over this time period.

However, these aggregates do not necessarily reflect changes in ACH discharge pattern in response to the implementation of the dual-payment rate structure, given the relatively small volume of LTCH users. Therefore we consider changes in the share of discharges for acute care hospitals stays by ICU length of stay and by areas of the country with high and low historical LTCH use.

Here we have discharge patterns across PAC and hospice from 2015 to 2017. Over this time, as you can see, there has been little change in the share of acute care hospital discharges using each PAC and hospice setting, in aggregate. Discharge patterns, in total, have been relatively stable since the implementation of the dual-payment rate policy.

Because we didn't see much change in acute care hospital discharge patterns to PAC in aggregate, we consider the use of these services in historically high-LTCH use markets and historically low-LTCH use markets. As

you can see from the chart, the use of PAC and hospice are quite different in the high-LTCH use markets on the left-hand side of the chart compared with the low-LTCH use areas on the right-side. However, similar to the trends in total on the prior slides, we observe minimal changes from 2015 through 2017, by type of market.

Lastly, we considered certain conditions that are more likely to use LTCH care from an acute care hospital. We find little change across low-LTCH use areas, so here I've provided changes based on areas with high LTCH use. As you might expect, the share of acute care hospital cases discharged to an LTCH increased for certain conditions that meet the criteria based on ventilator use, including MS-DRG 004 as provided in the table.

Here we see a 4 percentage point increase in the share of live acute care hospital discharges that use LTCHs from 2015 to 2017. In contrast, the next two diagnoses are less likely to use an ICU for three days or longer and therefore, the decrease in the share of these conditions discharged to an LTCH is not surprising. For these conditions, we find slight increases in SNF use. However, I again want to urge caution in the interpretation of these

results given the limited data available to analyze to date. We've given you a lot of information today and over the course of this cycle. In summary, a relatively large number of facilities have closed; however, these closures have primarily occurred in areas of the country with multiple LTCHs and have had lower shares of cases that meet the criteria, lower occupancy, and higher costs compared with LTCHs that remained open. The volume of cases not meeting the criteria has decreased while the share of cases that meet the criteria in LTCHs has increased.

Additionally, LTCH financial performance under Medicare has decreased over time, but cases that meet the criteria continue to be profitable under Medicare. We were unable to detect consistent or significant changes across the available LTCH quality measures to date. Changes in the supply or use of other PAC and hospice providers have been minimal. Keep in mind, however, that LTCHs comprise a relatively small share of PAC and hospice use therefore it is difficult to observe the effect of any policy especially given its recent implementation, which limits our capabilities in interpreting any changes in the use of

other providers and in quality measures.

The changes in the LTCH setting we presented today are consistent with the policy objectives. These trends were expected, align with the Commission's goals of its March 2014 recommendation to the Congress, and are expected to continue as the policy is fully phased-in. We will continue to monitor trends in use across PAC and hospice, facility closures, and quality as data become available.

That concludes today's presentation. We look forward to your questions and final comments on the information we presented today. And as a reminder, this is the final presentation of the Commission's response to the Congressional mandate. This information will be included in the Commission's June 2019 Report to the Congress.

And with that, I turn it back to Jay.

DR. CROSSON: Thank you, Stephanie and Emma. We are open for clarifying questions. David.

DR. GRABOWSKI: Yeah. Thanks for this great work. I wanted to ask two questions. First, on page 18 in the text you have a sentence, and I'll just quote it: "Research on the value of care provided in LTCHs has been

undermine by difficulties controlling for selection and patient case mix." There is this paper, and you cited in your references, from Einav and colleagues that is an NBER working paper right now, and I assume will be published at some point. But they try to get at exactly this issue of selection and case mix by exploiting entry of LTCHs in a particular market, as a kind of a strategy.

And I just wanted to get your thoughts on that paper. You cite it later, in a different context, but I think it could actually help with this text here maybe in explaining kind of the value LTCHs might bring relative to other settings. So your thoughts there.

MS. CAMERON: Sure. So that study looked at markets that had an LTCH entry over a period of time. I believe that ended in 2012. I believe the data was 2008 -- I might be wrong there -- but up until about 2012. And they looked at some pretty high-level quality metrics. One was mortality. They looked at time a patient, a beneficiary spent in the acute care hospital, the length of the entire episode, which included the acute care hospital stay plus post-acute. They looked at cost-sharing and I believe the use of SNF care.

And what they found was that spending for these episodes increased once an LTCH was opened in a market area. They found very little change in the length of the episode overall. They found substitution of LTCH use substituting for SNF care. But again, overall, they didn't find a lot of other change besides kind of that -- the site-of-care change, SNF to LTCH, and increases in spending.

I think one caveat, and I did want to be cautious about that, is the study did occur before this policy took place, and while they did do some -- they took into account patients that had a higher propensity for using LTCH care, which could be correlated with the patients that meet the criteria. It wasn't a one-for-one match, and that wasn't kind of how the propensity was identified.

So I think, David, you're right. I think what they found was LTCH added little to no value, and if anything, I think the punchline of that paper was they actually increased spending and waste, which was their kind of title, working title. And I think that that is absolutely correct. I think where, you know, I want to be cautious is that in recognizing that did not occur and the

data has not occurred since the slowing of growth in the LTCH industry and since the dual-payment rate structure began.

DR. GRABOWSKI: Just as a second question I wanted to get your opinion, either of you, on sort of linking this session with the prior one around site neutrality and payment. Here we have this sector that's different in a lot of ways. How does that fit in? We've gone to a lot of policy efforts to make certain the right individuals are receiving care in LTCH. Obviously, site neutrality is one way of hopefully ensuring that, or at least helping with that goal.

But I wanted to get your thoughts on how does this fit in? And maybe you no longer need the dual-payment rate structure once you have site neutrality, but what else do you need here, in this sector, to make certain that it's being used appropriately?

MS. CAMERON: So I think as we move towards a unified PAC-PPS I think you're absolutely right. The need for any dual-payment rate structure goes away. I think that, you know, as you saw in the paper on the stay-based and the updated approach there, that when we redefined what

it meant to be on a ventilator we saw that a vast majority, well over 95 percent of those cases, were being seen in an LTCH as we defined PAC. So if you look at all of the PAC settings, the LTCHs are by far seeing the vast, vast majority of those cases.

And so in the regression model the cost associated with majority LTCH care obviously captured, and so that cost is actually very heavily weighted towards LTCH. And so we would see, kind of depending on, you know, how the payment was set, but the cost are heavily, heavily weighted LTCH and would reflect that, presumably, in the ultimate payment.

And so, you know, in a lot of ways, again I think this is starting to identify a group of patients that are paid, you know, the LTCH rate, and as we move to a unified PAC-PPS, you're absolutely right. I think we do start thinking about more of site-neutral approach. And the patients that are able to be seen in a setting like a SNF, who I think a lot of us would consider being cases that don't meet the criteria today, would receive a reduction in payment. It would be a different metric. Right now it's a lesser of cost or an IPPS comparable rate. Obviously that

would be the rate that was indicated by kind of the regression and the cost.

I think LTCHs, one thing I will say, is I think a big portion of that transition for LTCHs is going to be the regulations. LTCH are certified as acute care hospitals. They have to meet a lot of those requirements. And as we move toward a unified PAC-PPS, you know, we have talked a lot about how important that regulatory piece is, and I think that is very true for LTCHs.

DR. CROSSON: Okay. I saw Pat and Kathy. Pat.

MS. WANG: In your observation of changes in supply of LTCHs and LTCH beds, did you, you know, whether qualitatively or quantitatively, observe differences in beneficiary access for those who met the criteria, for example, as LTCHs downsized the sort of non-qualified stays and focused on qualified stays in the new structure? Did you observe anything about occupancy, stable, up, down, in the remaining LTCHs? Any impact on wait times for beneficiaries who met the criteria and needed an LTCH bed, things of that nature?

MS. CAMERON: So from the quantitative data, we did not find much change in occupancy rates for the LTCHs

that have remained open. The data we used, as you'll recall, in our payment adequacy work when we looked at this was 2017, so, you know, here we are in 2019, and we will obviously continue to track on this because I think it's a really important point to keep an eye on.

We did not hear -- and I'll just step back and say the occupancies are hovering around 65 percent. So there are beds available. There is some seasonality to certain LTCHs in certain areas of the country. I think on especially kind of the east coast, flu season is a higher occupancy time for LTCHs compared to other parts of the year, and, you know, the mid-summer months are a lower occupancy time. But all in all, it's about 65 percent, and that's actually a very minimal down tick from where it was a couple years ago, but still in the ballpark. So we haven't seen any major changes there.

During our site visits, we did not hear from any hospital, referring hospital or from LTCHs themselves, of becoming too full to accept patients or that that beneficiary access was a concern. Again, I think as the policy becomes more fully phased in and the industry is settling out, we will obviously closely monitor this. But

we did not hear anything of that level of negativity for beneficiary access.

DR. MATHEWS: And just to add to that, Stephanie, if we go back to Slide 10, you do see a certain stability in the number of cases that meet the criteria that are being admitted over time at the same time that there is a reduction in cases that don't meet the criteria. So to the extent there are reductions in the non-criteria cases, that is going to positively impact ability of patients who do meet the criteria to get int.

DR. SAFRAN: On this point [off microphone]?

DR. CROSSON: Okay.

DR. SAFRAN: Did you look specifically at rural to see if that held true there? Because some of the data in Table 3 just made me have that -- in the paper made we have that question about rural was different?

MS. CAMERON: One of the difficulties is there are so few rural LTCHs that one change in one rural LTCH could draw us to conclusions that we may or may not be comfortable with. Rural LTCHs typically actually have a lower share of patients meeting the criteria, and part of that is a volume issue. You gain referrals from hospitals

within, you know, a 20-mile-ish radius on average, but there's obviously a much larger referral zone, up to two hours. For rural areas, having the number of acute-care hospitals drawing volume is a much more difficult threshold.

So what we do know is that the rural LTCHs do have a higher share of cases not meeting the criteria, but I have been concerned about really digging too deep because there are so few of them and drawing industry conclusions on a very small number is something I'm wary of doing.

DR. CROSSON: Kathy.

MS. BUTO: So I think the idea behind the report is really interesting, which is to say what happens when LTCHs concentrate more of patients who meet the criteria. It continues to strike me that a lot of patients, based on your data, are patients who, if there were no LTCH option, might be hospice patients. But, in fact, as you move to the dual payment system, I mean, LTCHs are going after more of those patients, sort of the high-intensity, very frail patients who may die within a short period of time.

So I'm wondering whether you saw any -- and you probably didn't look at this because there's so few LTCHs,

but any differences in the characteristics of LTCH patients who meet the criteria and hospice patients? Are hospice patients overwhelmingly cancer patients? Which wouldn't be LTCH patients. They're both in the similar situation where they're quite vulnerable, frail patients, and I wondered if you see any characteristics where you might say without LTCHs some of these patients or a larger number of them might be hospice patients.

MS. CAMERON: I think that's a good and challenging question to answer. LTCHs are required under law to maintain an average length of stay of 25 days or longer, and they do need to take that into consideration when they admit patients. And so they are not -- they do not want to admit a patient that is not expected to live post-discharge. You know, they're providing acute and rehabilitative care to a very sick group of beneficiaries. And in wanting to provide that rehabilitation, that includes a live discharge. And so I think, you know, theoretically there are some things we might be able to look at. I didn't do that here. And maybe we could talk after and think about that. But, you know, it is a different population. These LTCHs want -- the patients

that go there and the families of patients that go there are pursuing a curative care track, and they are interested in rehabilitation and ultimate discharge from a facility being alive. When one enrolls in hospice, that's not the expectation, and so, you know, there are two very different populations in a way, kind of in tracks.

Now, that said, I think we have heard in the past that some beneficiaries end up going to an LTCH after an acute-care hospital stay not understanding the road they have ahead of them, and it's only after the extremely acute phase of the illness occurs in that, you know, five-, seven-day acute-care hospital stay, they're discharged to the LTCH, and everyone exhales. It's the exhale after the emergency situation and the reactionary mode where there is some question of is this the path we want to be on. And we have heard that for some. It hasn't been the track they wanted to be on, and that's unfortunate that conversations of end-of-life care did not occur in the hospital, and that expectation wasn't set earlier in the course of treatment. And it puts LTCHs and LTCH caregivers in a very difficult spot as well.

MS. BUTO: Thanks. I wouldn't ask you to go back

and do any more analysis here, but it strikes me as exactly the case that people talk about, which is the last six months of life being a time for many people of the most expensive care, and LTCH is a very expensive setting. So it just struck me that there is this -- a little bit of a disconnect, as you say, and conversations that should happen sooner.

Thank you.

DR. CROSSON: Karen.

DR. DeSALVO: Kathy, I'm glad that you raised that, because I'm still stuck on this Figure 5, which Kathy actually talked about at the last meeting, too, which is that between a third and 40 percent of admissions for all cases -- you know, depending on criteria, either experience mortality in a narrow window or go back in the hospital.

And so I wonder if, thinking forward for the next generation of work, there is an opportunity to bring in, for example, the beneficiary and caregiver voice and some of the qualitative work about their expectation management and how they were spoken to even in the acute-care setting in the hospital, and then thinking about strategies that would really encourage and drive end-of-life conversations

or palliative care conversations in the acute side of the hospital before people end up in an LTCH, which maybe is where the family didn't really understand what that was going to be about and what it would be like.

And maybe you specific question is did we -- in the qualitative work, I didn't see that we formally spoke to families and caregivers, so we can't include any of that perspective in the chapter?

MS. CAMERON: We spoke with two patients --

DR. DeSALVO: Okay.

MS. CAMERON: -- and their families at one of the LTCHs we visited, and they were very happy with the outcomes and the care they received and live very full lives currently.

We did not speak with families of beneficiaries who died in the LTCH or kind of within that 30 days that you're referencing. That could be something we consider kind of for future work, if that's a direction we want to go in.

There was within the past couple months an article that did talk about kind of life after the ICU, and I thought that, you know, there are some corollaries

between that article, and it was -- I can't remember. I want to say it was either New York Magazine or it was in kind of an everyday publication, talking about the stress and the trauma that being in these very, very high intensity settings provides, taking a step away from LTCH a little bit but talking about the ICU, and that it's a very long process of what recovery is and understanding kind of how do we define recovery and how does one recover and what does that mean to be fully recovered, both from, you know, your physical and your mental state following ICU use. And that is far out of the scope of this paper, but I think it touches upon some of the issues you're bringing up and thinking about, you know, long-time patient satisfaction and family satisfaction.

DR. DeSALVO: And expectation management and clarity about what recovery would look like, et cetera. So maybe later, maybe in the future we can start to think about some policy directions that would encourage that even further.

Thank you.

DR. CROSSON: Pat.

MS. WANG: This is a really interesting

conversation, and I just want to -- there's a reason that hospice is not part of the PAC PPS. Hospice is a different thing. And, you know, everything that -- the questions that Kathy raised and, Karen, your point is all a good direction to pursue.

I guess that I would just think that we should be a little bit cautious about sort of a slide from -- I mean, you know, a of people die in the hospital, too. You don't expect that when they're sick and they go to the hospital that maybe they should be counseled to go to hospice instead. And I think whether it's LTCH or under the PAC PPS, an equivalent setting to take care of people who are acutely ill and do hope to recover -- I mean, these are licensed as hospitals. In the future version in the PAC PPS they will be licensed as something to take care of patients who are this critically ill. We should just be a little cautious about assuming that that is an automatic slide to hospice, because I really think they're two completely different things. It doesn't take away from the importance of counseling and expectation management, but it's very hard at that stage in somebody's illness to really manage expectations of a family, and also the

patient who thinks that they're going to walk out of there.

DR. DeSALVO: Thanks for that clarity. I didn't mean to imply that you could substitute one for the other, but I do think that we would owe it to beneficiary to make sure that we heard what their experiences were like and also understood if they were getting all of the options presented to them.

DR. CROSSON: Okay. Jonathan and then Marge.

DR. JAFFERY: So sort of on this same topic, and I do think this is a really important, interesting discussion, and I'm still struggling with where do LTCHs fit in. Are they really part of the post-acute-care space, or are they part of the acute-care space, and how does that make sense?

Maybe for the next -- again, I think this report is great for right now. I think maybe as part of the next stage analysis, there might be some other information that we can get at in terms of prognosticating a little bit who of the patients who are going -- who meet criteria, who are going to the LTCH, end up in that 30 or 40 percent of people who don't do well. You showed some very stable information for patients in the criteria that the 30

percent of them die within the stay or 30 days after. But, you know, thinking about that idea of counseling in the acute-care setting or even the early stage of the LTCH stay, that might start to think about, well, who are the right patients that should go to palliative care or hospice. If a family hears that 30 percent of people are going to die in that time frame, a lot of them will say, well, that means 70 percent won't. But if they hear, well, in my certain situation it's actually 75 percent or 80 percent, that may provide for some different kind of conversations. So I don't know if there's enough data to look at that down the road.

MS. CAMERON: I think what's difficult is, you know, that's a conversation that most likely occurs between a patient and the family and a social worker or a physician. And finding that data and when it occurs in an acute-care hospital is just something I don't know we are able to understand.

DR. JAFFERY: I guess what I -- if there's data that we could sort out that says what sort of conditions certain ages, certainly particular diagnoses that may or may not lead to a higher mortality, as a tool for the

physician and the social worker and a team to have the conversation with the family.

MS. CAMERON: I see, so thinking about kind of the unadjusted quality measures I showed up on the screen and that are in your Figure 5, but thinking about those potentially by certain diagnostic groups, you know, what does this look like for the ventilator patients, what does this look like for patients with other categories of illness.

DR. JAFFERY: Right. It's still a conversation, and some patients and families will say, well, if it's a 5 percent chance, that's better than 0, and so I want to do everything I can, but just giving people the opportunity to have as much information as they can.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: Nice work, Stephanie. This is great. I'm looking at Slide 11, which shows the difference between the for-profit and nonprofit. This is really a stark difference, and I guess I have a couple questions.

One, were you taken aback as much as I was about the different metrics here between those two? And I'm very

concerned about it, and I realize this is not about for-profit/nonprofit, but it does give one pause. And it makes me worried that it's more likely that nonprofit institutions will close shop eventually with these kinds of figures persisting.

So I'm curious about what your take was on this and whether this registers any concern on your part about what this means for the future.

MS. CAMERON: So we've been seeing this trend for quite some time and the variation in for-profit/nonprofit LTCHs. Over really the past five or more years, they began to diverge quite a bit. And one of the things to keep in mind is, you know, the for-profit and nonprofit facilities may have some different practice patterns in terms of their length of stay, in terms of their costs, in terms of their ability to control costs; and that, you know, for Medicare cases, while there is a negative margin, which is quite substantial when you look at kind of the overall across all LTCHs negative 13 percent, they still maintain -- you know, they still have other patient populations, and so this is, you know, thinking about their capability to control costs in their nonprofit environment. And so it doesn't seem as

though they are controlling them as well as the for-profit facilities.

DR. CROSSON: Jon.

DR. PERLIN: I'm confused. On page 9, you have 85 percent of the facilities that closed were for-profit, facilities that closed, and they have, among other things, higher standardized costs. So it's likely that there were other efficiencies in terms of the care since --

MS. CAMERON: So I think we need to be cautious a little bit here of kind of how we are triangulating the facilities that closed with kind of the overall for-profit facilities. I understand, you know, for the overall for-profit facilities, the standardized costs tend to be lower. However, for the group that closed, they were higher, and they don't necessarily look like the rest of the for-profits. So I just do want to give some caution on triangulating this is based on 50 facilities, which isn't -- I'd say it's not a small number, but it's not necessarily representative of the rest of the ones that remained opened that we're talking about here.

DR. CROSSON: Okay. We just completed Round 1.5, so we're going to move to a conclusion, and David is going

to bring us home.

DR. GRABOWSKI: Great. Thanks, Jay, and thanks again for a great chapter and presentation. I know we've been through this material several times so I'll be relatively brief.

I think a big focus among policymakers has been sort of determining what is a long-term care hospital and who should it be for. And, Jonathan, I was really struck by your comment, because I had something very similar written down here -- are they a hospital or are they a post-acute care provider? Both? Neither? Are they somewhere in between? When I've visited LTCHs they don't feel like other institutional post-acute care providers, like skilled nursing facilities or inpatient rehab, yet they also don't feel like a hospital.

And so -- and I think if you look around the country in areas where beneficiaries don't have access to an LTCH, we see this tension. Some end up staying in the inpatient hospital longer, some end up going to a skilled nursing facility that has built this infrastructure to really provide this type of service. So they're sort of a hospital and they're sort of a post-acute care provider.

Policymakers have gone through all these steps to make certain that the appropriate patients are being admitted to LTCHs. We saw this payment adjustment for short stay cases and we saw this 25 percent threshold rule, we saw the moratoria, and now this dual-payment rate structure. So all of these policy efforts just to make certain the appropriate individuals are getting services here.

I came away from your chapter believing the dual-payment rate structure is generally working towards ensuring that individuals who meet the criteria are being admitted to LTCHs and those who don't meet the criteria are beginning to find care elsewhere. So I think that's a good development, and based on your work I didn't see any adverse consequences.

So I think so far, so good. I do believe, however, we have more work to do with LTCHs, and this is one of the real reasons I'm glad we're moving towards a site-neutral payment system, because I think it's really hard to do something site-specific here. I think you really need to think about LTCHs in the bigger picture. And so I'm really glad we're moving towards site-neutral

payment in post-acute care.

The final point, once again, is this is another reason I'm really glad that we're moving towards value-based payment and ACOs because I think having a larger at-risk entity thinking about the value of these services is really important, and if they're offering value those at-risk entities will direct beneficiaries to these services. If they're not, they won't. And I really think that's important going forward because it's been really hard to regulate, with all these different steps, that the appropriate individuals get services here, and I think we can do this in a better way and also make certain that these services are adding value for the program and for the beneficiaries. Thanks.

DR. CROSSON: Thank you, David. So I would like to invite, you know, further suggestions to help Stephanie and Emma prepare the final report, if we have not already covered them. Jon.

DR. CHRISTIANSON: I guess I don't have any. I think my reading of the chapter is that we -- and the Congressional mandate -- is that we've fulfilled it with this chapter. And I think the comments that I hear David

making and others are, in the future, if we want to go forward with more work in this area here's what we might want to do.

But my own opinion is I don't think we need to go forward with more work between now and when this needs to be wrapped up, and I'm very comfortable having it in the June report.

DR. CROSSON: Okay. And I'd just like to add a couple of points here. First of all, I think there's -- I don't want to overstate this, but I think there's a certain reason for celebration here. I mean, here we have examined a policy that, in part, at least, originated here at the Commission, and up to this point at least it seems to have worked -- worked as intended, worked to the benefit of the program and potentially, as well, to beneficiaries, and arguably without obvious untoward consequences. And that doesn't happen often in a process of development and execution of policy, particularly in health care. So I think that's worthwhile to note in passing.

The second thing is it didn't come up in the presentation but just for clarity here, in the document and in the final report we will respond to that portion of the

mandate that asked us to comment on the need for continuation of the 25 percent threshold rule, even though that has been suspended by CMS. Nevertheless, we have done work on that before and it does appear in the report.

With that, Emma and Stephanie, thank you very much for the work and the presentation, and we look forward to seeing the final report.

With the end of the material today we now have time for a public comment period. If there is anyone who would like to comment on the work before the Commission come forward. I'll ask you in a minute to identify yourself and any organization or institution that you are affiliated with. We would ask you to keep your comments to approximately two minutes. When this light comes back on the two minutes will have expired.

MR. KOENIG: All right. Thank you. I'm Lane Koenig. I'm Director of Policy and Research for the National Association of Long-Term Hospitals.

I think the discussion on long-term care hospitals has been very helpful. I just wanted to make a couple of points. So one is there is a paper that recently came out, and I'll make sure Stephanie has it, that looked

at quality of life after -- on a ventilator in an LTCH. And the upshot is that -- because this is a big gap in what we know about quality of life after that, and the results, I think, were a bit surprising, I think you'll find surprising. Eighty-five percent of people who were weaned off the ventilator said they would do it again if they had the chance to do it, and quality of life was improved for those who survived and physical function and things like that. So I'll share that with Stephanie and make sure she sees that.

The other thing, too, just to mention, on the NBER paper, so if the NBER paper is a not-peer-reviewed paper and is going to be in the chapter I want to make sure that peer-reviewed papers that have been published on LTCHs are actually in the chapter.

A couple of things on the NBER paper. Actually, they looked back to 1998, so their period that they were looking at was 1998 to 2014. As Stephanie said, they identified the effects based on entry of the LTCH into the market. Most entry of LTCHs into the market, because of the moratorium and other things, happened prior to 2008. So basically they're identifying their effects largely

based on a period from 1998 to 2007. The population of LTCHs have changed, actually, significantly since then.

And then there are two peer-reviewed papers, one came out in 2015, that I was an author on, and another one that just came out that I was also a co-author on. The first one was published in Medical Care in 2015, and it showed some positive effects of LTCH for certain cases who spent three more days in the ICU or had multiple organ failure.

The other paper that just came out last month looked at the impact of the new criteria on severe wound cases. And the paper is kind of an interesting take. You know, I can say that because I'm an author on it, I guess, so I'm biased. But it looked at the change in severe wound cases, what happened to those cases after criteria, and what their outcomes were. And so I suggest that you sort of look at that.

The one thing that we found is we didn't find, for that population, any significant savings to the Medicare program as a result of the new criteria, and for certain cases that have a high propensity to go to an LTCH we found that severe wound cases had higher readmissions

and reasons for readmissions for sepsis, which might explain the lack of savings in that population.

So anyhow, I'll make sure the MedPAC staff has that and can share it with you all. Thank you.

DR. CROSSON: Thank you. Seeing no one else at the microphone, this concludes the March meeting. We will reconvene in April.

Thank you very much, everyone. Safe travels.

[Whereupon, at 11:20 a.m., the meeting was adjourned.]