

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 5, 2019  
10:43 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
PAUL GINSBURG, PhD, Vice Chair  
KATHY BUTO, MPA  
LAWRENCE P. CASALINO, MD, PhD  
BRIAN DeBUSK, PhD  
KAREN B. DeSALVO, MD, MPH, Msc  
MARJORIE E. GINSBURG, BSN, MPH  
DAVID GRABOWSKI, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM  
AMOL S. NAVATHE, MD, PhD  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
PAT WANG, JD

B&B Reporters  
29999 W. Barrier Reef Blvd.  
Lewes, DE 19958  
302-947-9541

| AGENDA   | PAGE |
|--|------|
| Context for Medicare payment policy  |      |
| - Jennifer Podulka.....  | 4    |
| The effects of Medicare Advantage "spillover" on<br>Medicare fee-for-service spending and coding   |      |
| - Jeff Stensland.....  | 52   |
| Public Comment.....  | 116  |
| Examining the effects of competitive bidding for<br>diabetes testing supplies; improving payment policies<br>for DMEPOS products excluded from competitive bidding |      |
| - Brian O'Connell, Eric Rollins.....   | 117  |
| MedPAC evaluation of Medicare's Hospital Readmission<br>Reduction Program: Update  |      |
| - Jeff Stensland.....  | 186  |
| Public Comment.....  | 215  |

P R O C E E D I N G S

1

2

[10:43 a.m.]

3

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

4

[Pause.]

5

6

7

8

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

9

10

11

12

13

14

15

16

17

18

19

20

21

22

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

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

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

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

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

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

1 data are published over the next few months.

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

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

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

1 keep in mind that we're showing year-to-year changes. From  
2 2011 through '13, growth was fairly slow across all three,  
3 generally because of decreased use of health care services  
4 and restrained payment rate increases. The Affordable Care  
5 Act in 2011 began lowering payments to MA plans to bring  
6 them more in line with fee-for-service spending and then in  
7 2012 reduced annual payment rate updates for many types of  
8 fee-for-service providers.

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

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

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

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

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

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

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

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



1 Part A spending.

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

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

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

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

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

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

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

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

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

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

21           Starting at the top of the figure, from 2007 to  
22 2017, premiums for individual and family plans grew by 49

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

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

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

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

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

1           Over the same time period, combined Medicare per  
2 capita costs, represented by that bottom line, grew by just  
3 15 percent. If fee-for-service Medicare had followed  
4 growth in commercial pricing, Medicare costs would have  
5 grown substantially more.

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

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

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

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

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

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

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

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

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

21           DR. CROSSON: Thank you very much, Jennifer.

22           So we'll start with a round of clarifying

1 questions, if there are any. Jon.

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

9 I have a specific question on page 14 or Slide  
10 14, where you showed the relative growth of Medicare versus  
11 employer-sponsored insurance. I understood the way you  
12 presented it here differently than it appears to be written  
13 in the chapter on pages, I think it is, 21 through 23.  
14 There in the chapter -- and this may get at your request on  
15 tone -- it seems to state that the employers -- the  
16 increases in the reimbursement from employer-sponsored  
17 insurance is creating an incentive -- or are forced to pull  
18 up the Medicare reimbursement, and that if it continues on  
19 that trajectory, that it would bifurcate care to Medicare  
20 providers and non-Medicare providers. I'm just wondering  
21 what data support that, because that seems to be in direct  
22 contradiction to the way you present it today, which is

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

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

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

15 MS. PODULKA: Okay.

16 DR. PERLIN: Thanks.

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



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

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

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

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

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

2 DR. CROSSON: Okay. Dana.

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

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

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

22 We'll continue to investigate a better

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

2 DR. SAFRAN: Thanks.

3 MS. PODULKA: Sure.

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

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

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

22 MS. PODULKA: I will definitely go back and check

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

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

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

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

15 MS. PODULKA: Yes. Okay.

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

1 these other countries.

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

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

11 DR. SAFRAN: Yeah. Thanks.

12 DR. CROSSON: Okay. Marge.

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

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

20 And then I have a second question as well.

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

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

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

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

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

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

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

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

5 MS. PODULKA: Thank you.

6 DR. CROSSON: Warner.

7 MR. THOMAS: Two quick questions.

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

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

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

22 MR. THOMAS: Okay.

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

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

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

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

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

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



1 what would happen.

2 DR. PAUL GINSBURG: If I could add something.

3 Historically, there have been a number of cases over many  
4 years where the Trust Fund was getting close to insolvency,  
5 and that just served to force congressional action on  
6 Medicare spending and payroll taxes.

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

11 DR. CROSSON: Okay. Bruce.

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

15 [Laughter.]

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

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

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

6 MS. PODULKA: I love this idea. I always seek  
7 opportunities to include the under-65 whenever I've got the  
8 65-and-older because it's incredibly frustrating to leave  
9 out this really significant portion of the population.

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

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

18 [Laughter.]

19 DR. CROSSON: Further questions?

20 [No response.]

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

1 from Brian.

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

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

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

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

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

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

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

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

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

17           But, as you talk about the case for change -- and  
18 I want to take a moment and sort of talk a little bit about  
19 on the innovation side -- for some reason, health care  
20 attracts all these car analogies, right? It's changing the  
21 tires on a moving car. It's rebuilding a car that's going  
22 60 miles an hour on the interstate.

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

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

8           [Laughter.]

9           DR. DeBUSK: What does he do? He pulls out a  
10 1965 -- he pulls out a '64; I pull out a '65 -- Ford  
11 Mustang. It's an instant classic, and that date isn't  
12 chosen by accident. That's the date -- '65 is the year  
13 that Medicare started. It's a timeless classic. It's a  
14 vehicle that has gotten us a very long way, over half a  
15 century. It's also a vehicle that requires us -- and on  
16 the commission, one of our duties -- and I think this is  
17 the sobering message that Jay sends us -- is we have to  
18 make sure this vehicle stays in top working condition.

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

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

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

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

12           [Laughter.]

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

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

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

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

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

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

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

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

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



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

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

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

10 [Laughter.]

11 DR. DeSALVO: So this person --

12 [Laughter.]

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

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

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

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

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

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

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

15           MS. BUTO: So I want to highlight, in the mailing  
16 materials, Jennifer, something that I've been reading this  
17 chapter for six years now. So I went back and looked, and  
18 this graph has been in the chapter for all those years, I  
19 believe. I went back a couple of years. And it's Figure  
20 14 on page 33, which is innocuously titled "Health care  
21 spending growth impacts future debt levels."

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

1 graph. So if you look at, as you've shown on the graph, a  
2 1 percentage point lower growth rate will really bend the  
3 cost curve. And so if there's a way that we can amp this  
4 section up a little bit and then tie it to, I think,  
5 something that -- possibly to Figure 6, which is sort of,  
6 for major segments in Medicare what are the growth rates,  
7 what are they looking like.

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

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

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

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

7

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

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

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

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

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

11 Thanks.

12 DR. CROSSON: Thank you. Jon.

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

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

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

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

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

16 Thanks.

17 DR. CROSSON: Thank you, Jon. David.

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

1 think it's a necessary exercise.

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

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



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

3 Thanks.

4 DR. CROSSON: Thank you, David. Jonathan.

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

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

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

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

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

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

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

1 percent of total per patient, per beneficiary spending.

2 MS. PODULKA: Okay.

3 DR. JAFFERY: Exactly.

4 DR. CROSSON: Thank you, Jonathan. Pat.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17           [Laughter.]

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

1 of urgency.

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

6           DR. CROSSON: Thank you, Warner. Marge.

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

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

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

1           That's all. Thank you.

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

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

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

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



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

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

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

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

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

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

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

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

9 DR. CROSSON: Thank you, Amol. Very insightful.  
10 Sue, last mini-talk.

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

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

1 have some opportunities as well.

2 DR. CROSSON: Okay. Very excellent comments.

3 Thank you all. Jennifer, you've now got a very full plate

4 -- a smorgasbord, as a matter of fact. So we'll see.

5 So let's move on to the next presentation.

6 [Pause.]

7 DR. CROSSON: Okay. I'd like to introduce

8 Professor Jeff Stensland who, by my reckoning, has just won

9 the award for the most erudite chapter that I've seen in my

10 time here.

11 Jeff, my only request is be gentle on the

12 Commissioners as you make this presentation.

13 [Laughter.]

14 DR. CROSSON: Go ahead.

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

16 or bad thing.

17 I'll start off just by saying that for Medicare

18 Advantage plans to profit, they're dependent on changing

19 the practice styles of physicians or the coding behavior of

20 physicians. And the physicians serving MA patients usually

21 also provide care to traditional fee-for-service patients,

22 and this raises the question of whether the changes in

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

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

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

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

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

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

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

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

22           Most studies use fee-for-service risk-adjusted

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

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

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

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

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

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

1 2014 looking at how much Medicare spending grew on an  
2 annual percentage basis -- and this data comes from the CMS  
3 actuaries -- and compared that to statewide MA penetration  
4 in 2014. So this is over a 23-year period we're looking at  
5 growth.

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10           We also control for changes in ACO penetration.

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

16           So let's just look at a descriptive statistic on  
17 the levels of spending in high-penetration and low-  
18 penetration markets. We assume that MA penetration will  
19 affect fee-for-service HCC scores and practice styles with  
20 a lag. Therefore, we just examine 2015 MA penetration and  
21 2016 price-adjusted spending.

22           High-penetration markets had MA penetration that

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

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

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

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

1 ACO penetration.

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

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

15           The models also suggest that a 10 percentage  
16 point higher level of MA penetration is associated with a  
17 0.7 to 0.9 percent slower price-adjusted spending growth.  
18 This suggests that higher MA penetration is associated with  
19 practice styles that lead to slightly slower cost growth.

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

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

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

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

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

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

22           The finding that spillover is small should not be

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

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

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

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

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



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

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

10 MS. WANG: Slide 8.

11 DR. STENSLAND: Okay.

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

22 DR. STENSLAND: In general --

1 MS. WANG: I'm confused.

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

11 On the other hand, if your benchmark is 115 or  
12 120 percent of fee-for-service and you're bidding 105  
13 percent of fee-for-service and then you're also adding on  
14 some extra benefits, those are clearly markets where you're  
15 going to end up spending more on MA than on fee-for-  
16 service.

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

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

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

7 DR. CROSSON: On that point?

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

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

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

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

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

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

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

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

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

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

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

12 [Laughter.]

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

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

19 DR. GRABOWSKI: Great. Thanks, Jeff.

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

22 I found it also somewhat confusing that you kind

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

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

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

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

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

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

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

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

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

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

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

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

17 [Laughter.]

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

19 DR. CROSSON: Bruce.

20 MR. PYENSON: Jeff, terrific report.

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



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

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

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

12 DR. CROSSON: Thank you, Bruce.

13 Jaewon.

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

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

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

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

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

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

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

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

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

1 variables that are correlated.

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

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

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

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

11           [Laughter.]

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

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

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

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

6           DR. CROSSON: Also on this point? No.

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

8           MS. MARJORIE GINSBURG: I'll pass.

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

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

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

1 would do better than I probably would have done.

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

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

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

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

1 interpreting it that way.

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

7

8 DR. STENSLAND: This would probably take more  
9 serious thought than I am going to have right here, but  
10 when I was going through it, my general -- the most  
11 important point that if I was speaking to a health service  
12 research audience to me was that I thought that probably  
13 the endogeneity problem probably wasn't that big of a deal  
14 now. I think it probably was a much bigger deal prior to  
15 2010 when the payment rules were different.

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

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



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

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

6 DR. CROSSON: Okay. Kathy.

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

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

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

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

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

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

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

17 DR. CROSSON: Okay. Last question, Jonathan.

18 DR. JAFFERY: Yeah, thanks.

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

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

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

17 DR. PAUL GINSBURG: Thanks, Jay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 for the minute.

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

19           And so we saw bed days per whatever, 1,000  
20 Medicare patients for a year come down from like 2,300 to  
21 1,200, pretty quickly. And that was -- but to go from  
22 1,200 to 1,100 turned out to be pretty hard. So it may be

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

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

9 DR. CROSSON: Thank you, Larry. Amol.

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

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



1 with you as well, Jeff.

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

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

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

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

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

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

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

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

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

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

1 therefore, not spilling over.

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

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

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

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

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

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

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

6 DR. NAVATHE: I agree with your point.

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

10 DR. NAVATHE: Correct.

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

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

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

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

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

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

14 Okay. Sorry, Larry.

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

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

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

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

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

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

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

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

16 Bruce.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14           MS. MARJORIE GINSBURG: I stand corrected.

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

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

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

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

5 Paul.

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

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

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

20 DR. PAUL GINSBURG: Yeah.

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

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

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

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

16 On this point?

17 DR. DeBUSK: On this specific point.

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

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



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

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

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

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

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

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

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

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

2 MS. THOMPSON: We definitely do.

3 DR. DeBUSK: Jaewon, you don't?

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

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

6 [Laughter.]

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

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

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

18 DR. CROSSON: A lot of things, actually.

19 DR. DeBUSK: Yeah, a lot of things.

20 [Laughter.]

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

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

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

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

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

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

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

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

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

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

1 managing through an MA plan.

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

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

11           DR. CROSSON: On this point?

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

22           DR. CROSSON: Warner.

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

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

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

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

22          Now, whether there's a policy implication from

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

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

9 DR. CROSSON: Yeah.

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

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

22 DR. CROSSON: Thank you.

1           On that point?

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

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

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

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



1           Andy came up with what? 7.2 percent coding  
2 adjustment?

3           DR. DeBUSK: Mm-hmm.

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

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

18           Thanks.

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

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

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

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

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

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

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

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

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

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

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

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

10 [Laughter.]

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

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

17 [No response.]

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

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

22

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

AFTERNOON SESSION

[2:15 p.m.]

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

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

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

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

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

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

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

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

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

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

20 CMS suspended competitive bidding for 2019 and  
21 2019 and is making technical changes to the bidding rules.  
22 This means that there will be a temporary gap period

1 without competitive bidding.

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

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

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

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

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

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

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

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

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

17           The National Mail-Order Program began in July  
18 2013. As the name implies, the program covers the entire  
19 country, including both urban and rural areas, but only  
20 applies to items supplies beneficiaries receive through the  
21 mail.

22           The Mail-Order Program substantially reduced



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

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

12           Looking at the geographic distribution of retail  
13 suppliers, we found that nearly all beneficiaries lived in  
14 a county with one or more retail test strip suppliers in  
15 2017.

16           Given that beneficiaries can access test strips  
17 on a mail-order basis or through retail suppliers, this  
18 slide shows total utilization of test strips from 2010 to  
19 2017, stratified by mail-order versus retail supplies. As  
20 you can see, total utilization -- the light blue line --  
21 declined after the implementation of the National Mail-  
22 Order Program in July 2013.

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

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

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

15           We paid particular attention to trends among Type  
16 1 diabetics and those who use insulin because our  
17 conversations with clinicians suggested that these  
18 beneficiaries are likely to be more negatively affected by  
19 disruptions in the supply of their test strips.

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

1 monthly hospitalization rates for any of our subpopulations  
2 studied.

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

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

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

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

1 test strips.

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

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

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

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

1 from the competitive bidding program or non-CBP products.

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

5           Over the same time when spending on CBP products  
6 was falling by more than half, spending on non-CBP products  
7 increased from \$3.3 billion to \$4.7 billion, an increase of  
8 44 percent.

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

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

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

1 and back braces.

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

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

10           For example, in the June 2018 report to the  
11 Congress, the Commission found that Medicare's payment  
12 rates for off-the-shelf orthotics ranged from 20 percent to  
13 50 percent higher compared with private payer rates.

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

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

22           In 2017, we identified about \$1.4 billion in

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

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

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

15           This last slide quickly summarizes our key  
16 findings from today.

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

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

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

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

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

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

9 We're now open for clarifying questions. Brian.

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

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

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



1 to quit using test strips.

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

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

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

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

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

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

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

15 DR. CROSSON: Larry.

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

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

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

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

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

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

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

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

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

16 DR. CROSSON: Dana.

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

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

1 PARTICIPANT: Influenza.

2 DR. CROSSON: Influenza.

3 PARTICIPANT: Holidays.

4 [Multiple inaudible comments.]

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

7 Okay. All right.

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

10 [Laughter.]

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

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

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

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

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

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

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

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

22 MR. ROLLINS: I think another consideration would

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

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

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

16 DR. SAFRAN: Yeah.

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

22 DR. CROSSON: Bruce.

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

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

22 DR. CROSSON: Jonathan, on that point.



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

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

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

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

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

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

8 DR. PERLIN: On this point, Jay?

9 DR. CROSSON: Yeah.

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

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

19 DR. CASALINO: The same topic, Jay.

20 DR. CROSSON: Yeah.

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

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

8 DR. CROSSON: Very good. Karen.

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

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

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

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

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

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

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

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

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

14 DR. CROSSON: Jon.

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

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

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

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

10 MS. BUTO: Thank you, Jay, and thanks for this  
11 paper. It's, I think, remarkable, and we have an example  
12 of Medicare trying something that seems to work pretty well  
13 across the board, in terms of saving money, maintaining or  
14 improving quality, and also reducing abuse, potentially.  
15 So it was encouraging to see this. I remember, in the  
16 '90s, when this idea first came up, I was still with the  
17 agency. It gives you some sense of how long it takes to  
18 get something like this going.

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

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

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

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

1 there was an experiment or two on that as well.

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

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

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



1 on, or whatever.

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

9           Thank you.

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

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

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

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

1 machines or procedures?

2 MS. BUTO: It was paying for the procedure.

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

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

7 DR. CROSSON: Machines. Okay.

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

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

12 DR. PAUL GINSBURG: For the service.

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

14 DR. CROSSON: Yeah, okay.

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

19 DR. CROSSON: Right.

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

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

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

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

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

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

1 include those products going forward.

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

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

8           MR. O'DONNELL: That's right.

9           DR. CROSSON: Okay.

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

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

1 any broader authority. That would be helpful.

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

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

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

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

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

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

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

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

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

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

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

22           DR. CROSSON: Just one question. The PDAC

1 letter, what is that?

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

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

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

9 You know, a couple years ago, I brought props. I  
10 wanted to show you what a wrist and forearm splint could  
11 be, and the -- I love props. But the lowest-end wrist and  
12 forearm split, which still qualifies for payment, looks  
13 dramatically different than, say, a high-end wrist and  
14 forearm split. I mean, you're not talking about a 20  
15 percent price difference. You're talking about probably a  
16 2-, 3-, or even 400 percent price difference on the item.  
17 So there's a process for basically submitting your product  
18 to make sure that it meets certain requirements.

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



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

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

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

12 [Laughter.]

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

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

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

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

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

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

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

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

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

21 MR. O'DONNELL: That's correct.

22 DR. CROSSON: -- of having patients see a

1 provider and having authorized.

2 MR. O'DONNELL: That's correct.

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

6 DR. CROSSON: Dana, on this?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 DR. DeSALVO: Thank you.

14 DR. DeBUSK: Yes.

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

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

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

22 DR. MATHEWS: DMEPOS.

1 DR. CROSSON: -- DMEPOS, one.

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

5 Marge.

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

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

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

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

6 DR. CROSSON: Yes.

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

9 DR. CROSSON: Okay. Jon.

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

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

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

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

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

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

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

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

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

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

14           Thanks.

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

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

1 consider.

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

11           DR. CROSSON: Episodes of care. Amol.

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

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

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

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

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

1 Then it's, I think, even easier.

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

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

8 DR. MATHEWS: No. We're --

9 DR. CROSSON: You like this?

10 DR. MATHEWS: Yeah, this is good.

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

13 DR. CROSSON: Right.

14 [Laughter.]

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

22 So a radiology benefits manager would bid on



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

3 DR. CROSSON: Right.

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

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

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

20 [Laughter.]

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

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

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

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

9 [Laughter.]

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

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

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

1 DR. CROSSON: Yeah.

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

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

8 DR. CROSSON: Right. Okay.

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

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

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

15 DR. DeSALVO: Okay.

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

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

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

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

12 MR. O'DONNELL: In Medicaid.

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

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

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

1 They pay less for labs as well.

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

11 If I remember correctly, I want to say it's maybe  
12 18 percent of the ED DME items go to Medicare.

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

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

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

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

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

8 Is that right? Have I got that clear?

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

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

13 PARTICIPANT: B.

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

15 [A show of hands.]

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

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

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

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

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

6 PARTICIPANTS: B.

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

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

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

16 DR. DeSALVO: The whole other world, okay.

17 MR. O'DONNELL: That's right.

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

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

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

8 DR. DeBUSK: I vote B because --

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

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

14 DR. CROSSON: Okay.

15 DR. DeBUSK: Thank you [off microphone].

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

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

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



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

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

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

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

10 DR. DeSALVO: Okay.

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

15 DR. DeSALVO: Okay.

16 DR. CROSSON: Yes, Larry.

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

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

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

14 Kathy?

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

22 DR. CROSSON: Right.

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

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

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

1 think about those kind of criteria, we can come back and  
2 say here are some things that could fit those criteria, and  
3 --

4 DR. CROSSON: That might be a first step.

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

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

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

12 Pat?

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

18 [Laughter.]

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

22 DR. CROSSON: Dana said earlier today we want big

1 ideas. We're getting them.

2 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

17           DR. CROSSON: David, last comment.

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

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

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

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

19           Oh, and Karen wanted me to say, sneaking in a  
20 comment, this is a fee-for-service approach, and that's  
21 something to think about here. This is very different than  
22 --



1 DR. DeSALVO: Right, as we pull money out of the  
2 system, it lowers [off microphone].

3 DR. GRABOWSKI: Yes, there you go.

4 [Laughter.]

5 DR. CROSSON: You don't have to hide.

6 DR. DeSALVO: I wasn't hiding.

7 [Laughter.]

8 DR. CROSSON: Okay. Good discussion. Thank you.  
9 We're going to move on.

10 [Pause.]

11 DR. CROSSON: Okay. It's Jeff again, and we're  
12 going to see you tomorrow.

13 DR. STENSLAND: Yeah.

14 DR. CROSSON: I hope you're getting extra  
15 compensation for essentially carrying half the load for the  
16 meeting. You can talk to Jim later about that.

17 DR. STENSLAND: I assume the paycheck will come.  
18 We'll see.

19 DR. CROSSON: Okay. So Jeff is going to take us  
20 through a review of the Hospital Readmission Reduction  
21 Program, give us an update, see where we are. Thanks. Go  
22 ahead, Jeff.

1 DR. STENSLAND: Okay. So today, as Jay said, I  
2 am going to try to give an update of the evaluation we did  
3 of the Hospital Readmission Reduction Program.

4 Just to give you a little background first on how  
5 it all started, first there was some increased awareness of  
6 excess hospital readmissions. I think in 2008 the  
7 Commission and some others discussed how a lack of care  
8 coordination and some poor transitions between acute and  
9 post-acute care may result in more readmissions than were  
10 necessary. And there was a belief that care transitions  
11 could be improved and readmissions reduced, but also a  
12 belief that hospitals did not have a financial incentive to  
13 improve care that occurred outside their walls and  
14 coordinate with those people, like the medical directors of  
15 the SNFs, et cetera.

16 Then in 2009, CMS started to publicly report  
17 hospitals' readmission rates. In 2010, Congress enacted  
18 the Hospital Readmission Reduction Program, and in 2013,  
19 hospitals with above-average readmission rates during 2010  
20 to 2012 had their payments reduced.

21 Now, Congress later mandated that MedPAC evaluate  
22 the success of the readmissions program. We assessed the

1 effects of the HRRP in 2016 and in our June 2018 report to  
2 Congress. We concluded that the readmission rates declined  
3 without causing an increase in risk-adjusted mortality  
4 following the passage of the HRRP, and today we're going to  
5 update that analysis.

6 We have three objectives behind today's  
7 presentation.

8 First, in the course of updating our work to  
9 2017, we discovered an error in our calculations that  
10 resulted in an understatement of 2016 readmission rates.  
11 The error affected only one year of readmission rates and  
12 did not affect computations of mortality rates. This  
13 presentation corrects the 2016 data.

14 Second, we use 2017 data to update both the  
15 readmission and mortality findings.

16 Third, we explain how the conclusions regarding  
17 the decline in readmission rates without causing an  
18 increase in risk-adjusted mortality do not change with the  
19 updated data.

20 So, first, let's talk about the understatement of  
21 2016 readmission rates. We understated those rates due to  
22 errantly not including the readmissions that occurred after

1 the end of the fiscal year when computing 2016 rates. Our  
2 mortality computations were not affected.

3 Originally, we reported unadjusted all-condition  
4 unplanned readmission rates declining from 16.7 percent in  
5 2010 to 15 percent in 2016. The true rate of decline was  
6 from 16.7 percent to 15.6 percent in 2016.

7 This is the updated data. This slide examines  
8 the unadjusted and risk-adjusted rates for all conditions.  
9 What you'll notice is that unadjusted rates declined and  
10 then leveled off in 2014. The decline is consistent with  
11 reported efforts we've heard from hospitals about their  
12 mechanisms for reducing readmission rates.

13 Now, risk-adjusted rates continued to decline,  
14 according to our models. But as we discuss in your mailing  
15 materials, some of this might be coding. Whether one  
16 concludes that readmission rates are continuing to decline  
17 or just leveling off depends on whether you believe that  
18 some of the reported increase in patient severity is real  
19 and not just coding.

20 After examining a wide range of literature and  
21 some other data, we believe that some of the increase in  
22 reported severity was due to coding, and some of the

1 increase in reported severity reflects a real change in the  
2 mix of patients admitted to the hospital.

3           With respect to coding, CMS allowed additional  
4 fields for additional coding of morbidities in 2011. This  
5 may have contributed to the increased reported severity.  
6 In addition, providers generally have had increasing  
7 incentives to more fully code over time due to payment  
8 incentives and risk adjustment in the outcomes that are  
9 publicly reported by hospitals.

10           However, we think some of the increased patient  
11 severity is real, and there are several pieces of data that  
12 we looked at that are not dependent on coding that suggest  
13 the patients admitted are getting sicker while easier cases  
14 are increasingly treated on an out-patient basis.

15           For example, from 2010 to 2017, the number of  
16 heart failure admissions per capita declined by 9 percent,  
17 suggesting that less complex cases may be increasingly  
18 treated on an outpatient basis. In addition, from 2010 to  
19 2017, there was an increasing share of patients discharged  
20 to either the hospice or the SNF, with fewer patients were  
21 discharged to home without home health care. And generally  
22 we think those who are discharged to SNF or the hospice are

1 going to be in worse shape than those discharged home.  
2 This suggests that patients really are getting sicker, but  
3 how much is a true increase in severity of illness and how  
4 much is coding is difficult to say.

5 In general, the combination of flat, unadjusted  
6 readmission rates, coupled with evidence that there has  
7 been at least some increasing severity, suggests risk-  
8 adjusted readmission rates have improved.

9 One concern is that if readmissions fall too much  
10 there may be a reduction in appropriate admissions. That  
11 may cause an increase in mortality, and this is a valid  
12 concern. To test this, we examine unadjusted mortality  
13 rates in this table. We highlight unadjusted mortality  
14 rates because they do not affect the coding issue we talked  
15 about before.

16 In this graphic I highlight heart failure  
17 mortality because this is the condition that has received  
18 the most attention in the literature. We measure mortality  
19 as death in the hospital or in the 30 days after discharge,  
20 and that's what you will see in this slide.

21 We see a slow increase in unadjusted heart  
22 failure mortality from 2008 to 2013. This increase

1 received the most attention in the literature. The concern  
2 was that the HRRP may have caused physicians to not admit  
3 patients that should have been admitted, and this maybe  
4 caused some harm.

5           However, our risk-adjusted numbers show a  
6 decline. A key question is whether the increased reported  
7 severity is real or simply due to coding, but as we  
8 discussed earlier we believe part of the severity is real  
9 and was not caused by a risk-adjusted mortality increase  
10 due to the HRRP.

11           We next turn to some other studies and what they  
12 have found.

13           The other studies that we looked at examined  
14 things a couple of different ways. When you look at how we  
15 looked at it, we first just looked at the time trend, and  
16 we found a slight increase and then a leveling off. There  
17 are some others who looked at it a little differently.  
18 They looked simply at the time trend and they found, in  
19 general, that risk-adjusted readmissions were going up  
20 according to their models, through 2014. And the two key  
21 differences are we looked at mortality during the admission  
22 and the 30 days after, and many of those other studies only

1 looked at the 30 days after.

2           The other thing is studies can look at this in  
3 different ways. The general studies that raise the most  
4 concern are those that say, well, the timing of these  
5 things coincide. We had the HRRP enacted, and then we had  
6 this increase in mortality, and they assume then that the  
7 timing of those two things seem to be causal.

8           There are some other ways to look at it, and we  
9 and some other people have said, well, let's look at this  
10 cross-sectionally. The places that had the highest growth,  
11 or the highest decrease in readmissions, did they have the  
12 most increase in mortality? Or when your readmissions go  
13 down did your mortality go up? And we and others found,  
14 no, that's not the case. The correlation actually went a  
15 little bit the other way. And that led us and some other  
16 to say that doesn't look like this timing of the two things  
17 moving together was causal.

18           There's another way of looking at this, and  
19 Professor Gupta from Penn looked at it by asking a  
20 different way. And said, well, let's look--he used an  
21 instrumental variables approach and look at hospitals that  
22 were expected to be most affected by the readmission



1 program. Did those hospitals then have worse outcomes,  
2 either in terms of mortality or anything else? And his  
3 conclusion was no. He actually concluded that the hospital  
4 readmission reduction program caused a reduction in  
5 readmissions and mortality.

6           So I think looking at the totality of that  
7 evidence, it led us to conclude that no, the hospital  
8 readmission reduction program did not cause an increase in  
9 risk-adjusted mortality. And also if you take a look --  
10 this is also partially reassuring here -- if you just look  
11 at the raw numbers that we have we'll see there has been a  
12 slight decline from 2015 to 2017, where the rate now, in  
13 the raw readmission rate, not even including the risk  
14 adjustment, is back down to where it was in 2012.

15           Now let's shift from focusing on heart failure to  
16 other conditions. A new concern in the 2017 data is we see  
17 a slight increase in unadjusted COPD and pneumonia  
18 mortality. If you look at the chart you see two little  
19 arrows popping up at the end. Risk adjustment rates still  
20 fell, but the increase in unadjusted rates is nevertheless  
21 surprising.

22           The showed the uptick in pneumonia as the white

1 line up there, and the uptick in COPD as the blue dotted  
2 line. As we discuss in your paper, this appears to be due  
3 to a shift in coding instructions that caused more cases  
4 with both COPD and pneumonia diagnoses to be classified as  
5 COPD cases. On a combined basis, which is that dashed line  
6 there, the combined level of COPD and mortality was flat as  
7 you see, staying roughly from 14.2 percent in 2013 down to  
8 13.9 percent in 2017.

9           So in sum we would say that mortality is an  
10 important indicator of quality, and asking whether the  
11 readmission incidents are so great that they've caused an  
12 increase in mortality is a valid concern, a valid thing to  
13 be researched. But after a broad look at the literature,  
14 coupled with an examination of data that is not dependent  
15 on coding, such as length of stay and patient discharge  
16 data, reductions in readmissions do not appear to be  
17 correlated with worse mortality.

18           So in summary, unadjusted readmission rates  
19 declined after the program was enacted in 2010, and  
20 hospitals with greater readmission declines did not see an  
21 increase in their mortality. We and others have found  
22 this. There are indicators that patient severity is

1 increased, and these include indicators that aren't  
2 dependent on coding. And finally, therefore, on a risk-  
3 adjusted basis it appears that readmissions have declined  
4 in 2010 to 2018, without causing a material increase in  
5 mortality.

6           The HRRP may have resulted in some improvements  
7 in readmissions, but that does not mean that the program is  
8 perfect. You may recall, in the past, MedPAC had some  
9 recommendations. Specifically, we had said initially the  
10 readmission program should move to all condition, and that  
11 would allow lowering the magnitude of the penalty for each  
12 individual readmission, and there should also be a  
13 prospective target.

14           When you look to last year, we combined our  
15 readmission recommendations into a broader Hospital Value  
16 Improvement Program, or the HVIP, and this was a system of  
17 payment incentives that was recommended in our March 2019  
18 report to Congress. And the summary of the HVIP is shown  
19 on this slide.

20           In terms of the net effect, the net effect was to  
21 increase the incentive to reduce hospital mortality across  
22 all conditions, increase the incentive for patient

1 satisfaction, bring down the financial incentive to reduce  
2 readmissions so that it is equal to the incentives for  
3 mortality and patient experience. And you could see this  
4 as leveling of the incentives between mortality,  
5 readmissions, and patient experience. There remained some  
6 incentives for reduced infections and lower episode costs.

7           So I think there is broad support for these  
8 directions, even from those that may have different view on  
9 the effect of the HRRP on mortality.

10           And now I will bring it back to Jay for  
11 discussion.

12           DR. CROSSON: Thank you, Jeff. Very clear. We  
13 are now open for clarifying questions. I see Jon and then  
14 David.

15           DR. PERLIN: Just a quick question. Thanks for  
16 this update. It's very, very helpful.

17           Did you look at the rates of observation stays or  
18 ER visits for those patients, and maybe you could give  
19 maybe a sentence or two on what you found?

20           DR. STENSLAND: Yeah. So in general we did see  
21 an increase in observation stays and ED visits that  
22 coincided with this decrease in the readmissions. But we

1 saw an increase in observation stays for people who were  
2 never admitted. So they were initially admitted for  
3 observation. It wasn't just the people who were admitted  
4 and then sent for an observation stay to avoid the  
5 readmission, suggesting this was a broader trend that was  
6 going on. And recall that this happened at the same time  
7 as the RAC audits, where the RAC started saying, well, if  
8 you admit somebody for a short period we might not pay you  
9 at all, and I think that was more likely a cause for the  
10 increase in observation stays.

11 We also see an increase in ED visits, but that  
12 increase in ED visits was broadly spread across individuals  
13 too, not just those who had an admission prior.

14 DR. CROSSON: David.

15 DR. GRABOWSKI: Could I ask you about Slide 5,  
16 just where you show the unadjusted and risk-adjusted  
17 unplanned readmissions. Does the risk-adjusted  
18 readmissions, does that cap the number of codes at 9, or  
19 are you allowing it to go from 9 to 24 in 2011?

20 DR. STENSLAND: So we're allowing it to go from 9  
21 to 24 in 2011. We had a categorical model, so how much  
22 that affects the risk model may be different from like the

1 paper that you were involved with Chris Ody. But that  
2 effect will be in here, so we would expect some of the  
3 decline we see, especially in maybe that 2011 range, to be  
4 due to the change in the coding opportunities.

5 DR. GRABOWSKI: Yeah, and maybe I would need to  
6 dig in a little bit more on the categorical approach, but I  
7 wonder if there's a way to kind of tease out the coding.  
8 Like we just -- we capped it and showed this huge  
9 difference between capping it a 9 over time versus, you  
10 know, what happened. You know, coders are going to code,  
11 and that's what happened.

12 DR. STENSLAND: Yeah.

13 DR. GRABOWSKI: And I wonder if you could do  
14 something similar here with your categorical model, where  
15 you might limit that, and then we could take the whole  
16 coding issue off the table and see what actually happened  
17 with risk-adjusted readmissions.

18 DR. STENSLAND: Yeah. The coding, it should --  
19 that thing should mostly affect that little period around  
20 there, and it was more straightforward. I think it's more  
21 -- I talked to Chris Ody about this and we kind of have a  
22 different opinion on whether that's a fully -- the basic

1 assumption, I think, from that model you're involved in was  
2 when there were only 11 slots they are going to have a  
3 certain amount of effort to fit all the most important  
4 things in those 11 slots. And then when there's 24 slots,  
5 they're going to have exactly the same amount of effort to  
6 fit the important stuff in the first 11 slots.

7           And my interpretation was that just seemed too  
8 strong, that some people might just start putting codes in  
9 and then after they have all the important codes then they  
10 realize they haven't run 24 slots, so they say, okay. But  
11 maybe when you only had 11 slots they get the 11th slot  
12 filled up and then they realize something else is important  
13 and maybe they go back and switch something.

14           So if somebody does that then I think this  
15 assumption that the coding of the first 11 slots didn't  
16 change when the rules changed I think is a little bit  
17 strong. When he did his analysis, the key thing in the  
18 appendix is to show that while the marginal effect of each  
19 additional code was pretty much similar before 2011 and  
20 after 2011, so maybe they're doing the same thing.

21           But I was concerned that there was some  
22 offsetting effect. The one effect was, oh, now you have

1 more codes and so maybe you're not so critical about these  
2 getting in the first 11 slots, and so that makes the effect  
3 go one way. But on the other side I think people were  
4 actually getting sicker. So I think you would actually  
5 expect the effect to actually go up over time on each one  
6 of these slots, and it didn't go up. It kind of stayed the  
7 same. And, to me, that's a long explanation but that's why  
8 I was a little reluctant to just assume that when you go  
9 from 11 codes to 24 codes the coding in the first 11 slots  
10 doesn't change.

11 DR. GRABOWSKI: And the final point on this -- I  
12 promise, Jay. Is there a way to rank order such that you  
13 get those most expensive codes up front? Just playing  
14 around -- it's what you said, they're fitting them all  
15 across the 24. Is there a way to mechanically do that in  
16 the post period?

17 DR. STENSLAND: You could do that, and we hadn't  
18 done that, and Chris didn't do that either. I asked him if  
19 he had done that but he has a lot of -- he's a smart guy  
20 and he has a lot of faith in the first 11 code method.

21 DR. CROSSON: Amol.

22 DR. NAVATHE: On that topic, so again, not to



1 belabor the point, but so if you look post 2011, does the  
2 number of -- because the average number of codes per claim,  
3 is that increasing over time? Or when you get that switch  
4 is it pretty static? Because I think if it's pretty static  
5 then you can essentially wash away your 2008 to 2010 pre  
6 period and the trend should still hold. If it's dynamic,  
7 which is what I think it probably is, is people are  
8 learning to code over time, then it's a little bit trickier  
9 here.

10 DR. STENSLAND: David does, but I thought it  
11 mostly one big change.

12 DR. GRABOWSKI: What we observed, Amol, is like a  
13 pretty big -- I mean, it happened very quickly. They were  
14 onto this and it exploded almost overnight. So that would  
15 be supportive of, you know, like --

16 DR. NAVATHE: So if that's the case then if we  
17 just ignore 2008 to 2010, the trend that comes after that  
18 should still be internally valid.

19 DR. CROSSON: Questions?

20 Seeing none we'll move on to discussion, and I  
21 think, you volunteered. No? Did I make a mistake? You  
22 misunderstood. Okay.

1           So did I get that wrong or did someone else  
2 volunteer to begin?

3           DR. CASALINO: [Off microphone.]

4           DR. CROSSON: There's a basic rule. You never  
5 raise your hand. Okay, so let's open it up broadly then.  
6 Jon.

7           DR. PERLIN: Again, thanks for this terrific  
8 work. This is an area where I think the data are  
9 interesting but not entirely clear, and I appreciate the  
10 research that you did.

11           I wanted to bring to your attention the recent  
12 work from University of Michigan, Karan Chhabra, who just  
13 notes that the decrease in readmissions actually preceded  
14 the initiation of the actual readmissions reduction  
15 program. In fact -- and you alluded to this in your data  
16 as well, that the major decrease occurred during the period  
17 where there was a specter of this coming, and then it kind  
18 of leveled off. He goes through some pretty elegant  
19 machinations to demonstrate that even the risk-adjusted  
20 hasn't really come down, and similar to what Mark notes, of  
21 course, it's in modern health care as well.

22           So I just wonder about the utility of measures

1 broadly, where there is sort of not a tight relationship to  
2 the -- let me rephrase that. There is accountability  
3 without necessarily the authorities or the data, or even  
4 the clarity of relationship to yield the best possible  
5 outcome.

6           And I mention that, too, you know, being on the  
7 hospital side, so put that on the table and full  
8 disclosure, is that, you know, if something happens the  
9 first week to 10 days, we didn't button something down, but  
10 goodness, from, you know, 10 days to a month, any number of  
11 other factors have been well reported as being, you know,  
12 responsible for a patient's change in health status.

13           I also said, when this came up the last time,  
14 that when I had the privilege of leading the VA Health  
15 System I actually refused to have a 30-day readmission  
16 measure other than for information, because I was worried  
17 about the incentives for not caring for patients until they  
18 got to some arbitrary, you know, period of time.

19           One of the principles of measurement, then, is  
20 that, you know, an actor has the ability to control the  
21 factors that would change the outcome for what's being  
22 measures. I think there's a real problem in the way this

1 has been implemented by CMS, and that's that, if someone  
2 looks, for example, at the CMS star ratings, the current  
3 star ratings are up. I would ask anybody, how old do you  
4 think the data are that are currently displayed under star  
5 ratings? Any guesses?

6 PARTICIPANT: Three.

7 DR. PERLIN: Three years. Great guess, but  
8 actually they go from the second quarter of '14 to the  
9 first quarter of '17. I sometimes say that lagging  
10 indicators are a little like driving your car by looking in  
11 the rearview mirror. This is like driving your car by  
12 looking in the rearview mirror of the car three cars behind  
13 you. It's just very difficult to operationalize.

14 So I think we have responsibility to really think  
15 about measures that drive, you know, the best outcomes, the  
16 greatest efficiency, the highest value, the highest safety,  
17 but also simultaneously abide by the principles of good  
18 measurement, which would include the ability to link  
19 definitive actions with the accountability and with data  
20 flow. And at a minimum, one of the data flow pieces that  
21 would be necessary for hospitals would be having timely  
22 data evaluation for patients who were readmitted

1 specifically outside of their own hospital or system, so  
2 that they actually can get cognizance into what the  
3 mechanisms of failure are in terms of a patient potentially  
4 requiring care that might have been obviated had certain  
5 processes been buttoned down. So thanks.

6 DR. CROSSON: David.

7 DR. GRABOWSKI: Great. I also want to thank you  
8 for this work. I'm glad you stayed at it.

9 I just wanted to pick up on one sort of part of  
10 this. You've been on this point, Jeff, for a long time,  
11 that readmissions aren't the only kind of thing falling  
12 here. You know, the index admissions are falling as well.  
13 And you could have used that as support for maybe that's  
14 leading to an increase in reported severity. I guess the  
15 marginal admission that's being averted is actually kind of  
16 a less acute maybe individual.

17 I also, however -- and this maybe sounds like  
18 something Jon Perlin's professor would have said -- you  
19 can't be readmitted if you're not originally admitted. You  
20 know, we can't perfectly predict who's going to have a  
21 readmission, and there's a lot of variability there. It's  
22 interesting. Some of my colleagues have a manuscript

1 that's coming out in Health Affairs where they did  
2 something I think really clever. They just simulated, by,  
3 you know, taking out admissions, kind of randomly from the  
4 distribution and it turns out they can simulate the same  
5 decline we're seeing in readmissions by doing that. And it  
6 suggests there's just a lot of noise here as to who's being  
7 readmitted to the hospital.

8           And so I think we just want to be a little bit  
9 more careful in interpreting what's going on with  
10 admissions there. It's not just kind of the severity  
11 that's changing. It's also potentially changing the  
12 opportunity to readmit. I think that's something we'd want  
13 to think about here.

14           DR. CROSSON: Thank you.

15           Marge and then Amol.

16           MS. MARJORIE GINSBURG: So I take, David, from  
17 your comment and from the other comments that we may want  
18 to be more circumspect on how we summarize the results  
19 here, because on page 7, it says, "The HRRP has been  
20 successful in reducing the emissions without an adverse  
21 effect on beneficiary mortality."

22           So I guess the question is, Do we need to kind of

1 modify our summary, our conclusions about this? We're not  
2 sorry this is in place, but there may be other events that  
3 impact reduction and just have a fair representation of  
4 those other issues rather than give unqualified -- make  
5 this an unqualified success. Is that kind of what you're  
6 saying?

7 DR. GRABOWSKI: Yeah. I think Jeff has been very  
8 careful in how he's framed this, and so I think continuing  
9 to be cautious here. I agree with the finding that we  
10 haven't seen an increase in mortality. I don't believe the  
11 HRRP kills papers. I don't think that's going on. I want  
12 us to be really careful about how we kind of interpret the  
13 size of the decrease in hospitalizations if it's, indeed,  
14 there.

15 But I think Jeff has been really good about  
16 balancing this, and I think admissions is another area just  
17 to add to that list.

18 DR. CROSSON: Amol.

19 DR. NAVATHE: So I think I just wanted to sort of  
20 give an analogous point to Jon about measurement when it  
21 comes to designing programs and evaluating them, not with  
22 respect to your workbench, in some sense, the implications

1 or the commission's role maybe in making a comment on how  
2 HRRP has played out.

3           So I think if we look at the literature, broadly  
4 speaking, it looks like there's a variety of different  
5 results, depending on the variety of different methods that  
6 have been tried, and we actually have a study that's  
7 currently under review, where we tried basically 15 or 20  
8 different specifications for HRRP. We showed that if you  
9 pick a few, you can get an answer. If you pick another  
10 few, you get a different answer. So it's a little bit  
11 dangerous to over-interpret any particular study is where  
12 I've landed on this.

13           So that doesn't nullify, I think, as David said,  
14 the way that you have worded things here, but I think it  
15 perhaps give a caution around the idea of mandating  
16 national programs without some sort of testing period or  
17 demonstration project or at least following some of the  
18 methods that CMMI has been using, something like that.

19           I think to the extent that if we actually take a  
20 look at the evidence and the methods that have been used, I  
21 think probably most researchers would agree that there's no  
22 perfect evaluation strategy for HRRP because of the way



1 that it was implemented. So we're not really setting  
2 ourselves up to do a very good job of understanding what  
3 the effects are and importantly whether there are  
4 unintended effects. So I think that's probably a sort of  
5 suggested recommendation that comes out of the work on HRRP  
6 would be my thought, something that we can add into the  
7 recommendations.

8 DR. CROSSON: Bruce.

9 MR. PYENSON: I am very supportive of the  
10 conclusion and the work that was done, with one exception.  
11 I'm not sure that we're ready yet to say that the  
12 reductions in readmissions have leveled off.

13 I think one of the principles in setting quality  
14 improvement is to look for best practice benchmarks. We've  
15 been looking at averages, and the averages, in my mind,  
16 show that the program has been a terrific success. But if  
17 we were to look at the 10th percentile, we might find a  
18 much lower readmission rate in certain areas, in certain  
19 systems, certain parts of the country.

20 So I'm not ready to say that things have leveled  
21 off and we've gotten as good as we can get. I think there  
22 could be a lot more that would be done with respect to

1 readmissions, and that's not to say we should delay moving  
2 to the value-based purchasing program. But I'm not  
3 satisfied looking at the national average and say we've  
4 gotten as good as it can get.

5 DR. CROSSON: Thank you, Bruce.  
6 Paul.

7 DR. PAUL GINSBURG: Yeah. I'm very glad that  
8 Jeff included the last slide because this HRRP was to me a  
9 first-generation program in trying to provide incentives  
10 for quality for hospitals. It was crude. It only focused  
11 on three conditions. It focused all its incentives on  
12 poor-performing hospitals, left good-performing hospitals  
13 along, so they had no incentive.

14 So the fact that it seemed to have done fairly  
15 well under those conditions to me is very encouraging and  
16 the implications that the HVIP could do a much better job  
17 at this type of program.

18 Amol brought up something about that this was one  
19 of the few programs to pursue quality or pursue cost that  
20 was just launched without a demonstration, nationally  
21 rolled out, and of course, it makes it harder to evaluate  
22 it.

1           But given the profusion of research that we've  
2 seen and all the attention on the program, I'm not so  
3 worried about putting the policy in place, and if it works  
4 really badly, we'll know it, even without the best designed  
5 evaluation.

6           And that the potential for progress, getting back  
7 to the challenge in our context chapter, I wouldn't want to  
8 give it up so that we couldn't do anything without spending  
9 five years first for an evaluation.

10           I think part of the time series that you and  
11 others attract is a period where a lot of different things  
12 are happening. Your typical evaluation would miss some of  
13 those things, and it would always be an issue of "Well,  
14 things have changed. Is the research really relevant  
15 anymore?" So, in a sense, I think there is an argument for  
16 not being too cautious in pursuing policies.

17           DR. CROSSON: Okay. Larry.

18           DR. CASALINO: Jeff, I probably should know the  
19 answer to these two questions, but I don't.

20           One is, Did you guys or has anyone else with  
21 reasonable analysis looked at effects on subgroups; for  
22 example, poor patients or racial or ethnic minorities? So

1 has this kind of work been done for them? That's the first  
2 question.

3           The second, kind of a twist on what Bruce was  
4 saying, if you take the 10 or 20 percent of hospitals that  
5 reduce readmissions the most, what's the relationship  
6 between readmission reductions and mortality in the  
7 hospitals that reduced it the most?

8           DR. STENSLAND: Second one first. Generally,  
9 when we looked at it last time, we saw, on average, those  
10 that reduced their readmissions more had a little bit  
11 better mortality changes. So that was a positive.

12           Harlan Krumholz did something similar, and he  
13 found the same thing.

14           Now, Professor Gupta's article, one of the things  
15 he did was he said, "Well, let's look at the hospitals that  
16 are going to be most affected by this, and one of my  
17 instruments for indicating that is the share of their  
18 patients that are minorities." In that case, he didn't  
19 find any ill effects of the program on mortality.

20           There's also been some studies that have looked  
21 at different hospitals based on whether they're treating  
22 lots of poor folks or not as many poor folks, and those

1 ones that were treating more poor folks actually seemed to  
2 have a little greater improvement in their readmissions  
3 rates.

4           Then there was a study, RAND that did a study,  
5 and they looked at changes in mortality, and I should  
6 remember. But I can't remember if it was poor individuals  
7 or individuals from minority groups, but those were  
8 individuals that were expected to have higher readmission  
9 rates and to see if they were adversely affected by this  
10 over time. And that answer was no for that group.

11           The other, the effect actually was bigger for the  
12 disadvantaged group. The disadvantaged group looked like  
13 they may have had some -- the advantaged group may have  
14 looked like they had some increase in mortality, not the  
15 disadvantaged group, which wasn't consistent with the  
16 hypothesis.

17           So there has been a fair amount of research in  
18 those areas, and in general, I think that research has been  
19 fairly reassuring.

20           That is the effect of this policy on outcomes on  
21 the individual, but we also want to say there's been lots  
22 of research that has shown hospitals that serve poor

1 individuals tend to get a bigger readmission penalty. And  
2 that's why we had pushed for categorizing hospitals based  
3 on the share of their beneficiaries on SSI or the way that  
4 the administration did it based on the share of dual  
5 beneficiaries. So you don't have the Mayo Clinic competing  
6 against Cook County. Cook County is competing against  
7 Grady Memorial when they're evaluating whether they're  
8 going to be penalized, and they made that change in law.  
9 And I think there's been some very positive response to  
10 that of taking into account socioeconomic status when  
11 you're evaluating how much penalty somebody should receive.

12 DR. CROSSON: Bruce.

13 MR. PYENSON: I just realized I misspoke when I  
14 said I wanted to proceed with the VBP. I meant let's go  
15 with the HVIP.

16 DR. CROSSON: We figured that out.

17 [Laughter.]

18 DR. CROSSON: Don't be bothered because you may  
19 have -- particularly, our new commissioners may have  
20 noticed that we have a lot of acronyms and a tendency  
21 towards acronym creep, and a lot of the acronyms sound like  
22 each other. So you're not alone in that regard, and I'm

1 still trying to figure out how to pronounce that "DMEPOS."

2 [Laughter.]

3 DR. CROSSON: Okay. Well, this has been a very  
4 good discussion. Thank you very much, Jeff, again, and  
5 have a good night's sleep. We'll see you in the morning.

6 [Laughter.]

7 DR. CROSSON: We now have time for Public Comment  
8 session. If there are any members or any of our guests who  
9 wish to make a comment on the work that's been before us  
10 this afternoon, come to the microphone.

11 Hang on for a minute. I'll give you some  
12 instructions. I'd like you to identify yourself and any  
13 organization or institution you're affiliated with, and  
14 please limit your comments to two minutes. When this light  
15 comes back on, the two minutes will have expired.

16 MR. McTERNAN: Good afternoon. My name is Joe  
17 McTernan. I am with the American Orthotic and Prosthetic  
18 Association. I am on staff with that organization.

19 Two very brief comments. First, I would just  
20 like to make a comment regarding the discussion earlier on  
21 the potential to give CMS broad authority to expand  
22 competitive bidding in the DMEPOS environment. Obviously,

1 my organization has an interest specifically in orthotics  
2 and prosthetics.

3           Just something to consider, I would agree with  
4 some of the commissioners' comments about making sure that  
5 competitive bidding be applied where it really should be  
6 applied, and that is within commodity items. So when  
7 you're talking about custom prosthetics especially and, to  
8 an equal degree, custom orthotics, custom orthoses, you're  
9 dealing with more than just commodity items. You're  
10 dealing with items that are custom-fabricated to the  
11 specific needs of a particular patient; in this case, a  
12 Medicare beneficiary.

13           There is a very significant clinical aspect of  
14 care that is part of that overall process, and to just open  
15 that up, open those non-commodity items up, even though  
16 they are part of the DMEPOS universe by acronym, I would  
17 just like the commission to consider the potential  
18 consequences of that, if making a recommendation that CMS  
19 have well-expanded authority to increase competitive  
20 bidding beyond the true commodity-type items. So that's  
21 comment one.

22           Comment two, I think I will ask for the



1 commission's continued support in their report to Congress  
2 back in June of 2018. They were very specific when they  
3 talked about off-the-shelf orthoses, and trust me, AOPA was  
4 at the forefront of criticizing the folks that were  
5 creating call centers and shipping out knee and back braces  
6 to anybody who they could convince over the telephone they  
7 need it.

8           So we are very much of the vein that orthoses and  
9 prostheses are required to have at least some level of  
10 clinical care, whether it's off the shelf, whether it's  
11 custom fit, whether it's custom-fabricated, but in the  
12 report, in your report to Congress from June of 2018 --

13           DR. CROSSON: Please conclude your remarks.

14           MR. McTERNAN: Will do.

15           That the commission recommended that providers  
16 such as orthotists and prosthetists who provide a  
17 significantly low volume of off-the-shelf orthoses, 16 to  
18 18 percent on average have a consideration of an exemption  
19 from competitive bidding. It would not reduce -- it would  
20 not cause impact to the Medicare program because they would  
21 be reimbursed at the single pricing amount. It would just  
22 allow access to qualified, properly educated, properly

1 trained providers to continue to provide the limited number  
2 of off-the-shelf services that they are currently  
3 providing.

4           So thank you for your time. Appreciate it.

5           DR. CROSSON: Thank you.

6           Seeing no one else at the microphone, we are  
7 adjourned until 8:30 tomorrow morning.

8           [Whereupon, at 4:16 p.m., the Commission meeting  
9 was recessed, to reconvene at 8:30 a.m. on Friday,  
10 September 6, 2019.]

11

12

13

14

15

16

17

18

19

20

21

22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 6, 2019  
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
PAUL GINSBURG, PhD, Vice Chair  
KATHY BUTO, MPA  
LAWRENCE P. CASALINO, MD, PhD  
BRIAN DeBUSK, PhD  
KAREN B. DeSALVO, MD, MPH, Msc  
MARJORIE E. GINSBURG, BSN, MPH  
DAVID GRABOWSKI, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM  
AMOL S. NAVATHE, MD, PhD  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
PAT WANG, JD

B&B Reporters  
29999 W. Barrier Reef Blvd.  
Lewes, DE 19958  
302-947-9541

| AGENDA   | PAGE |
|--|------|
| A value incentive program for post-acute care providers  |      |
| - Ledia Tabor, Carol Carter.....   | 3    |
| Indirect medical education (IME): Current Medicare Policy, concerns, and considerations for revising |      |
| - Alison Binkowski, Jeff Stensland.....  | 78   |
| Public Comment.....  | 144  |

P R O C E E D I N G S

[8:30 a.m.]

1  
2  
3 DR. CROSSON: Okay. Good morning, everybody. Welcome  
4 back. We're going to have a good morning this morning  
5 talking about a couple of very important issues.

6 Jon Perlin has an unavoidable conflict that has  
7 required him to not be here this morning.

8 The first presentation is on the value incentive  
9 program for post-acute care. We've got Ledia and Carol  
10 here, and Carol is starting.

11 DR. CARTER: Good morning, everyone.

12 The Commission's work on a uniform value incentive  
13 program for post-acute care began in 2016. The Commission  
14 recommended adopting a value incentive program for all  
15 post-acute-care providers at the same time that a unified  
16 payment system is implemented. At that point, we undertook  
17 work to develop a common set of outcome measures across PAC  
18 providers.

19 In 2018, the Commission laid out a set of principles  
20 for designing quality payment programs and used these  
21 principles to design a Hospital Value Incentive Program, or  
22 HVIP.

1           This year, Ledia and I plan to apply these principles  
2 and design features to a value incentive program for post-  
3 acute care.

4           Today I will outline a proposed illustrative design,  
5 and Ledia will provide many of the details, and these are  
6 consistent with the HVIP. At the end, we'd like to get  
7 your input on a few design decisions.

8           The Commission and CMS have stated that Medicare needs  
9 to tie its payments to the quality of care furnished to  
10 beneficiaries. In its 2016 report to the Congress on a  
11 unified payment system for post-acute care, the Commission  
12 noted that a value incentive program should be implemented  
13 concurrently as a way to counter the incentives inherent in  
14 fee-for-service to furnish unnecessary volume and to lower  
15 quality if that would lower a provider's costs.

16           When a unified payment system is implemented,  
17 distinctions between providers would narrow. A single  
18 program that uses the same metrics and approach should be  
19 used to evaluate PAC provider performance. Moreover, given  
20 the overlap of the types of beneficiaries treated in  
21 different PAC settings, a common set of metrics and way of  
22 translating performance into payments will be key to

1 putting all PAC providers on a level playing field.

2 Currently, there are two value-based payment programs  
3 in place for PAC providers: the home health agency  
4 demonstration and the skilled nursing facility program.

5 Neither program meets the Commission's principles for  
6 tying payment to outcomes. The Commission recommends using  
7 a small set of outcome measures to gauge provider  
8 performance: The home health demonstration includes 20  
9 measures, including some process measures, but does not  
10 include a measure of resource use. The SNF program  
11 includes only one measure -- readmissions -- with no  
12 resource use or patient experience measures.

13 The home health program does not prospectively set the  
14 performance targets so agencies do not know the targets  
15 they should try to meet or exceed. Both programs include  
16 cliffs in their incentive payments, and neither considers  
17 social risk factors in translating performance into  
18 payments. And there is no program for IRFs or LTCHs.

19 With the HVIP as a model, we plan to illustrate a  
20 design for post-acute care that uses a small number of  
21 risk-adjusted, claims-based outcomes and resource use  
22 measures. These include hospitalization rates, successful

1 discharge home, and Medicare spending per beneficiary.  
2 While the measures are consistent with those developed by  
3 CMS, our measures use uniform definitions and risk  
4 adjustment across the four settings. Ledia will discuss  
5 each measure in detail in a minute.

6 The quality measures will help counter the fee-for-  
7 service incentives to lower the quality of care when that  
8 lowers the providers' costs while the resource use measure  
9 will create incentives for efficient care. This is not  
10 intended as an exhaustive list of measures. Additional  
11 measures could be added in the future. For example, the  
12 paper discusses the absence of a measure of patient  
13 experience for all PAC providers that we hope could be  
14 added at some point.

15 You'll also note that we've avoided measures based on  
16 patient assessments since our work earlier this year raised  
17 questions about the consistency of the recording of the  
18 function items included in patient assessments.

19 We plan to pool an individual provider's performance  
20 data over multiple years because there are so many small  
21 PAC providers. This will help increase the reliability of  
22 the measures and increase the number of providers that can



1 be included in the example program.

2 Performance would be scored using absolute, national  
3 prospectively set targets. We do not plan to pool  
4 performances of providers that are parts of chains. That  
5 way, each provider will know its own experience and  
6 performance. To account for social risk factors, providers  
7 with similar shares of dual-eligible beneficiaries will be  
8 compared in determining a provider's reward or penalty.

9 We plan to model a 5 percent withhold to fund the  
10 incentive payments. Because Medicare margins for many PAC  
11 providers are relatively high, a sizable withhold may be  
12 needed to influence provider behavior. We'd like to get  
13 your input on the size of the withhold.

14 As context, the recommended HVIP proposed a 2 percent  
15 withhold that could increase over time. The withhold for  
16 the home health program started at 3 percent and will  
17 increase to 8 percent by 2022. The SNF program withholds 2  
18 percent of payments, but some observers have questioned  
19 whether this is large enough to change behavior.

20 Now Ledia will talk about the measures in more detail  
21 and the scoring methodology.

22 MS. TABOR: The first measure we propose to score in

1 the PAC-VIP is a measure of all-condition hospitalizations  
2 within the PAC stay, meaning admissions, readmissions, and  
3 observation stays. Hospitalizations are a major source of  
4 patient and family stress and may contribute substantially  
5 to loss of functional ability, particularly in older  
6 patients.

7 We want to score a claims-calculated outcome measure  
8 that would hold PAC providers accountable for their patient  
9 outcomes and care they provide during the stay. Unlike a  
10 measure developed by CMS, the within-stay hospitalization  
11 measure we developed uses identical definitions and a risk-  
12 adjustment model that is uniform across all four PAC  
13 settings.

14 We calculated provider-level results using multiple  
15 years of data. The mean hospitalization rate was 17  
16 percent, and a lower rate is better.

17 We also found that the risk-adjusted within-stay  
18 hospitalization rates varied across all PAC providers, with  
19 providers in the 90th percentile of hospitalization rates  
20 having a rate that was more than three times the providers  
21 in the 10th percentile.

22 The relatively high mean rate and variation signals

1 opportunities to improve the quality of care and the  
2 potential to use the measure to compare quality across all  
3 PAC providers.

4       The second measure we propose to score in the PAC-VIP  
5 is a successful discharge to the community measure.  
6 Discharge to a community setting is an important health  
7 care outcome for many patients for whom the overall goal of  
8 post-acute care includes safely returning home. However,  
9 PAC providers should not discharge patients who are not  
10 medically ready to return to the community because this may  
11 result in hospital events. Unlike the hospitalizations  
12 within-stay measure, successful discharge to community  
13 captures a patient's outcomes after discharge from the PAC  
14 provider.

15       The measure defines successful discharge to the  
16 community from a PAC setting as having been discharged to  
17 the community and having no unplanned hospitalizations and  
18 are still alive after the next 30 days.

19       We used CMS' measure specifications as the basis of a  
20 successful discharge to the community but with uniform  
21 definitions and risk-adjustment variables that were the  
22 same across settings.

1           We calculated provider-level results using multiple  
2 years of data. The mean hospitalization rate was 57  
3 percent. A higher rate is better.

4           We also found that the risk-adjusted successful  
5 discharge to community rates varied across PAC providers,  
6 with providers in the 90th percentile of rates having a  
7 rate that was more than two times the providers in the 10th  
8 percentile.

9           Again, this relatively low mean rate and variation  
10 signals opportunities to improve the quality of care and  
11 the potential to use this measure to compare quality.

12           The first two PAC-VIP measures are outcome measures,  
13 but consistent with the Commission's principles, the PAC-  
14 VIP should also include a measure of resource use. So the  
15 third measure we propose to score in the PAC-VIP is a  
16 measure of Medicare spending per beneficiary, or MSPB.  
17 This measure incentivizes providers to furnish efficient  
18 care and discharge patients to high-quality PAC providers  
19 with low hospitalization rates.

20           Similar to the hospital MSPB measure, the MSPB PAC  
21 measure holds a provider responsible for Parts A and B  
22 spending during the PAC stay and the following 30 days. We

1 used a CMS measure as the basis for our measure but, again,  
2 used uniform definitions and risk adjustment. Carol  
3 presented this measure development work to the Commission  
4 in April of 2018.

5 We found that the MSPB rates varied across PAC  
6 providers, with providers in the 90th percentile of rates  
7 having a rate that was almost two times the providers in  
8 the 10th percentile.

9 As with the other two measures, the variation signals  
10 opportunities to improve the quality of care and the  
11 potential to use this measure to compare quality.

12 We found that there was considerable variation in  
13 performance on the three measures not just within but also  
14 across PAC settings. For example, the mean  
15 hospitalizations within-stay rates for IRFs was 8 percent  
16 while the mean rates for home health was 21 percent.

17 This variation is likely due to three factors.

18 First, PAC stays vary considerably in length. For  
19 example, IRF stays are, on average, the shortest at about  
20 13 days and home health stays are the longest at about 45  
21 days. Because we would expect hospitalization rates to be  
22 higher, on average, for longer stays, this contributes to

1 the variation in this measure across settings.

2         Second, each setting has its own conditions of  
3 participation. IRFs and LTCHs have the same conditions of  
4 participation as acute-care hospitals, so they are more  
5 likely to be able to manage acute episodes in their  
6 facilities while a SNF or home health patient with a  
7 similar condition might need to be admitted for hospital-  
8 level care.

9         Third, across the PAC settings, the utilization  
10 attributable to beneficiaries who qualify for both Medicare  
11 and Medicaid differs across settings, ranging from 19  
12 percent of IRF stays to 40 percent of LTCH stays.

13         Because utilization and spending trends reflect the  
14 design and underlying incentives of the current PPSs, we  
15 propose to score providers on setting-specific targets and  
16 peer groups.

17         In the future, under a unified PAC PPS, we would  
18 expect differences in service use patterns to narrow as  
19 distinctions between "settings" becomes less meaningful, so  
20 we could move to using the same standards across providers.

21         Consistent with the Commission's principles, the PAC-  
22 VIP would reward or penalize a PAC provider based on its

1 performance relative to prospectively set targets for each  
2 measure.

3 Like the HVIP, we propose to model the PAC-VIP using a  
4 continuous performance to points scale set along a broad  
5 distribution of national historical data for each setting  
6 so that most providers have the ability to earn points.

7 Each provider's total PAC-VIP score is the average of  
8 the points across the three measures. In quality payment  
9 programs, the Commission contends that Medicare should take  
10 into account, as necessary, differences in providers'  
11 populations, including social risk factors.

12 However, adjusting measure results for social risk  
13 factors can mask disparities in clinical performance. So  
14 Medicare should adjust performance payments through peer  
15 grouping so that, for purposes of rewards and penalties,  
16 each provider's performance is compared with that of its  
17 "peers" -- defined as providers that treat a similar mix of  
18 beneficiaries with social risk factors.

19 Again, like the HVIP, to define peer groups, the PAC-  
20 VIP would use eligibility for full Medicaid benefits as a  
21 proxy for a PAC provider's patients' social risk factors.

22 Because of the variation across settings, we would

1 convert PAC-VIP points to payment adjustments within  
2 setting-specific peer groups.

3 Each peer group will have about the same number of  
4 providers, and those providers have about the same share of  
5 Medicare patients that are fully dual-eligible  
6 beneficiaries. We plan to explore the appropriate number  
7 of peer groups to use in the PAC-VIP.

8 Each peer group has its own pool of dollars that is  
9 redistributed based on the group's PAC-VIP points. Each  
10 peer group has its own "percentage adjustment to payment  
11 per PAC-VIP point" based on the group's pool of dollars and  
12 their PAC-VIP points. Like the performance-to-points scale  
13 from the previous slide, each peer group's percentage  
14 adjustment to payment per point is prospectively set and  
15 known by providers.

16 In summary, a PAC-VIP is essential to incentivize  
17 provider improvement. This year we intend to model the  
18 effects of the proposed PAC-VIP and present our results in  
19 the spring.

20 For the modeling, we would like your feedback on the  
21 proposals we have presented, including the measure set, the  
22 scoring methodology, and modeling the PAC-VIP with a 5



1 percent withhold.

2 Thank you and we look forward to the discussion.

3 DR. CROSSON: Thank you, Ledia and Carol.

4 We'll now start questions. Jonathan, Dana, David.

5 DR. JAFFERY: Thanks, Jay, and thanks, that was a  
6 great presentation or report, and it's really nice to see  
7 all these programs start to come in the same direction and  
8 follow these -- you know, get consistent principles and  
9 whatnot.

10 One of the questions in front of us is the size of the  
11 withhold, and, Carol, you presented some information about  
12 how various programs have a variety of different withholds.  
13 And I'm just wondering, as we start to discuss and think  
14 about what we think is the right size, I'm trying to figure  
15 out what we should go on, and this is a question maybe that  
16 others can answer weighing in as well. But what do we know  
17 about what drives behavior in this setting? There's a  
18 reference to these having good margins in some settings,  
19 and so maybe it needs to be relatively large. And I don't  
20 know if that actually makes a difference or not. But it  
21 feels like the question of how big may be a little bit  
22 random to me right now or sort of a gut question, and I'm

1 wondering if we have evidence to support how big it should  
2 be to drive behavior.

3 DR. CARTER: We have a little evidence. I know in the  
4 SNF, the first year of the value-based purchasing program,  
5 there wasn't that much difference between the performers at  
6 the highest end and at the lowest end, and some of that  
7 isn't that surprising. It's a 2 percent withhold, and the  
8 program's keeping 40 percent of that as savings. So it's  
9 just not moving a whole lot of money around, and so I would  
10 suggest some -- well, really, the 2 percent ends up being  
11 60 percent of that, so definitely something bigger than  
12 that I think would be on point.

13 The home health starts at 3. It is three-quarters of  
14 PAC stays, and so that is the volume that's kind of driving  
15 the whole PAC PPS and the design features and the  
16 coefficients that we've used and all of the risk  
17 adjustment. You know, we've pooled all the stays, but home  
18 health dominates that just by volume. So in some sense,  
19 that may be a bit more of a metric of sort of where is the  
20 home health design, and it started at 3, it's going up to  
21 8. So those are maybe a couple of benchmarks.

22 We could also model a couple -- you know, something on

1 the small end and something on the big end. I mean, once  
2 you've done the programming, it's not a big deal to have a  
3 different size withhold just to sort of see how much  
4 difference we expect the withholds to affect providers. So  
5 that would be another option, to pick something on the  
6 smaller end and something on the larger end and sort of  
7 see.

8 It wouldn't surprise me if, you know, in the end the  
9 home health is transitioning from small to big, and that's  
10 always a good idea to start something more on the  
11 conservative side and have it grow over time. We plan to  
12 only model one year, so at least as a one-time snapshot,  
13 that wouldn't be an option.

14 DR. JAFFERY: I guess we don't know of a lot of  
15 evidence and literature that suggests how big something  
16 needs to be before it drives that -- you can model the  
17 different amounts, and we can figure out how much the  
18 financial impact is. But it's not clear.

19 DR. CARTER: I personally don't know that.

20 MS. TABOR: You know, I don't know the literature as  
21 well, but I would say just consistently across the settings  
22 -- because home health is one example that it's going from

1 3 to 8, and home health agencies are starting to pay more  
2 attention to it, and I think we're hearing the same thing  
3 with physicians or clinicians as opposed -- regarding MIPS,  
4 because it started out at 2 percent, and that's going up to  
5 9 percent. And as the incentive is getting bigger, they're  
6 paying attention more to meeting the requirements and  
7 getting good performance. So it's really just kind of  
8 qualitative.

9 DR. CROSSON: Dana.

10 DR. SAFRAN: Thanks. Excellent chapter, and as  
11 Jonathan said, it's exciting to see the convergence of, you  
12 know, applying the principles around measurement and the  
13 basic approaches across programs. So really great work,  
14 and I really like a lot of what you're structuring in terms  
15 of the thoughtfulness about different settings and  
16 different populations.

17 The questions I have are mostly methodological ones  
18 and may be ones you can't answer until you go through this  
19 period of testing. But maybe they'll inform the testing.

20 So the first one is: What do we know so far about the  
21 sample size needed to get stable, reliable measures of the  
22 three measures you're proposing in these different

1 settings? Do we have that information yet? Because I'm  
2 concerned that the "n" may be too small to do a lot of what  
3 we're aiming to do here.

4 MS. TABOR: I'll start off. So we have looked at this  
5 already, and that was a big part of the measure development  
6 work that we did with the contractors. And we've also had  
7 a lot of internal discussion about this.

8 So we know with PAC providers -- we're dealing with a  
9 lot of small providers -- they have a small number of  
10 patients they're treating. So we went in with it knowing  
11 that we're going to have to use multiple years of data to  
12 get more reliable measures, and that's one thing we've  
13 done, and that has improved the reliability.

14 We also wanted to use a really strict measure of what  
15 is reliable, so we did a 0.7 reliability, which is  
16 different than CMS, who uses a 0.4. But, again, we just  
17 wanted to have like really accurate measures, and we  
18 thought also because we're using multiple years of data, we  
19 could kind of get up to that 0.7.

20 So that basically translated into a minimum  
21 denominator of 60, so a provider would have to treat 60  
22 beneficiaries over the three years that we measured to get

1 that 0.7.

2 That still leaves out a good chunk of providers. It's  
3 about 10 percent of SNFs, about 20 percent of home health,  
4 and like 2 to 4 percent of LTCHs and IRFs. And we were  
5 kind of like, oh, we don't want to leave out that many  
6 providers, especially for SNF and home health. But then we  
7 thought, you know, if you're not treating at least 60  
8 beneficiaries over three years, like moving money around is  
9 not going to do much. So we kind of settled on we're  
10 having good reliability at 0.7, we're going to leave out  
11 some small providers, but that's probably okay.

12 DR. SAFRAN: Okay.

13 MS. TABOR: And, I mean, that's open for the  
14 Commission's discussion.

15 DR. SAFRAN: Yeah, I'll come back around to that in  
16 the commentary section.

17 MS. TABOR: Yeah.

18 DR. SAFRAN: So thanks for that. And does that same  
19 sample size requirement apply on the resource use measure?  
20 Because that usually has a lot more variability, so you --

21 DR. CARTER: It's -- yes, it does work for that.

22 DR. SAFRAN: Really?

1 DR. CARTER: Yeah, yeah.

2 DR. SAFRAN: Okay.

3 DR. CARTER: We've checked that, because based on the  
4 work that I had done a year ago, we looked at how much  
5 variation there was in that measure, and so we were  
6 particularly concerned about that measures. So 60 does  
7 work.

8 DR. SAFRAN: Great. Then two other small questions.  
9 One, is stratification based on duals for the social risk,  
10 is that -- remind me whether that's what we're doing on the  
11 hospital side, too. That seems like it could be a pretty  
12 thin risk adjuster or stratification factor.

13 MS. TABOR: It is. We used share of fully dual-  
14 eligible beneficiaries treated, and we do acknowledge that  
15 kind of the literature is growing about what's the best  
16 kind of measure to use to kind of note as a proxy of social  
17 risk factors, and we're tracking that. ASPE is still doing  
18 a lot of work on area deprivation indices --

19 DR. SAFRAN: Yeah.

20 MS. TABOR: -- but I don't think it's there yet for us  
21 to use in our modeling. So I think kind of the best thing  
22 we have as far as data is concerned is the share of fully

1 dual-eligible beneficiaries.

2 DR. SAFRAN: Okay. And then the last question is:  
3 You referenced -- and I remember it, but I don't remember  
4 the specifics -- the problems with functional status  
5 assessment. But that seems like a really glaring miss from  
6 a measure set in this setting. So I just wonder whether  
7 you have any thoughts about how the program could begin to  
8 build toward better measures, you know, paying for  
9 participation in terms of measurement that we can count on,  
10 or, you know, what you're thinking about that area of  
11 functional status, because it seems to leave that out in  
12 this area of care is kind of ignoring the main point.

13 MS. TABOR: Well, where we started, I mean, so where  
14 we kind of landed in the June 2019 report was we don't want  
15 to kind of give up on the function for quality measurement,  
16 but we kind of identified three strategies that could be  
17 used and encouraged CMS to use those strategies to improve  
18 the function data.

19 One of those was monitoring and auditing. A second  
20 one was perhaps using hospital discharge information to  
21 kind of monitor an audit as well as even just kind of  
22 another source of function data, and third was explore the



1 use of potential patient-reported outcomes.

2 We didn't kind of feel like we're there yet but don't  
3 want to kind of give up on it.

4 DR. CROSSON: Thank you, Dana.

5 David.

6 DR. GRABOWSKI: Let me echo others in saying what a  
7 great chapter and presentation.

8 I wanted to ask about Slide 10 and just the variation  
9 across sectors. You showed some rates in the reading  
10 materials that were really stark, and I think all the  
11 explanations you have up there are true.

12 I worried about how well the risk adjustment works  
13 across sectors. I don't know if you could speak to that.

14 Did you try any kind of conditioning by stroke or  
15 lower extremity joint replacement, heart failure? Is there  
16 any opportunity to see kind of conditioning on a particular  
17 diagnosis? What do these rates look like across sectors?  
18 I'm just curious how much of this is the risk adjustment  
19 not doing enough work here and how much are these other  
20 explanations like length of stay or just some of the  
21 different patients that we're seeing.

22 DR. CARTER: Yeah. So when CMS developed its

1 measures, it used setting-specific models that were, more  
2 or less, similar, more or less, and we decided we didn't  
3 want to do that because we want uniform measures.

4 But I am sure that having setting-specific  
5 coefficients would improve these models. But it kind of  
6 violates one of our principles of trying to have a uniform  
7 design. You're trading off accuracy for having something  
8 that's uniform, and that's the tradeoff.

9 We haven't looked at sort of how these models do by  
10 condition. It's something we could do to see, just sort of  
11 seeing how those rates varied, but we haven't done that  
12 work yet.

13 DR. GRABOWSKI: I'm not advocating that I like the  
14 global measure.

15 DR. CARTER: Yeah.

16 DR. GRABOWSKI: But just as a way to sort of check the  
17 model and see what's kind of going on underneath, it's one  
18 way to sort of maybe better compare apples to apples across  
19 settings.

20 DR. CARTER: Yeah. I see what you're saying. Yeah.  
21 That's a good idea.

22 DR. CROSSON: On this point, Kathy?

1 MS. BUTO: Yes.

2 Carol and Ledia, I had a similar question to David's,  
3 which is I think one of the things we envision is that  
4 these providers might evolve to be more specialized under a  
5 unified PAC, that they'd really focus on things they do  
6 well, say, stroke treatment for rehab facilities, in which  
7 case I worried about risk adjustment really being able to  
8 account for that evolution, if you will. Maybe there's  
9 plenty of time to get to that specificity and precision,  
10 but I think if we imagine what these might evolve to that  
11 we -- and I support a uniform set of standards, but I'm  
12 just wondering how that's going to work as these evolve.  
13 So it's really more of a comment than a question.

14 DR. CROSSON: Sue.

15 MS. THOMPSON: Thank you, Jay.

16 Thank you, Carol and Ledia. You're back.

17 I should probably remember this, Carol, but I'm going  
18 to ask again. You referenced the number of home care  
19 visits that are predominant in this dataset. A good number  
20 of admissions to home care come from the community versus  
21 the acute setting. Do we think about those different? Are  
22 they all post-acute, even though a good portion of them

1 really have not been in an acute setting? Remind me of  
2 that.

3 DR. CARTER: So you're right. Home health is about  
4 three-quarters of the PAC stays, and about two-thirds of  
5 home health is community-admitted.

6 We did not include adjustors for a community admit in  
7 the models, but all the stays are in because we would  
8 expect the PAC PPS to cover all stays.

9 Next month, we'll be talking about aligning coverage  
10 and cost sharing, and that would be something to think  
11 about because the coverage rules differ by setting. But at  
12 least for now, we were trying -- you know, our mandate back  
13 in '16 was to move the current PPS's to a unified payment  
14 system and the current PPS's pay for community admissions.

15 MS. THOMPSON: I have one more question. Remind me  
16 again. As we begin and have worked through this, have we  
17 taken a look at the relationship of any of these post-acute  
18 care organizations to ACOs? In other words, do we have any  
19 data on the impact, being part of an ACO network, might  
20 have on this work, on these scores, on their quality, on  
21 additional resources to small number, low sample size, SNF  
22 units?

1 DR. CARTER: We haven't looked at that. I don't know  
2 that the --

3 MS. THOMPSON: I didn't remember that we had.

4 DR. CARTER: Yeah, yeah.

5 MS. THOMPSON: Thank you.

6 DR. PAUL GINSBURG: I've got a follow-up too.

7 I would imagine that a well-functioning ACO, which is  
8 reducing post-acute care, would mean that those that do go  
9 to post-acute care have greater needs.

10 MS. THOMPSON: Could you repeat that, Paul?

11 DR. PAUL GINSBURG: Yeah. If an ACO is reducing post-  
12 acute care use, not referring as much, presumably those it  
13 does refer to post-acute care have greater needs.

14 DR. CROSSON: Larry.

15 DR. CASALINO: Yeah, a few questions. Again, I  
16 thought this was to me very interesting and very clearly  
17 presented.

18 In terms of the size of the peer groups, which you  
19 mentioned could be 60 -- I'm sorry -- the sample you need  
20 to get a reliable measurement, you gave some pretty low  
21 figures for how many post-acute care providers that would  
22 exclude needing to get to 60 over three years, I guess.

1           But how about when you separate them into peer groups?  
2           Would that have any impact? I guess the 60 is all  
3           patients, not just the duals that wind up in a peer group.

4           MS. TABOR: Right. It would just be the 60 we'd apply  
5           kind of firsthand before we even put them into peer groups.

6           DR. CASALINO: Okay.

7           MS. TABOR: So to make it into a peer group, you'd  
8           have to have the minimum sample of 60.

9           DR. CASALINO: Okay. The peer group doesn't really  
10          impact the number you can get with the minimum sample.

11          In terms of the length of stay, I'm sure you've  
12          thought of this, and maybe it was in the manuscript. But  
13          if it was, I missed it. It would be easy to adjust for  
14          admission rates for length of stay if one wanted to compare  
15          across settings. Is that right?

16          DR. CARTER: Yes, it would.

17          We also developed another measure, which was looking  
18          at readmission rates for the first 14 days, sort of  
19          controlling for length of stay across the settings, so we  
20          looked at those at hospitalization rates.

21          But we didn't go with that, and that's because the  
22          commission has long held that providers should be

1 accountable for patients throughout the entire stay. When  
2 the patients are under their control, we want measures that  
3 reflect the quality of care throughout the stay. So we  
4 decided not to go with that, that measure.

5 DR. CASALINO: Is there a downside or a reason to just  
6 not adjust length of stay, not adjust admission rate,  
7 readmission rate for length of stay?

8 DR. CARTER: We could think about that.

9 DR. CASALINO: Okay.

10 Then I think David and Kathy and Sue were all bringing  
11 up this concern in different ways, but several places in  
12 the manuscript, there are assertions that the patients are  
13 the same across settings, and therefore, it's okay to  
14 compare everybody, eventually to compare everybody to  
15 everybody. And maybe this discussion happened before I  
16 joined the commission.

17 How can I say this? As a physician who has taken care  
18 of people who were in different settings, that assertion,  
19 face value, I was surprised at that assertion. So is there  
20 evidence for that, or is it driven mostly just by the  
21 strong principle of wanting to compare across all four  
22 settings using the same measures?

1 DR. CARTER: We've done a fair amount of work on this,  
2 and also the PAC demonstration that CMS did several years  
3 ago looked at how much overlap there was in the patients  
4 across the four settings. And they looked at a variety of  
5 measures, including function, for example.

6 When we looked at, say, the over -- we did quite a  
7 deep dive, and the patients -- this is before the unified  
8 PAC PPS. We looked at site-neutral payments between SNFs  
9 and IRs and compared the overlap in those patients and  
10 found a fair amount of overlap.

11 If you look at all of the -- we've looked at a number,  
12 something like 40 different clinical groups, and you do see  
13 a distribution across the four settings. Invasive event  
14 patients may be the most concentrated in sort of one  
15 setting. That's not a bad marker for LTCH, if you will, a  
16 clinical condition that actually is very highly  
17 concentrated in LTCHs, but there SNFs that take care --  
18 there are some SNFs that take care of those patients.

19 So I would say that -- and I hope that the text is  
20 careful to say we see overlaps in many patients or many  
21 clinical conditions because, obviously, patients who are in  
22 LTCHs can't be in home health, and there are many SNFs that



1 are not capable of taking care of many LTCH patients.

2 So there is not a complete overlap, and we would never  
3 say that. But I think there's enough overlap, particularly  
4 in certain patient conditions, that I think that that  
5 should be a qualified statement. And I think we could  
6 stand behind it.

7 DR. CROSSON: Brian.

8 DR. DeBUSK: First of all, thank you on a fantastic  
9 chapter. It was exciting to see PAC PPS meets HVIP.

10 So before I ask any questions, I just want to be  
11 wildly complimentary to this because I'm actually nervous  
12 about asking questions, thinking it's going to detract.

13 I do want to build on the comment David made about  
14 those conditions specific and then the question Kathy asked  
15 about the provider specializing, and this is truly just to  
16 clarify.

17 Your risk adjustment model does account for reason for  
18 treatment and comorbidities. Would that account for --  
19 let's say Kathy's scenario plays out and you do get  
20 specialization of these providers. Is it reasonable to  
21 think that the risk adjustment model is going to absorb  
22 that?

1 DR. CARTER: I would say with a uniform set of  
2 relative weights and the coefficients, I think that might  
3 not be true.

4 So let's say you have an indicator in the model for  
5 whether the patient is on an invasive event, but the weight  
6 of that coefficient is going to be reflecting the entire  
7 pool of patients. So it may not sway the payments enough  
8 for a concentrated -- a provider who concentrates in that  
9 type of patient.

10 DR. DeBUSK: Okay. Let me see if I get it correctly  
11 the other way.

12 For example, let's say that one PAC provider got  
13 really, really good at stroke. All they did was PAC  
14 strokes. Presumably, they, through specialization, had  
15 better outcomes.

16 In theory, in the risk adjustment model, there could  
17 be arbitrage there, because they would always look like  
18 they're beating the expected outcome, but they really would  
19 be because they're good at it. Is that a bug, or is that a  
20 feature?

21 DR. CARTER: Well, I guess the other thing to think  
22 about, because what you just said made me think about the

1 Value Incentive Program, if you're concentrating in a  
2 particular type of case and doing really well on the  
3 outcome and resource use, then depending on the withhold,  
4 you may always actually beat your peers. So even though  
5 you're being -- so you may be made whole through the  
6 incentive program. I'm not sure.

7 DR. DeBUSK: Okay. I was just thinking it may be a  
8 way to beat the system --

9 DR. CARTER: Yeah.

10 DR. DeBUSK: -- but beat it in a way that benefits  
11 beneficiaries.

12 Okay. Those two got me thinking when they asked those  
13 questions because, Kathy, I knew exactly where you were  
14 going.

15 The second question, I like the measures you chose,  
16 the three measures, but is there an element of triple  
17 jeopardy here? Let's say you do have a hospitalization  
18 during a PAC stay. So I'm going to flunk the  
19 hospitalization measure, but then I'm also going to flunk  
20 the discharge to community measure, because clearly you're  
21 not going home or at least immediately, and then I'm also  
22 going to flunk the MSPB measure. It's almost like --

1 MS. TABOR: There's an element of double jeopardy.  
2 I'm not sure both because the first measure is looking  
3 really just at within stay. So if you have a  
4 hospitalization within stay, that will count once.

5 Once the patient leaves the PAC provider, if there's a  
6 hospitalization within 30 days, they'll get dinged on the  
7 successful discharge-to-community measure, and they'll also  
8 get dinged on the MSPB measure.

9 DR. DeBUSK: Okay. So a hospitalization or a  
10 readmission within 30 days of discharge doesn't count  
11 against the first measure.

12 MS. TABOR: Exactly.

13 DR. DeBUSK: Okay.

14 MS. TABOR: That's only within stay.

15 DR. DeBUSK: Okay. That's one thing just to keep your  
16 eye on.

17 MS. TABOR: Yeah.

18 DR. DeBUSK: I had some questions about that in the  
19 reading, because I really like your measures. It's just an  
20 aggregate. It looked like if I flunk one, I flunk them  
21 all.

22 MS. TABOR: Yeah. We kind of dealt with this also in

1 the HVIP too, like readmissions and MSPB or kind of also  
2 double counting, but I think we've kind of landed on it's  
3 okay to double count these things because they're bad.

4 DR. DeBUSK: No, that was my other question. Maybe an  
5 element of double or triple jeopardy makes sense.

6 MS. TABOR: Yeah.

7 DR. DeBUSK: The final thing I was going to ask, in  
8 the reading, you mentioned that there isn't a uniform  
9 patient experience. Some of these areas, you don't even  
10 have the CAHPS for some of these. Could you speak to your  
11 impression of having, say a unified CAHPS-type instrument,  
12 versus say something like a net provider or net promoter  
13 score? I only know a little bit on the fringes of that,  
14 but if there isn't a CAHPS already in place, is this a  
15 chance to cross over to something that's perceived as more  
16 contemporary?

17 MS. TABOR: I think there is an opportunity, and I  
18 will say the AHCA, which has developed what's more similar,  
19 it's lighter than the CAHPS survey. It's about three  
20 measures. So it's a little bit more than net promoter  
21 score, but it is kind of getting that idea. We do  
22 understand that SNFs kind of do use this tool, and I think

1 CMS has also considered using it. They proposed it in, I  
2 think, two years ago in proposed rulemaking, but then we  
3 have not heard of it since then.

4 So I think there are things out there like a net  
5 promoter score, like this AHCA tool, that could be used,  
6 but it's just currently not being used systematically  
7 across the settings.

8 DR. CROSSON: Thank you, Brian.

9 Pat.

10 MS. WANG: Good morning.

11 I was wondering. I wanted to ask you a little bit  
12 more about home health. I understand the principle of  
13 uniformity of measures across settings, et cetera. I think  
14 the fact that these are really different settings and home  
15 health being the only non-institutional setting, that  
16 you've tried to control for that by saying we'll do within  
17 setting comparisons at least to start.

18 But I guess I just wanted to ask you whether for home  
19 health in particular, the particular measures are the most  
20 appropriate. Whether you had thought about that  
21 particularly within stay admission as well as the  
22 readmission, I mean, given the nature of home health, the

1 value of uniformity is important but not if it obscures the  
2 most appropriate measure of quality for that setting. I  
3 just wondered whether you thought that you had thought  
4 about that, because some of the -- even the spending per  
5 beneficiary, there's sort of verbiage in the chapter about  
6 giving incentives to PAC providers to make recommendations  
7 for the highest quality providers, et cetera, et cetera.

8         Could you say more about what you're feeling about  
9 home health agencies, the reality of they are really doing  
10 that, given the nature of what they're doing?

11         Usually, when we think about home health contributing  
12 to avoiding admissions and readmissions, it's been in the  
13 context of working with organized delivery systems. Since  
14 this is going to apply to the agency that's freestanding,  
15 whether they're part of an ACO or not, I wondered if you  
16 had thought about that or struggled with it a little bit in  
17 your mind about one of these things is not like the other  
18 in terms of uniformity of the quality measures or not. I  
19 don't know.

20         DR. CARTER: So we haven't really thought about a  
21 measure that would be a better fit for home health. These  
22 seemed like good measures for post-acute care, more

1 generally, and so then your question is maybe they're not  
2 great fits for home health.

3       It is a reason why in the hospitalization measure, we  
4 were very keen to include hospitalizations and not just  
5 readmissions, since so much of home health care is not  
6 preceded by a prior hospital stay. So we were trying to  
7 accommodate a feature of home health in the design of that  
8 measure.

9       The MSPB measure, because the spending for home health  
10 is one-sixth of institutional stays, that measure is always  
11 going to have to have some kind of adjustor for looking,  
12 even when you get to being able to compare across settings.  
13 You're going to have to have a home health adjustor because  
14 the spending for home health just starts from a lower  
15 place, and so that would be another accommodation for the  
16 realities of the PAC landscape, even under a unified  
17 payment system and the breaking down of the laws between  
18 the settings.

19       I guess the one place where I'm not sure, the  
20 successful discharge home, home health patients are already  
21 home, and so then the question is once your home health  
22 care ends, is that a fit for home health care that's really



1 a good measure compared to other settings? Probably.  
2 There's a lot of home health care that's back to back, back  
3 to back. So trying to think about when it's really  
4 appropriate, home health care, I think, is a reasonable  
5 measure for successful discharge home.

6 But we haven't thought about a measure that's a good  
7 fit for home health and then thought, oh, could this apply  
8 to other settings. We didn't start there.

9 DR. CROSSON: Okay. Warner.

10 MR. THOMAS: A couple of questions.

11 DR. CROSSON: On this? Sorry. Sorry. Are we on this  
12 point?

13 MS. BUTO: I was on Pat's point.

14 DR. CROSSON: Go ahead.

15 MS. BUTO: Actually, when I was looking at this I  
16 thought of the successful discharge to community as being  
17 more appropriate to home health, because they're already  
18 home, than, say, an LTCH patient or many SNF patients. So  
19 I actually thought that was the one indicator or standard  
20 that would be more likely to fit home health.

21 DR. CARTER: Yeah, and we did, and this doesn't get at  
22 your question, but thinking about the appropriateness of

1 the settings for patients who are discharged home but are  
2 really going to nursing homes, because that's really their  
3 home now, we did include those patients. And I know some  
4 of CMS' measures do not consider that as discharge to  
5 community. But for those patients, that's where they're  
6 living. So we were trying to tailor the measure to the  
7 realities of nursing home residents.

8 DR. CROSSON: Okay. Thank you. Warner.

9 MR. THOMAS: Just a couple of questions. First of  
10 all, did you look at the types of hospitalizations? I  
11 mean, is it -- and should that be considered in this whole  
12 process? You know, because obviously there could be some  
13 that are totally unrelated. I don't know if that plays out  
14 in this situation at all.

15 MS. TABOR: Well, so we looked at -- when we looked at  
16 -- we looked at admissions, observation stays, and  
17 readmissions, and we were very thoughtful to include the  
18 observations stays, because in Commission discussions that  
19 even came up yesterday about how there's this move towards  
20 observation stays. And from a patient perspective those  
21 are just like an admission.

22 We didn't look, like, specifically at reasons for

1 admissions. I mean, we could look at that. But we just  
2 did include all admissions plus observation stays.

3 MR. THOMAS: Okay.

4 DR. CARTER: But in the risk adjustment, for some of  
5 the measures, the principal reason for the hospitalization  
6 is the primary reason to treat. And if you were a patient  
7 who was community admitted, we ran your PAC claim through  
8 the DRG group to get a DRG assigned to you so that we could  
9 put you in a primary reason to treat, just like the other  
10 patients. So the reason for your hospitalization is  
11 captured in the risk adjustment.

12 MR. THOMAS: Okay. On the -- you had the question  
13 about the percentage of payment that should be at risk and  
14 whatnot. What is the current percentage today on post-  
15 acute payments that are at risk?

16 DR. CARTER: Doing math in my head in front of a crowd  
17 is always a bad idea. So home health is three-quarters of  
18 stays but it's about, what, 40 percent of PAC payments?  
19 I'm not sure.

20 MR. THOMAS: But, I mean, my point is what percentage  
21 of their -- like what percentage of their payments would be  
22 at risk today, based upon quality? So it says, you know,

1 in Slide 4, basically there's no value-based payments inn  
2 IRFs and LTCHs, so for home health and SNF what percentage  
3 of payment is it? Is it a percent? Is it 5 percent? Is  
4 it 2 percent?

5 MS. TABOR: Well, so for home health I think it's --  
6 is it 4 now?

7 DR. CARTER: Yeah, it is, yeah.

8 MS. TABOR: It's 4, and in SNF it's 2, and those are  
9 the lion's share of the PAC stays.

10 MR. THOMAS: And have we seen any change in outcomes  
11 based upon the implementation of those programs and those -  
12 - you know, those withholds or those value-based programs?

13 DR. CARTER: I would say there's been not as much  
14 change in the SNF as you might have thought. I think one  
15 reason is there just isn't really that much money at stake.  
16 In the home health you see the patient-reported outcomes  
17 have improved -- I mean, not the patient. The provider-  
18 reported outcomes have improved and the claims-based  
19 measures really haven't improved.

20 MR. THOMAS: Okay.

21 MS. TABOR: The process measures, most have improved.  
22 So home health agencies are paying attention.

1 MR. THOMAS: Okay. And then last question. Did you  
2 look at any of this information based on volume of the  
3 provider? So is there any variation based on low volume  
4 versus high volume providers? Should that be something  
5 that is thought about as a potential measure?

6 MS. TABOR: We didn't look at large versus small  
7 providers, so that's something that we could do. I would  
8 say that we do capture some of this in the fact that we do  
9 have a minimum sample size. So you've got to have 60  
10 beneficiaries that you treat over three years to even make  
11 it into the process.

12 MR. THOMAS: Okay. And then the last question -- and  
13 I know you've looked at this some -- as far as the types of  
14 patients that actually get accepted by post-acute  
15 providers, and when it comes to the risk of  
16 hospitalization. This idea of cherry-picking or not taking  
17 certain patients, I mean, is there any concern about that,  
18 or have you -- do you see any trends of that for post-acute  
19 to have quality measures in there today?

20 DR. CARTER: I think in the SNFs basically you do see  
21 some cherry-picking. We haven't looked at it but just  
22 looking at the design of the payment system you would think

1 that there is some. Since it's a payment system that  
2 currently really rewards therapy and doesn't pay adequately  
3 for medically complex patients, I would think that there is  
4 some selection. The IRF and the LTCH have admission  
5 criteria --

6 MR. THOMAS: Right.

7 DR. CARTER: -- kind of that are screening at the door  
8 who is admitted.

9 We've also heard, anecdotally -- not me, but  
10 Stephanie, on her site visits -- that LTCHs are careful  
11 about who they take, and so there's a little bit there.

12 I will say, then, under the PAC PPS where we're hoping  
13 to redistribute money, based on patient complexity and  
14 clinical characteristics, you will see less of that. And  
15 with the redesign of the home health and the SNF PPSs that  
16 are starting, well, next month for SNF and then in January  
17 for home health, that's going to move money around. Those  
18 are really redistributing payments based on clinical  
19 characteristics as opposed to therapy. So some of the  
20 cherry-picking that may be going on I think will diminish  
21 with just the advent of these redesigns.

22 MR. THOMAS: Thank you.

1 DR. CROSSON: Okay. Thank you. And let's move on to  
2 the discussion. Could we have the last slide? I'd like to  
3 focus your attention on the last bullet point in the sub-  
4 bullets. Carol and Ledia would like some input. We've  
5 already had some snuck into the questions. But  
6 specifically on the measure set -- does everybody like it  
7 or would you like to have some more things added to that,  
8 the arguments for that -- the scoring methodology -- would  
9 people like to continue a scale, peer grouping, other  
10 suggestions there -- and then the size of the withhold,  
11 which is proposed to be 5 percent. There are arguments --  
12 I think we'll hear arguments that it's too large, and I  
13 think there's maybe a case to be made that it should be  
14 even larger than that. So try to focus your comments on  
15 those issues if you would.

16 I'm sorry. David, you're going to start.

17 DR. GRABOWSKI: Yes. Thanks. And once again I'm  
18 really excited that you're doing this work. As Brian said,  
19 it's really kind of a marriage of all of the unified  
20 payment work we've been doing with the HVIP and quality  
21 measurement. I said to you yesterday it's like a MedPAC  
22 greatest hits chapter, you know, and we're touching on a

1 lot of the issues we've been discussing for quite some  
2 time.

3       You can't have unified payment in post-acute care  
4 without some sort of PAC value incentive program. It  
5 doesn't work. And one of the criticisms I've heard of this  
6 whole effort is are home health agencies, for example,  
7 going to take patients that aren't appropriate for that  
8 setting, and a quality program helps guard against that  
9 sort of activity and really helps encourage each of the  
10 settings to admit patients that are appropriate for that  
11 setting. So I'm really happy we're doing this.

12       There's not a program -- and I think you did a really  
13 nice job of reviewing what's out there in the post-acute  
14 care space. There's really not a program we can take off  
15 the shelf. Home health, it's a big program with 20  
16 measures and really doesn't fit well here. The SNF, value-  
17 based purchasing program is very narrow with just the  
18 readmissions measure. So I like that we're building  
19 something that fits across all four sectors.

20       To the questions up here, do we have the right  
21 measures, I like the three measures that are currently  
22 proposed. I want to sort of make two points, and I know



1 maybe we're not there on either of them yet, but I really  
2 think patient experience needs to be in here. And I know  
3 the data aren't there yet with the CAHPS. Other  
4 Commissioners may have ideas of other places we could go  
5 for better patient experience data, but I think we want to  
6 continue to say that in the chapter, continue to push CMS  
7 that we want a uniform patient experience measure that we  
8 can use in this model, because I think that's really the  
9 missing measure relative to the HVIP and some of the other  
10 programs that we've discussed.

11 Dana raised my other point here and that's functional  
12 status, and that's really what post-acute care is supposed  
13 to do is get individuals back to full functioning and get  
14 them successfully discharged to the community. I  
15 appreciate we have this community discharge measure already  
16 in the kind of measure set. I really think some sort of  
17 functional status -- once again, that's provider-reported  
18 right now. It's not ready for prime time. But I think,  
19 once again, we have to stay on CMS to -- if it's auditing,  
20 if it's trying to use something from the hospitals, that's  
21 a measure that belongs in this program, and currently the  
22 data aren't up to snuff. But I hope we can continue to

1 encourage CMS to push on that front.

2       Towards the scoring methodology I wanted to make two  
3 points there. I think I already pushed you a little bit on  
4 the risk adjustment, and Kathy and others had good ideas  
5 here as well. I really worry when I look at those kinds of  
6 rates that you presented in the chapter across sectors,  
7 that we're not comparing apples to apples here. And how  
8 can I look at, for example, a hospitalization rate for a  
9 home health patient and compare that to an LTCH patient and  
10 think, how much of that difference is really quality versus  
11 just these are totally different patients, even after we  
12 apply our risk adjustment?

13       So I think two parts to this. The first is that I  
14 really like that you're initially going to score within  
15 settings, and I think that's really important. Downstream,  
16 as you begin to implement this payment system, I do think  
17 this will level out, because once you start paying a  
18 unified rate you actually then can look at apples to  
19 apples. And so I think over time we will be able to go to  
20 using similar standards across settings, but initially  
21 these differences are too big to sort of be believable,  
22 that this is true quality. It's really there's something

1 else going on here.

2       The other point I was going to make, I like your peer  
3 groupings. I think that's also essential. There was a  
4 Health Affairs paper a couple of months back that just  
5 showed, in the SNF VBP, which doesn't adjust for social  
6 risk factors, that just proportionately those facilities  
7 that were being punished were caring for more dual-  
8 eligibles. You know, the current programs aren't working  
9 very well around this issue, so I think the peer grouping  
10 is really an important element.

11       Finally, on the size of the withhold, I like 5  
12 percent. Jonathan, you kind of challenged us. What is the  
13 right rate here? I think 5 percent sounds reasonable. I  
14 wouldn't be opposed to going even slightly larger. I do  
15 think, however, there has to be an on ramp, so maybe  
16 starting in year one, 2 or 3 percent, and then sort of  
17 getting up to those rates to allow providers to get  
18 familiar with the program.

19       I'll stop there, other than to say again that I'm  
20 really excited we're doing this. This is great work and I  
21 think it's essential that we marry the unified payment  
22 system with a PAC-VIP, so thanks.

1 DR. CROSSON: Thank you, David. I've got Brian.

2 DR. DeBUSK: First of all, thank you again for a great  
3 chapter. I echo David's basic comments. I'm a huge fan of  
4 sort of both the pieces of work that have merged to make  
5 this work.

6 I do like your measures, and to David's point I would  
7 like to see a patient experience measure in there. And in  
8 the absence of having this CAHPS, I do think there is an  
9 opportunity for us to explore some more contemporary  
10 measures, something that's maybe a little bit lighter  
11 weight that we could use. I mean, I think we should take  
12 advantage of the vacuum, basically, is what I'm saying.

13 I also like the pragmatism of being able to go by  
14 setting and peer group. I thought that was nice to see in  
15 the article because so much of what you guys are doing is  
16 very theoretically pure and very theoretically satisfying.  
17 It's nice to see us depart, when the data just doesn't  
18 support it, to depart to a more pragmatic theme, like peer  
19 grouping by setting. I did like the fact that you did  
20 speculate that as the PPS side drives realignment of the  
21 industry that maybe we go back and revisit that, because  
22 with realignment and the risk adjustment model you may be

1 able, ultimately, to do one peer group. So I guess I like  
2 the pragmatism now but I like the way that you were also  
3 looking forward to the future and saying we may be able,  
4 ultimately, to reconsolidate that.

5 The final comment that I want to make was something  
6 that came up -- well, two things -- in round one. I would  
7 keep my eye on the specialization thing. I think the risk  
8 adjustment model, being able to accommodate that, watching  
9 these providers specialize might be a really, really good  
10 thing. And if we see it in the data, in the outcomes data,  
11 maybe it's okay to have some arbitrage there where they're  
12 always going to come out one or two or three points ahead  
13 on the withhold, just because they're really good at  
14 specifically what they do. So I wouldn't necessarily see  
15 that as a problem. I would see that as a potential feature  
16 to reward providers who decide to specialize or focus on a  
17 particular condition.

18 And then, finally -- and again, David, I echo you,  
19 actually in the same order -- but I would consider making  
20 the withhold larger. I mean, I think you're in a space,  
21 particularly with, say, SNFs and home health, where there  
22 is some overpayment here, and I think you could take

1 advantage of that, to maybe a 6, 7, 8 percent holdback  
2 that's ramped up over time.

3 Thanks.

4 DR. CROSSON: Okay. Amol, on this point.

5 DR. NAVATHE: On the point of specialization, because  
6 I think it's an important one, I totally agree with Brian  
7 that it's something to keep our eye on. I would probably  
8 characterize it, or at least the reason to keep an eye on  
9 it I think actually also has the other side, which is, you  
10 know, potentially while our risk adjustment models  
11 hopefully will get better and better over time, there's the  
12 type of care that's actually being provided.

13 And I think, Carol, you alluded to that in the Q&A  
14 session in one of your responses, which is if they're  
15 providing more intensive services that require any  
16 additional technology, additional capital investment,  
17 additional other stuff, variable costs, that that actually  
18 may not end up being factored in. And that more severe  
19 population, who requires that more intensive care, even  
20 given the same reason for admission, those would be  
21 unobservably essentially to our model, sicker people. And  
22 maybe what we want is to spur that type of specialization,

1 but this kind of model could potentially penalize that type  
2 of specialization, which would be not in the best interest  
3 of the beneficiary.

4 So I think no model is ever going to be perfect, but I  
5 think it's important to keep both the good sides of  
6 specialization and potentially, or the benefit  
7 specialization as well as the potential harms of  
8 specialization in view here as we go forward.

9 DR. CROSSON: Larry.

10 DR. CASALINO: Yeah. I would pretty much second  
11 everything that's just been said, but a question and then a  
12 comment.

13 The question is, so in terms of the risk adjustment,  
14 with the claims data that would be available, will that be  
15 able to differentiate between someone who has a stroke that  
16 produces just mild, pretty temporary, you know, improving  
17 relatively rapidly, weakness in your left arm, for example,  
18 as opposed to someone who's got permanent hemiplegia and an  
19 inability to speak, because those are very different. One  
20 could go to home health. The other is going to spend, you  
21 know, a long time in a facility probably. Will claims data  
22 nowadays allow differentiation between those two things?

1 DR. CARTER: I don't know. I can look at that. That  
2 is a condition, when we were doing the SNF/IRF comparison  
3 many years ago, but that was using ICD 9 data. That was  
4 one of the concerns we had, is that a stroke is not a  
5 stroke, and we're very aware of that. But let me -- I can  
6 get back to you on that, because it is a real concern.

7 DR. CASALINO: A stroke is not a stroke is, in a way,  
8 true of almost any diagnosis, but with stroke it's really  
9 important, and particularly in the subject we're discussing  
10 now. In fact, it could sink the whole thing, honestly.  
11 And particularly if the idea is to compare across all four  
12 settings.

13 So then my comment was -- and there's a lot of  
14 attention being given to this, I think, by the  
15 Commissioners -- the idea of comparing home health to the  
16 other settings. So I understand, conceptually, and, you  
17 know, it's kind of beautiful to read it conceptually, let's  
18 compare across all four settings. But I'm trying to think  
19 concretely, what would be the purpose. And to the extent  
20 the purpose is to aid decision-makers about where is a  
21 patient going to go -- so if I'm a physician who has a  
22 patient with whatever, or even a family member that is



1 trying to decide, as a physician am I going to believe  
2 admission rates, say, between home health and any of the  
3 institutional settings? And the truth is I suspect it  
4 would be very hard to convince physicians that those are  
5 comparable numbers.

6 So if there's not a decision-maker going to be making  
7 decisions based on the comparison of home health to the  
8 institutional settings, one could ask a little bit, well,  
9 what's the purpose of it or what's the good of it? If it's  
10 not good enough for a physician to make a decision then  
11 maybe it's not something that should be used to compare --  
12 you know, maybe there shouldn't be comparison across all  
13 four settings for rewards.

14 DR. CROSSON: Yeah. Did you want to answer first,  
15 Carol, or not?

16 DR. CARTER: I guess the only thing I would say is  
17 part of what we're trying to do is get Medicare to tie its  
18 payments to performance. And so if you have a provider  
19 that looks more like a SNF, or another that looks more like  
20 an IRF but they're actually treating very similar mixes of  
21 patients, eventually you would want to be able to directly  
22 compare their performance. I understand we need to go

1 through a transition, and I think it's really important,  
2 but at some point those distinctions are going to certainly  
3 blur more than they do now.

4 DR. CASALINO: I guess what I'm concerned about, and  
5 maybe some of the other Commissioners as well, are home  
6 health agencies ever going to really treat patients who are  
7 very similar to patients who are institutionalized? I  
8 mean, I think that's a really key question in this  
9 otherwise very tight structure.

10 DR. CROSSON: Karen, on this point.

11 DR. DeSALVO: I have a similar clinical intuition  
12 about this that I think I've raised before, that not all  
13 home health is the same. And maybe one way to look at this  
14 is to pull out those that are community referrals, because  
15 there's an evolution perhaps where home health is becoming  
16 a substitute for ambulatory care rather than a pure post-  
17 acute-care option. And the post-acute care probably  
18 relates more to these -- is more similar clinically and  
19 socially to the other patients versus those that are  
20 community referred. It may just give you some view on  
21 differences and whether those are apples-to-oranges  
22 comparisons.

1 DR. CARTER: I'm wondering whether -- and we haven't  
2 talked about this, but in the PAC PPS work, we had about 40  
3 different patient groupings and provider groupings that  
4 helped us test sort of how good is this model and are we  
5 aligning payments with costs. And this is giving me the  
6 idea that when we get to doing our PAC VIP, we should do  
7 more than provider characteristics but starting to look at  
8 characteristics of, like, social risk factors or community  
9 versus prior hospitalization. So doing a little more  
10 analysis, not just by provider -- our usual provider  
11 categories would maybe help there.

12 DR. CROSSON: We'll have you next, on this point and  
13 you're still in line?

14 DR. NAVATHE: Yes, I'm still in line, separate point.

15 DR. CROSSON: Okay.

16 DR. NAVATHE: Okay, so on this point first and then  
17 the next point.

18 So on this point, I think I'm a little worried that  
19 we're kind of mixing two different objectives and then how  
20 we sort of converge those objectives to get to the final  
21 path. So I think there are two objectives as I see them.  
22 One objective is we want to do value-based purchasing for

1 post-acute care, right? So we want to link it to quality  
2 and have payments tied to quality. That makes perfectly  
3 good sense to me. I think in the context of the first  
4 phase of this where we do it within setting, that seems --  
5 you know, other issues notwithstanding -- sort of not  
6 problematic.

7       The other piece that we start moving to a PAC PPS, it  
8 seems like we're also embedding within that is appropriate  
9 setting of care choice, right? And so we want to match  
10 patients to the right setting of care, and we're presumably  
11 using PAC PPS as a way to drive that as well as link to the  
12 value-based purchasing piece of this.

13       And I echo sort of Larry and Karen's comments because  
14 if we think about this from an end-state situation, you  
15 know, we may actually want the types of patients that live  
16 in IRFs and the types of patients that live in LTCHs to be  
17 very different from the patients that are living in home  
18 health agencies. And if that's indeed true and there's  
19 perfect separation of that from a clinical perspective and  
20 from what we observe in the data, and probably a lot of  
21 what we don't observe in the data, from a risk adjustment  
22 perspective we could get this -- we could kind of create

1 the wrong incentives here to underprovide intensity in a  
2 way that actually could end up harming beneficiaries in the  
3 long run.

4 And so the two objectives to me I think are crystal  
5 clear in terms of what we're trying to get to. I'm a  
6 little worried about the idea of eventually converging them  
7 and how that works unless we're really confident in our  
8 risk adjustment model. And I realize that you just  
9 mentioned, Carol, that there's data there that you could  
10 bring, and I think as part of -- as we continue this  
11 conversation, perhaps that should reemerge, as you point  
12 out. I would agree with that suggestion.

13 The other thing that I think it calls upon us to think  
14 about is, you know, other models that we've been talking  
15 about here in terms of ACOs and bundled payments. They  
16 have an incentive and have -- you know, particularly  
17 bundled payments have largely worked on this idea of  
18 reallocating people who go to a SNF who would otherwise be  
19 just as well served by going to home health. And so is PAC  
20 PPS necessarily the right mechanism to drive that piece of  
21 the sort of appropriateness infrastructure or  
22 appropriateness piece? I'm not sure about that yet. I

1 don't know that we know definitively, but I would call that  
2 into question as something that we should be worrying about  
3 going forward and whether, again, these two objectives  
4 belong together or whether we should actually think about  
5 them separately.

6 DR. CROSSON: Okay. Kathy, on this point or --

7 MS. BUTO: Yeah, I just wanted to clarify. I'm not  
8 sure I totally followed what your concern is, but let me  
9 see if I can articulate where I think we're coming from  
10 generally, which is, as I understand it, we are trying to  
11 unify post-acute-care payment particularly for patients  
12 with similar clinical conditions, so the overlap groups.  
13 Where patients are quite different, we are looking to make  
14 sure that the payments for those patients' care is  
15 appropriate, and we are thinking also that there are  
16 certain settings that just by virtue of having specialized  
17 already in treating some of those patients more severely or  
18 more acutely in need, that those institutions might  
19 gravitate toward those patients.

20 But I think at least where I've always thought we were  
21 going with the unified PAC was to really deal with the fact  
22 that these settings pay for or reimburse for care for

1 similar patients very differently, and that's what we're  
2 really trying to address, not necessarily in the main  
3 because we want to make sure that care is appropriately  
4 paid for, but it's okay with us if there's some  
5 specialization as long as, where patients are similar,  
6 there are not distorted incentives just based on  
7 reimbursement to go to one setting versus another.

8 So I think that's where we were coming from, and I  
9 don't know if that's what you're getting at.

10 DR. NAVATHE: Yeah, I don't disagree. I think, you  
11 know, the first point of the sort of value-based purchasing  
12 piece is sort of we want home health to be the best that it  
13 can be, right? And we want -- the better the home health  
14 you are, services you provide, the more you get paid  
15 because you're providing that value. That's kind of  
16 objective number one. That's where we are right now.

17 And then I think the other objective is the point,  
18 Kathy, you were just making, which is to the extent that  
19 there's a patient who right now could end up at SNF or  
20 could end up in home health or could end up at SNF and  
21 could end up at IRF and right now we pay them differently  
22 even though essentially they require the same thing and

1 they're getting the same thing and they're getting the same  
2 care, that's a matching piece. We need to get  
3 appropriateness. We need to get the person who can go to  
4 home health should go to home health, and the person who  
5 needs to go to SNF should go to SNF.

6 And because of the overlap in that setting, I don't  
7 disagree with the intent of saying that PAC PPS could help  
8 get there. I think what I'm wondering is kind of like with  
9 the patient experience or the patient-reported outcomes.  
10 Is the data there yet for us to be able to actually provide  
11 rational payments that don't end up creating a perverse  
12 incentive? That's what I'm worried about. I agree with  
13 the intent. I'm just worried if our data infrastructure  
14 and other pieces will have caught up at the time that we  
15 want to make that shift, and I think we should just be  
16 mindful that we keep that in focus. Otherwise, we could  
17 end up creating the wrong incentives here.

18 DR. CROSSON: Thank you both. That was a good  
19 point/counterpoint and I think important.

20 DR. NAVATHE: So can I make my separate point?

21 DR. CROSSON: Oh, you --

22 [Laughter.]



1 DR. NAVATHE: That was just on that topic.

2 DR. CROSSON: Okay.

3 DR. NAVATHE: My second point is hopefully a shorter  
4 one.

5 So Dana was sort of pushing on the number of patients  
6 required to have a stable measure of 60-plus, and as I  
7 understand it, if you're -- by pooling to three years, then  
8 we have more low-volume providers. But the pooling to  
9 three years is going to happen regardless whether you're a  
10 low-volume provider or a high-volume provider. And so  
11 instead of 60 per year -- I'm just going to make a number  
12 up -- if you're at 6,000 per year, then effectively your  
13 sample size becomes 18,000 over three years. And my  
14 concern about that is if -- we're creating perhaps an  
15 imbalance in the ability to actually move measures. So if  
16 I am that 18,000 volume provider over three years and in  
17 the next year I do really well on my next 6,000, I am still  
18 held to 12,000 of the previous ones, which may not have  
19 done as well; whereas, if I'm that smaller-volume provider  
20 and I have 100 per year, then that next 100 proportionately  
21 is a lot bigger in some sense where I'm able to move that  
22 measure more.

1           And so I think that's important for us to think  
2 through because, otherwise, we might actually harm the  
3 providers who are improving who are actually high volume to  
4 the extent that we know there's some volume-outcome  
5 relationship that exists across health care. That, again,  
6 may be something that we should be thinking about. A  
7 potential way to think about this would be to have a  
8 minimum threshold and then have a cap or something like  
9 that and say we'll take the most recent X thousand patients  
10 or, whatever, X hundred patients, whatever it is, so that  
11 way that measure still becomes movable, but we retain some  
12 of minimum threshold. So just something to think about.

13           MS. TABOR: I will say this did come up with the HVIP,  
14 and so I believe it was Jon Perlin who had the idea of  
15 maybe we weight the last year more than the other two years  
16 to kind of get at this, and we kind of talk about that as  
17 something policymakers could consider. We haven't actually  
18 implemented it in our modeling, but we could talk more  
19 about that.

20           DR. CROSSON: Dana, do you want to make a comment on  
21 this?

22           DR. SAFRAN: I have [off microphone] earlier.

1 DR. CROSSON: You are in line. Do you want to jump  
2 the line?

3 DR. SAFRAN: No.

4 [Laughter.]

5 DR. CROSSON: Larry wants to make --

6 DR. CASALINO: Just very briefly. I think the  
7 weighting idea that was in the managed care is a good idea,  
8 and based on what Amol was just saying -- and this is off  
9 the top of my head, but maybe give some thought to the idea  
10 that there could be weighting across the three years with  
11 the most recent year weighted mostly highly, but that maybe  
12 could differ by volume somewhat. Not to make this too  
13 complicated, but if you were really high volume, you know,  
14 maybe you don't weight the previous two years very highly;  
15 whereas, with a lower-volume provider, you could weight  
16 them more equally, whatever.

17 DR. NAVATHE: Agree, yeah.

18 DR. CROSSON: Pat is next.

19 MS. WANG: So I just want to say I agree with many of  
20 the comments that were made by the Commissioners, you know,  
21 David's comments around the importance of risk adjustment  
22 and being careful there.

1 I want to really talk a little bit more about social  
2 determinants and the adjustment there, because as the  
3 Commission, you know, advances, these more sophisticated,  
4 more uniform quality measurement systems, I really would  
5 like to see us be more proactive in finding better and more  
6 predictive assessments of the impact of socioeconomic  
7 status, particularly, you know, in the hospital. So dual  
8 status is definitely better than nothing, okay? But as you  
9 noted, Ledia, there is a lot of work going on. I'd prefer  
10 as we kind of take on our front foot with the development  
11 of these more advanced measures, that we not wait for those  
12 things to develop, because I think the importance of  
13 introducing more refined social determinants adjustments is  
14 critical, particularly when you're talking about things,  
15 measures of discharge to community. So just for example, a  
16 full dual can be somebody who has been poor or on and off  
17 of Medicaid during their life, has enough work quarters and  
18 is aging into Medicare, but lives in a very, very low-  
19 income, crime-ridden, food-desert community versus somebody  
20 who has spent down to dual status, has worked during their  
21 life, has had consistent health insurance coverage and  
22 health care, and really actually lives in a more middle-

1 class, stable environment. For a measure like that, full  
2 dual status is not sufficient, I think, to really get at an  
3 accurate measure of who's doing a better job, for example,  
4 discharging to community.

5 So there is definitely a lot of work that's out there.  
6 States like Massachusetts have introduced -- it seems like  
7 people are really going towards where you live as being  
8 more predictive of your burden from social determinants,  
9 whether it's nine-digit ZIP code level or what have you.  
10 And I think that Massachusetts has actually introduced much  
11 more granular determinations even into stratifying their  
12 Medicaid population.

13 So, you know, again, it's my request, it's my urging  
14 that the Commission, as we are very proactive in developing  
15 these newer approaches towards measuring quality, that we  
16 not leave the social determinants thing, you know, for  
17 somebody else to figure out. I'd really like us to be more  
18 proactive. We have the ability to do that, and I think we  
19 could make a big contribution to the field.

20 DR. DeBUSK: First of all, I totally agree, Pat, with  
21 what you're saying on the social determinants side. Along  
22 those lines, specifically discharge to community, I know

1 right now we do the risk adjustment first -- and we've had  
2 this conversation before. We do the risk adjustment first.  
3 Then we do the peer grouping.

4 Just a request. Throughout the analysis periodically  
5 do a check there, because, I mean, Pat -- and I think is  
6 where you might be going -- finding a better way to get at  
7 some of those social determinants, for example, discharge  
8 to community -- and this is just me speculating on that. I  
9 would think a very affluent person, probably their age  
10 doesn't affect their discharge to community rate nearly as  
11 much, say an affluent person, because they're going to have  
12 more options like nursing at home, they're going to have  
13 better surroundings than, say, someone of low socioeconomic  
14 status, they're probably going to be a lot more sensitive  
15 to age and how it affects their ability to be discharged to  
16 community.

17 So I would just -- as you do the analysis, we're  
18 always looking for something better than dual status,  
19 obviously, to do the stratification with, but I would also  
20 periodically go back and look at those variables, because  
21 what would happen if you compared the top 10 percent to the  
22 bottom 10 percent in SES and got dramatically different

1 coefficients relating to, say, age as a function of  
2 discharge to community? Because, intuitively, I think  
3 there will be cases where things like that are going to pop  
4 up.

5 DR. CROSSON: Thank you. Jaewon, I had you -- you  
6 passed. Okay. Bruce.

7 MR. PYENSON: I want to compliment the work, and my  
8 comments are on a framework for thinking about the size of  
9 the withhold. I think my comments are hopefully  
10 generalizable. We struggle or we have that question about  
11 just about every area that we look at on payment policy,  
12 how to set an appropriate withhold, whether it's hospitals  
13 or hospices or others. And I know it's -- some of the  
14 approaches Jonathan and Dana and David had talked about it  
15 earlier, and one of the approaches is kind of behavioral,  
16 to say, well, how much is enough that it matters to get  
17 someone to pay attention, and that's one way, and what's  
18 the evidence for that?

19 I'd like to suggest a different, an additional  
20 approach, which gets at the underlying financial risk, and  
21 a withhold can be thought of as a financial risk. It could  
22 be gained or lost, and the outcome is uncertain until the

1 end of a period. And at what point does that withhold  
2 actually threaten the solvency or the financial viability  
3 of the organization?

4 So, for example, if there was a 100 percent withhold -  
5 - of course, it's absurd, but an organization would have to  
6 borrow money to meet payroll and supplies and things like  
7 that, which conceivably some organizations might be  
8 creditworthy enough to do that, but many may not be.

9 I think the approach that is established for those  
10 sorts of issues, one of the approaches is to think about --  
11 is used for risk-based capital for insurance organizations  
12 to look at the underlying fluctuations in financial  
13 outcomes that happen historically with organizations. So  
14 within SNFs or home health agencies or others, the cost  
15 reports might give us insight into the year-to-year  
16 fluctuations that happen anyway because a business is risky  
17 and things happen, either business or management or  
18 environment or other things that happen, and gains and  
19 losses fluctuate from time to time. And adding looking at  
20 the portion of businesses that go out of business is  
21 another way to do that. Some of that data I think is  
22 available. For sure we'll see that the size of the



1 organization, the enterprise, has a lot to do with its  
2 financial fluctuation.

3 So I think that's a useful framework not just for PAC  
4 but for other kinds of enterprises, including physician  
5 organizations, and it's a way to also think about capital  
6 and access to capital.

7 So if we do that, I suspect we'll think about whether  
8 the withhold should vary with the size of the enterprise.  
9 And while I think it's very appropriate that the quality  
10 metrics are presented at the individual enterprise level,  
11 the individual site level, as opposed to the organization,  
12 collective organization, I think the withhold and the  
13 financial risk is probably more at an enterprise level, so  
14 that a nursing home network or nursing home company with  
15 multiple sites can withstand more fluctuation than an  
16 individual site organization could. And, in fact, that  
17 could be part of their business strategy, the expectation  
18 that some sites will make more or less over time.

19 So I think having that kind of framework could -- an  
20 analysis could actually create a boundary on how big the  
21 withhold could be or how big it shouldn't be. And that's  
22 one end of looking at this. Of course, the behavioral

1 aspect is another approach to that.

2 Thank you.

3 DR. CROSSON: Okay. Paul, on this point?

4 DR. PAUL GINSBURG: I'm really glad that you brought  
5 up this analysis, Bruce, and I agree that that's the way to  
6 go.

7 Ironically, I was on a call last night as a board  
8 member and member of the investment committee of a  
9 nonprofit organization, and one of the topics was how much  
10 should they carry in cash to protect themselves for  
11 unplanned reverses.

12 When I think of this, a large withhold really  
13 increases the amount of capital needed to enter this  
14 business as viable, and I think it really requires some  
15 simulations of who could be affected and not just focusing  
16 on averages, because we know that the averages, average  
17 returns and post-acute care, cover up a lot of variation,  
18 particularly nonprofits versus for-profits. So I think you  
19 really opened up a rich part of our inquiry, Bruce, and I'm  
20 glad you did it.

21 DR. CROSSON: On that point?

22 DR. JAFFERY: Yes. I would echo that. I really glad

1 you brought those points up, Bruce.

2 I guess the other thing, I had mentioned this, I  
3 think, in some other conversations related to shared  
4 savings model. I'm just thinking also about we do these  
5 things with annual payments, often with a very lengthy  
6 delay, so that the payment comes back two years after the  
7 payment period or the evaluation period. I wonder if we  
8 can get to things where we're having this in a little bit  
9 more real time and thinking about organizations,  
10 particularly ones that may be pretty small and thinking  
11 about their cash flow concerns that may make the  
12 requirements to keep cash on hand a little bit less if  
13 they're getting these things back in more real time. I  
14 think it just may help organizations think about how they  
15 transform their models, if it's more tied to sort of an  
16 ongoing revenue cycle, if you will.

17 DR. DeBUSK: On the point Bruce had made and Paul made  
18 as well, I think that it's really novel, the idea of  
19 scaling the withhold based on the size of the institution.

20 The one thought that popped into my head is what would  
21 keep me, say, as an operator, the hospital, and I've got a  
22 SNF, what keeps me from just spinning that out and setting

1 that off to the side, and all of a sudden, instead of being  
2 exposed to a 6 percent withhold, because I'm part of a  
3 major system, now all of a sudden, I look a lot like a  
4 standalone little guy. Now I'm back to a 2 percent  
5 withhold.

6 I love the idea, and it's novel. I just think we have  
7 to think about how to operationalize it.

8 DR. CROSSON: Okay. Dana? I'm sorry. Bruce, did you  
9 want to answer?

10 MR. PYENSON: Just on that point, I think that that's  
11 already -- more sophisticated organizations think about  
12 that with their other risks as well, diversification and so  
13 forth. So this would just be another layer of what's the  
14 value of diversification.

15 DR. CROSSON: Dana, you have the floor, and you have  
16 the last discussion.

17 DR. SAFRAN: Okay, great. I'll be brief.

18 I had four points, and most of them have been  
19 mentioned, but I'll just add a little bit.

20 On sample size, my main concern was the same one that  
21 Amol mentioned and that Jonathan referenced yesterday,  
22 which is carrying your performance from three years ago is

1 really a burden and a de-motivator for improvement, and  
2 this is trying to be a program that's motivating  
3 improvement.

4       So I'd like us to do everything we can to avoid having  
5 to have three years of data. I thought Amol's idea of like  
6 if you don't need it to have adequate sample size, then  
7 maybe you only use this year's performance.

8       The other thought I had was, Do we have access to all-  
9 payer claims data, and could we actually base performance  
10 for smaller organization on all-payer data rather than  
11 having to go back several years? There's tradeoffs either  
12 way, but that seemed like something to consider.

13       I would even consider sacrificing a little on the 0.7,  
14 reliability. I was stunned to hear you say CMS had 0.4. I  
15 mean, worse than a coin toss? That doesn't seem like a  
16 good idea, but we could maybe justify 0.6. But it would  
17 have to tie to the issue of how high the withhold is. The  
18 less certain we are of our information, the less  
19 consequential it has to be.

20       But I wouldn't tie ourselves to 0.7 necessarily,  
21 though I do like a program that is at 0.7 or higher, just  
22 for what it's worth.

1           On the duals, I was going to make a point similar to  
2 Pat's and others that have been made. I heard you say that  
3 you are going to keep testing and try to improve on the  
4 methodology. I just wonder if we have the data available  
5 during this period of testing you're going to be doing, to  
6 include nine-digit ZIP, we know that that adds so much  
7 richness. If you have it, you can go out and get the  
8 Census block-group-level variables, but maybe you don't  
9 need to. Maybe you just use nine-digit ZIP as a dummy  
10 variable, and that really enriches the model a lot. I  
11 think that's worth looking at.

12           Functional status. As I intimated my question around,  
13 I just think that we have to find a way to begin to include  
14 that, even if it's in the initial round, paying for  
15 adoption and much more valid measurement than we've seen to  
16 date. But we have to find a way that functional status  
17 measurement and outcomes becomes part of this and similarly  
18 for patient experience.

19           Then the last comment was just to offer feedback on  
20 the 5 percent level. I like it as a starting point and  
21 agreed with -- I think it was David suggested that maybe  
22 it's a starting point and it ramps up from there, but based

1 on the dialogue that was had there this morning, I feel  
2 pretty assured that 5 percent is meaningful enough to  
3 particularly the SNFs who are coming from 2. But from what  
4 you said, Ledia, about home health and 4 and that that  
5 seems to really be getting folks' attention, then 5  
6 certainly would too. So I think 5 sounds like a good  
7 starting point, and that you could ramp up from there was  
8 you get more certain and really starting of our risk  
9 adjustment, realizing certain of our social stratification,  
10 et cetera.

11 Thanks.

12 DR. CROSSON: Thank you. Thank you, Dana.

13 Thank you, Ledia and Carol.

14 I say this often. This was an excellent presentation,  
15 an excellent formulation, but also the discussion, I think,  
16 was one of the richest I've seen in a while. The points  
17 that were brought up here, I hope you find those useful  
18 because I think they're going to turn out to be very  
19 valuable to all of us.

20 So thanks again. We'll move on to the last  
21 presentation.

22 [Pause.]

1 DR. CROSSON: Okay. I think we can begin here.

2 The commission has had an interest in the payment from  
3 the Medicare program to institutions for graduate medical  
4 education now for almost 10 years. We spent some time in  
5 2009, ultimately, and 2010, made a series of  
6 recommendations at that time.

7 When the expenditure level was about \$9 billion, as I  
8 remember, now I think we're looking at something like \$13  
9 billion.

10 So we're going to take another cut at this. I think  
11 one that will enrich the physicians that we've had  
12 historically, but I also think that as we think this  
13 through, the whole issue of what the Medicare program is,  
14 in fact, getting for this substantial investment is a  
15 critical issue for the commission.

16 Alison and Jeff are here, and who's going to begin?  
17 Alison? Terrific.

18 MS. BINKOWSKI: Good morning. In this last session of  
19 the commission's September meeting, we will be discussing  
20 indirect medical education payments to acute care teaching  
21 hospitals. We would like to thank Stephanie Cameron for  
22 her assistance.



1           This presentation will cover three IME topics. The  
2 first topic is IME background, including the history of  
3 IME, how IME payments are calculated, and how IME payments  
4 are distributed across settings and hospitals.

5           Medicare makes two types of supplemental payments to  
6 acute care teaching hospitals for the provision of graduate  
7 medical education. The first type--and focus of this  
8 presentation--is indirect medical education payments, which  
9 totaled \$9.3 billion in fiscal year 2017.

10           These payments support teaching hospitals' higher  
11 costs of patient care that are not otherwise accounted for  
12 in the inpatient prospective payment system, such as  
13 additional tests and procedures ordered by residents and  
14 specialized services provided by teaching hospitals. IME  
15 payments are made as an adjustment to IPPS payments.

16           The second type is direct graduate medical education  
17 payments, which totaled \$3.7 billion in fiscal year 2017.  
18 These payments support teaching hospitals' direct costs of  
19 sponsoring residency programs, such as resident stipends  
20 and physician salaries, and are made outside of the  
21 inpatient prospective payment system.

22           The treatment of acute care teaching hospitals'

1 indirect costs of medical education varies across the two  
2 hospital inpatient prospective payment systems.

3       When Congress implemented the inpatient operating PPS  
4 in 1983, it explicitly specified the formula and level of  
5 an IME adjustment, which it described as a proxy for a  
6 number of factors which may increase costs in teaching  
7 institutions that were not fully accounted for in the new  
8 PPS.

9       In response to concerns that the new PPS would  
10 adversely affect teaching hospitals, the IME adjustment was  
11 originally set at twice the empirically justified level  
12 estimated by the Secretary. The level has been gradually  
13 reduced but remains significantly above MedPAC's estimate  
14 of the empirically justified level.

15       In contrast, when Congress established the inpatient  
16 capital PPS in 1991, it did not specify if an IME  
17 adjustment should be included. The Secretary chose to  
18 implement an IME adjustment, using a different formula.  
19 The level has not changed since its enactment.

20       Congress also left discretion to the Secretary when it  
21 established the outpatient PPS in 2000. The Secretary  
22 stated that Medicare determined an IME adjustment to the

1 outpatient PPS was not necessary to ensure equitable  
2 payments to teaching hospitals.

3 Teaching hospitals receive an IME payment for each  
4 inpatient stay by a Medicare beneficiary. I will provide  
5 more details on how this process differs across the  
6 inpatient operating and inpatient capital PPS's on the next  
7 slide, but at a high level, teaching intensity is measured  
8 as the hospital's residents relative to its inpatient size.  
9 Teaching intensity is converted to an IME percentage add-on  
10 through formulas specified in law or regulations. This IME  
11 percentage add-on is multiplied by the base DRG payment  
12 rate for a Medicare beneficiary's inpatient stay, and the  
13 result is Medicare's IME payment to the acute care teaching  
14 hospital for that stay.

15 While IME policy under the inpatient operating and  
16 inpatient capital PPS's have the same broad components  
17 described on the prior slide, they differ in several  
18 respects.

19 In particular, the PPS's differ in how teaching  
20 intensity is measured. For example, while both PPS's use  
21 the same count of residents, the inpatient operating PPS  
22 measures teaching intensity as residents per available

1 inpatient beds, while the inpatient capital PPS measures  
2 teaching intensity as residents per average daily inpatient  
3 census.

4       The Secretary chose this latter measure and stated it  
5 was more appropriate as costs were more closely to a  
6 hospital's ratio of residents to patients than a ratio of  
7 residents to available, but potentially unoccupied,  
8 inpatient beds.

9       The IME adjustment to the PPS's also differ in other  
10 respects, such as the formulas to calculate the percentage  
11 add-on and the treatment of fee-for-service and MA  
12 beneficiaries, which we would be happy to discuss during  
13 the discussion period, as helpful.

14

15       The formulas presented on the prior slide result in  
16 IME percentage add-ons that vary substantially across  
17 teaching hospitals, as a result of the wide variation in  
18 teaching intensity.

19       In fiscal year 2017, the median IME percentage add-on  
20 to inpatient operating rates, as indicated by the middle  
21 line in the box, was 6 percent, corresponding to a  
22 resident-to-bed ratio of 0.11, or one resident per nine

1 inpatient beds. However, the IME percentage add-on varied  
2 substantially across teaching hospitals, as indicated by  
3 whiskers, ranging from less than 1 percent to 78 percent,  
4 corresponding to a resident-to-bed ratio of less than 0.001  
5 to greater than 2.

6 Despite the different measure of teaching intensity  
7 and formula specification, the median and range of the IME  
8 percentage add-on to inpatient capital rates was similar,  
9 though subject to an absolute maximum of 53 percent.

10 Despite similar IME percentage add-ons in the two  
11 inpatient PPS's, the IME percentage add-on to inpatient  
12 operating rates account for nearly all IME payments, as  
13 inpatient operating rates are substantially higher than  
14 inpatient capital rates.

15 Among inpatient operating IME payments, \$6.2 billion  
16 was for the care provided to Medicare fee-for-service  
17 inpatients and \$2.7 billion was for the care of Medicare  
18 Advantage inpatients, similar to the distribution of  
19 Medicare beneficiaries in fee-for-service and Medicare  
20 Advantage.

21 While there are approximately 1,100 acute care  
22 teaching hospitals, both residents and Medicare's IME

1 payments are concentrated among a small subset of teaching  
2 hospitals. For example, the 100 teaching hospitals with  
3 the largest IME payments in fiscal year 2017 accounted for  
4 47 percent of residents. These 100 teaching hospitals also  
5 accounted for 51 percent of the \$9.3 billion in IME  
6 payments.

7 I will now turn to summarizing concerns with  
8 Medicare's current IME policy and potential revisions the  
9 commission could consider.

10 The Commission and others have raised concerns with  
11 Medicare's current IME policy, which can be grouped into  
12 four categories.

13 First, IME payments are only made for care provided in  
14 inpatient settings and policy has not evolved to reflect  
15 the contemporary spectrum of settings in which hospital  
16 care and resident training occurs.

17 Second, IME payments are not reflective of the  
18 empirically justified effect of residents on patient care  
19 costs and result in overpayment of IME for care of  
20 inpatients while making no IME payment for the care of  
21 outpatient patients.

22 Third, IME payments have no link to performance or

1 accountability for how they are used. Specifically, IME  
2 payments are not linked to whether teaching hospitals  
3 achieve desired educational goals and outcomes, and while  
4 some have argued that IME adjustments above the empirically  
5 justified effect of residents on patient care costs are  
6 appropriate in order to help fund social missions that  
7 teaching hospitals operate at a loss, there is no  
8 requirement on how hospitals use IME payments or way to  
9 track how hospitals use IME payments.

10 Fourth, the inpatient PPS's are also inconsistent,  
11 including in their treatment of fee-for-service and  
12 Medicare Advantage beneficiaries.

13 To address these concerns and other inconsistencies  
14 with current IME policy, the commission could consider  
15 several revisions. Specifically, the commission could  
16 consider moving to an IME policy that applied to care  
17 provided in both inpatient and hospital outpatient  
18 settings; updating IME payment levels to reflect the  
19 empirically justified effect of residents on patient care  
20 costs in each setting, levels that could be episodically  
21 recalculated; adding a link to performance by using any  
22 current aggregate IME payments above the new empirically

1 justified payments to fund a new performance-based program,  
2 consistent with the commission's June 2010 recommendation;  
3 and moving to a consistent IME policy, with Medicare making  
4 payments for the care of fee-for-service and MA  
5 beneficiaries.

6 Collectively, these revisions could maintain aggregate  
7 medical education payments to acute care teaching hospitals  
8 while aligning IME payments with the settings in which care  
9 is provided, removing disincentives to shift patient care  
10 to hospital outpatient settings, and adding rewards for  
11 high performance.

12 Moving to a revised IME policy with the features  
13 described on the prior slide would involve key  
14 implementation decisions.

15 One key decision is how to measure Medicare Advantage  
16 beneficiaries' hospital outpatient use. Currently,  
17 hospitals are required to submit information-only claims  
18 for MA beneficiaries' use of inpatient services but not  
19 hospital outpatient services.

20 As part of a revised IME policy, Medicare could  
21 require hospitals to submit information-only MA outpatient  
22 claims. This new requirement would not only support more



1 accurate IME payments but also provide a valuable data  
2 source to validate MA plan-submitted encounter data.

3       Until informational MA outpatient claims are  
4 available, Medicare could estimate MA hospital outpatient  
5 use. For example, one option would be to estimate that MA  
6 outpatient use has the same relationship to fee-for-service  
7 as it does for inpatient use.

8       A second key implementation issue is how to measure  
9 teaching intensity. Both current measures of teaching  
10 intensity are inpatient-centric. One option for a new  
11 inpatient plus outpatient measure of teaching intensity is  
12 residents to average daily total equivalent census, which  
13 could be calculated as average daily inpatient census,  
14 scaled up by the hospital's inpatient and outpatient  
15 revenue relative to its inpatient revenue.

16       A third key implementation decision would be how to  
17 maintain budget neutrality. Consistent with MedPAC's June  
18 2010 report, aggregate payments to teaching hospitals could  
19 be maintained under a revised, empirically-justified IME  
20 policy by adding a new performance-based program that  
21 rewarded teaching hospitals meeting educational standards.

22       The standards could be established by the Secretary,

1 after consultation with stakeholders, including accrediting  
2 organizations, patients, and consumers, and the level of  
3 performance-based payment could be tied to the hospital's  
4 performance on these new standards.

5 This new program could support workforce skills needed  
6 in a delivery system that reduces cost growth while  
7 maintaining or improving quality.

8 While the effect of a revised IME policy would depend  
9 on the specific design features chosen and related  
10 implementation decisions, to give the Commission a sense of  
11 how IME and overall Medicare payments to acute care  
12 teaching hospitals might change, we modeled one  
13 illustrative policy consistent with the design features  
14 described in earlier slides.

15 As you will recall, this includes moving to an IME  
16 policy that applied to care provided in inpatient and  
17 outpatient hospital outpatient settings, setting payments  
18 at the empirically-justified level in each setting, adding  
19 performance-based payments, and Medicare program making IME  
20 payments for both FFS and MA beneficiaries.

21 Under our illustrative policy, aggregate IME plus  
22 performance-based GME payments would be maintained, but the

1 distribution across settings would change and performance-  
2 based payments would be added.

3 In particular, moving from left to right in the graph,  
4 inpatient operating IME payments for both fee-for-service  
5 and MA beneficiaries would substantially decrease,  
6 consistent with MedPAC's prior estimates of the portion of  
7 the inpatient IME payments that were empirically justified.  
8 Inpatient capital IME payments would decrease from \$0.4  
9 billion to \$0, as our regressions found no empirical effect  
10 of residents on inpatient capital costs.

11 This lack of a significant effect of resident  
12 involvement on capital costs suggests that residents do not  
13 systematically affect hospitals' capital costs and  
14 therefore an IME adjustment to the inpatient capital PPS is  
15 not warranted. Outpatient IME payments would increase from  
16 \$0 to \$4.8 billion, reflective in part of our estimate that  
17 the effect of residents on costs was larger in outpatient  
18 than inpatient settings; and performance-based payments  
19 would increase from \$0 to \$1.1 billion, such that aggregate  
20 IME plus performance-based payments would be equal those  
21 under current law.

22 Under the revised IME policies, many teaching

1 hospitals would have material changes in their IME  
2 payments, consistent with the wide variation in hospitals'  
3 inpatient to outpatient use and the reduction in aggregate  
4 IME payments and shift to performance-based payments. More  
5 outpatient-centric teaching hospitals and those with better  
6 performance on the new standards would have the largest  
7 increases in IME payments, while more inpatient-centric and  
8 poorer performing teaching hospitals would have the largest  
9 decreases.

10         However, despite this substantial redistribution of  
11 IME payments, most teaching hospitals' overall Medicare  
12 payments would change by less than 2 percent. Furthermore,  
13 financial impacts resulting from these new policies could  
14 be mitigated through transition policies, such as phasing  
15 in the revisions over multiple years and adding transition  
16 corridors limiting the change in payments teaching  
17 hospitals could experience in any given year.

18         That concludes our presentation. In summary, current  
19 IME policy does not reflect the increasing shift towards  
20 hospital outpatient care nor the empirically-justified  
21 effect of residents on patient care costs. During the  
22 upcoming discussion session, we look forward to answering

1 any clarifying questions Commissioners may have.

2 In addition, we would like the Commission's feedback  
3 on the concerns with current IME policy and potential  
4 revisions outlined in this presentation. We would also be  
5 interested what next steps the Commission would like staff  
6 to take regarding exploring potential IME reform.

7 With that, I turn it back to Jay and look forward to  
8 the discussion.

9 DR. CROSSON: Thank you, Alison and Jeff. We will now  
10 take clarifying questions. I see Brian. I see Paul and  
11 Jaewon.

12 DR. DeBUSK: First of all thank you for the great  
13 chapter, but I'm going to save a lot of my comments for  
14 round two.

15 I did have two questions, the first one being have we  
16 looked at the economics of a residency slot? I mean, let's  
17 say that DGME is \$90,000 per slot, the IME is probably  
18 \$120,000, \$150,000. You know, I'm just kind of giving  
19 round numbers here. But those two spots can generate  
20 dramatically different amounts of revenue, say a third-year  
21 primary care resident versus a fifth-year orthopedic  
22 surgery resident. Could we enter analysis -- or, I mean,

1 you may have already done this already -- looked at the  
2 economics of a residency spot? Because even though we,  
3 Medicare, pay consistently the same amount regardless of  
4 specialty, I think the revenue generated would be  
5 dramatically different. Has there been any research or  
6 have you guys done any work in this area?

7 MS. BINKOWSKI: It's a great question and the short  
8 answer is no, that there's not great data to use at this  
9 point to do so. In our June 2010 report we did note how  
10 there are both financial costs associated with residents as  
11 well as financial benefits, and how those can vary by  
12 specialty as well as year, and we recommended that the  
13 Secretary collect data on that and report it. It's  
14 something that we could consider trying to explore more  
15 with available data, but there are challenges. I'd be  
16 happy to discuss more later.

17 DR. DeBUSK: Okay. Well, it opens up an interesting  
18 avenue and I wondered if there had been any research.

19 The second question was, you know, you speak in the  
20 chapter and in the presentation of this performance-based  
21 concept, and again, I love the concept of performance  
22 based. But could you elaborate just a little bit? I mean,

1 what would be good performance versus bad performance in a  
2 residency program?

3 MS. BINKOWSKI: I think that's a ripe area for future  
4 Commissioner discussion.

5 [Laughter.]

6 DR. DeBUSK: Well played. Very well played.

7 DR. CROSSON: I'm going to jump in there, because I  
8 was going to make this point a little later. But having  
9 been here during our discussions and recommendations in  
10 2010, we had, you know, a fairly simple concept here and  
11 that was, as I said before, that the Medicare program is  
12 making a tremendous investment on the part of its  
13 beneficiaries and the public in residency training. And  
14 it's not unreasonable to think that the program has an  
15 interest in having some level of accountability for the use  
16 of those dollars.

17 It's become clear, I think, to the Commission, that  
18 issues such as the balance of the physician workforce  
19 that's coming out of training, for example, the ratio  
20 between primary care and specialty care, is of interest to  
21 this Commission. It has been in a number of other  
22 discussions.

1           In addition, I think the readiness of residents coming  
2 out of program to deal with the reality of health care as  
3 it's delivered today is important. Issues like the  
4 understanding and readiness of physicians to participate in  
5 collective quality improvement efforts, the sensitivity of  
6 residents coming out of training to the problem of  
7 inappropriate care and overuse of services and resource  
8 stewardship.

9           So our proposal in 2010, which was fundamentally based  
10 on this set of physicians, was that we would request the  
11 industry to take this accountability to heart and to make  
12 recommendations to the Secretary for what that performance  
13 measurement process would be. That has not been  
14 forthcoming.

15           And so this proposal that we have today is a little  
16 bit stronger than that and suggests that, in fact, in the  
17 absence of the industry coming forward with its own  
18 proposal for accountability, both in terms of the nature of  
19 the specialties that are being produced -- and this is in  
20 keeping with Brian's point here that there may, in fact, be  
21 economic incentives we are not aware of, which is adding to  
22 the disparity of availability of physicians for Medicare



1 beneficiaries -- as well as the nature of what's taught in  
2 training programs relative to the reality of the world that  
3 physicians in training are going to face.

4 In the absence of that, the proposal on the table here  
5 could be that the Secretary could, in fact, with  
6 consultation, determine the nature of those performance  
7 parameters and incentives.

8 Sorry. Go ahead.

9 DR. PAUL GINSBURG: Yeah, and that's what I was going  
10 to ask, about performance. I think it would be -- I don't  
11 want to stray too much into round two, but I think the idea  
12 of looking to the industry to come up with ideas is very  
13 valuable.

14 This seems to be something beyond the specialty mix,  
15 which, you know, people have talked about for years. I've  
16 never seen anything getting concrete about other aspects of  
17 performance of a teaching program. And, certainly, I don't  
18 think we're set up to explore it very well, although I  
19 think that if we write a chapter on this we really should  
20 have some ideas, if only at the level of what Jay was  
21 sketching out a minute ago, as to some of the directions it  
22 could go.

1 But I'll hold off until round two with the rest.

2 DR. CROSSON: Okay. Karen.

3 DR. DeSALVO: I'm really excited that we're taking up  
4 this work and I hope this is the beginning of more than we  
5 can do, because there are many component parts. We've got  
6 to build a workforce ready to meet the challenges we talked  
7 about yesterday.

8 I had a question for you all, because I don't know the  
9 answer, which is about the context in which Medicare  
10 payments are supporting residents in training, and what the  
11 scale is, for example, compared to VA support for residency  
12 training, and I'm pretty sure that HRSA funding is quite  
13 small relative to the CMS investment.

14 I'm interested in whether or not that context, first  
15 of all the numbers, but also if we could start to think  
16 about how all of those various resources could be more  
17 strategically aligned to develop a workforce of the future.  
18 So as we're thinking of the opportunity here it may be  
19 helpful to start thinking about how this nests in the  
20 broader view. But I wonder if you all have looked at the  
21 VA and the way that they fund GME and what they're  
22 spending.

1 MS. BINKOWSKI: So partially, I'm actually going to  
2 give a shout-out to a recent GAO report that looked at GME  
3 funding across payers. Medicare is by far the largest. I  
4 don't want to cite the number offhand, but it is over 75  
5 percent. I can get back to you on the exact statistic of  
6 funding, but yes, VA and HRSA are the two other major  
7 players and there are some smaller ones.

8 The short version is Medicare is the largest payer but  
9 VA and HRSA are the next two largest funders of GME.  
10 There's also Medicaid programs. The IOM, in its report,  
11 did talk about possibly trying to harmonize all of those  
12 different payers and should even move to a new entity that  
13 does GME across all. I think that's beyond the scope of  
14 MedPAC, but it's something the Commissioners could discuss.

15 DR. DeSALVO: Thank you. I think the Medicaid  
16 component of this may be on the edge of MedPAC's role, but  
17 given that a lot of states have been thinking about  
18 innovation for performance-based residency payments it  
19 would be so helpful to have some of that as aligned as  
20 possible, and at least be aware of what the VA is thinking.  
21 There may be some good ideas growing from their work.

22 I have a second question, which is about this

1 startling fact that 10 percent of the hospitals in the  
2 country have about half of the residents and resources, and  
3 whether that's been sort of a fixed number over time or if  
4 that's been a trend of concentration of training, and if  
5 anyone has looked at whether that is related to later  
6 geographic distribution of physicians as they go out into  
7 practice, or diversity of physicians, or even experience of  
8 them. I just wondered about if there's a sort of -- if  
9 you'll pardon me for saying it -- the rich getting richer,  
10 and as concentrating training at some geographic areas that  
11 some experiences, when, in fact, beneficiaries live all  
12 across the country.

13 MS. BINKOWSKI: I don't know the exact numbers. I can  
14 look into the trends over time. But it definitely has been  
15 highly concentrated from the beginning of the program. But  
16 it's something I can look into more.

17 DR. PAUL GINSBURG: I can comment on this. I think  
18 whatever the trends might have been, to concentrate or not,  
19 the fact that the DME payment is tied to, historically,  
20 each hospital, how many residents did you have at a certain  
21 point in time in the 1980s, probably works against movement  
22 in that distribution.

1 DR. CROSSON: Okay. I have Jaewon next.

2 DR. RYU: Yeah. I had a question around distribution  
3 as well. It seems like there's a comment on Slide 17 where  
4 you say that most teaching hospitals overall, Medicare  
5 payments will change very little. And so it just strikes  
6 me that if we're trying to redistribution, in some way, to  
7 be more accurately representative of where teaching  
8 activities take place today, whether an inpatient versus  
9 outpatient or geographically too much concentration, or  
10 maybe it's even by specialty, too much concentration in  
11 specialized areas versus primary care, as an example, I  
12 just wonder if this approach fundamentally moves enough  
13 money. And I don't know if you've done any modeling around  
14 how much money would actually move, because a lot of these  
15 organizations, they're doing inpatient but they're also  
16 doing a lot of outpatient.

17 And so if this is the new approach it seems like they  
18 would still get roughly the same amount and maybe this  
19 wouldn't achieve sort of the redistribution or the  
20 reallocation that we might be shooting for. So I was just  
21 wondering if you had any sense of what is that amount.

22 MS. BINKOWSKI: Yes, I do have some things to say on

1 that. Two points to make on the slide is there would be  
2 wide distribution in IME payments, which is the first  
3 bullet on this slide. It's then just putting it in the  
4 context of most hospitals are large and have many lines of  
5 business and IME is a smaller share of their overall  
6 Medicare payment.

7 DR. RYU: I see.

8 MS. BINKOWSKI: Within the IME payments itself, as I  
9 said, the distribution would be wide. To give you a flavor  
10 of that, about a fifth of teaching hospitals would have  
11 more than a 25 percent decrease, and a sixth would have  
12 more than a 25 percent increase in IME payments. When you  
13 add performance based on top of that it would obviously  
14 shift, depending on performance, and there is large  
15 variation in the degree of outpatient centricity, to coin  
16 the term.

17 DR. CROSSON: Yeah, on this point.

18 DR. CASALINO: So I think this is related. I just  
19 want to try and understand the difference between two  
20 numbers, the one that Jaewon is referring to in the next to  
21 the last slide, Slide 17, that most hospitals, their  
22 payments would change by less than 2 percent. And then on

1 the previous slide, Slide 16, where, if I'm understanding  
2 correctly, the estimate that there would be \$1.1 billion in  
3 performance-based payments, which, if you kind of want to  
4 look at that as a withhold, in the language of our previous  
5 discussion, that would be \$1.1, if I understand correctly,  
6 of the \$9.3 total in IME payments, which would be more like  
7 kind of an 11 percent withhold, or 12 percent, whatever.

8 So if I'm understanding that correctly we have a 12  
9 percent withhold, which is much bigger than we were talking  
10 about in the previous discussion, but yet we'd only expect  
11 the hospitals' aggregate IME payments to change by 2  
12 percent.

13 MS. BINKOWSKI: So again, I think maybe to clarify,  
14 it's that they're overall Medicare payments across all  
15 lines of business, not their IME payments.

16 DR. CASALINO: I see. They're overall, because IME  
17 payments could change quite a lot --

18 MS. BINKOWSKI: Dramatically --

19 DR. CASALINO: -- according to this slide.

20 MS. BINKOWSKI: -- as well could their performance-  
21 based payments.

22 DR. CASALINO: Okay. Thanks.

1 DR. CROSSON: Okay. Larry, you're also up next.

2 DR. CASALINO: No. That was it.

3 DR. CROSSON: That was it. Okay. Warner.

4 MR. THOMAS: So this was a great analysis. Thanks  
5 for the information. Just a couple of questions.

6 Did we look at -- and I know there's questions about  
7 like MA pays, you know, some of this but doesn't pay on  
8 others. Did you look at what the impact would be if MA  
9 paid consistent with fee-for-service Medicare, because I  
10 know right now it's inconsistent.

11 MS. BINKOWSKI: so we haven't done any analysis on it  
12 to clarify if it's currently consistent on the inpatient  
13 operating side. Where it's inconsistent is for inpatient  
14 capital IME. We do know, anecdotally, that some MA plans  
15 do build that into their contracts.

16 MR. THOMAS: Okay.

17 MS. BINKOWSKI: But we don't have data on the extent  
18 to which that is done.

19 MR. THOMAS: Okay. Do you know -- and I don't know if  
20 this is even knowable. I know there are many organizations  
21 that have unfunded slots. Do we have any idea of the  
22 magnitude of that, you know, kind of nationally? Is that



1 something that we should have as part of our analysis and  
2 kind of know how unfunded slots kind of line up with these  
3 funding mechanisms?

4 MS. BINKOWSKI: So, yeah, some of that is buried in a  
5 footnote in the paper, but there are roughly 84,000 funded  
6 residents and roughly 100,000 total residents. There are  
7 several reasons for that spread. I think we defer it to  
8 the Commission on what the right sequencing is of looking  
9 at residency slots.

10 DR. DeSALVO: Sorry, but do you know of -- so that's  
11 about a fifth -- do you know if they are in the same  
12 markets where most residency slots are concentrated, or if  
13 they're filling the gaps across the country where there are  
14 unfunded slots?

15 MS. BINKOWSKI: I don't have that off the top of my  
16 head. I can look into it.

17 MR. THOMAS: What's that again? I didn't hear.

18 MS. BINKOWSKI: There are slightly different counts of  
19 residents for IME purposes and DGME purposes, and so the  
20 exact numbers that we're talking about vary, but those are  
21 rough ball parks across the two.

22 MR. THOMAS: And then, you know, going back, you had

1 mentioned that there's a pretty wide swing in the impact of  
2 payments if we're going to make these changes. Is it  
3 knowable to then know the impact on -- because I know we  
4 look at Medicare margins, you know, we kind of look at  
5 Medicare rates. Is it knowable to know the impact on  
6 Medicare margins as you relate to different groups of  
7 facilities? Or have we run any of that information?

8 DR. STENSLAND: We could do that once we know exactly  
9 how the performance-based payments would be distributed and  
10 somehow model that. Until you know that, you'd have to  
11 make some sort of broad assumption, assuming everybody just  
12 gets their share of it or something like this. And then,  
13 of course, since this is budget neutral, on average  
14 everybody's margins are going to be the same, because, you  
15 know, we're spending \$9.3 billion now. We're still going  
16 to spend \$9.3 billion. So, in aggregate, it's not going to  
17 change the margins for teaching hospitals. But who gets  
18 that money might move a little bit. But in terms of their  
19 overall Medicare margin, it really shouldn't move, as  
20 Alison said, by more than 2 percent for very many of these  
21 because this is going to be less than 2 percent of their  
22 revenue in almost all the cases.

1 MR. THOMAS: 2 percent of total revenue, okay.

2 DR. STENSLAND: Not the total all-payer but just from  
3 their Medicare --

4 MR. THOMAS: Total Medicare revenue.

5 DR. STENSLAND: Yeah.

6 MR. THOMAS: Okay, great. Thank you.

7 DR. CROSSON: Thank you, Warner. Pat -- on this  
8 point, Amol.

9 DR. NAVATHE: So just to get a sense of data, do you  
10 have a sense of how the distribution of payments right now  
11 relate to margin? So, in other words, those hospitals that  
12 are disproportionately getting the payments right now, are  
13 they higher margin relative to other teaching hospitals? I  
14 think that might be helpful just as a starting point to  
15 understand what the downstream impact would look like, and  
16 the equity in some sense of where the -- what the economics  
17 -- trying to tie kind of Warner and Brian's pieces  
18 together.

19 DR. STENSLAND: When you say margin, do you mean  
20 Medicare margin or all-payer margin?

21 DR. NAVATHE: I actually mean both. I think we'd be  
22 curious in Medicare margin, but also just overall operating

1 margin.

2 DR. CROSSON: Pat.

3 MS. WANG: I was wondering if you could say more about  
4 the origin of the capital IME adjustment. If it's not  
5 empirically justified today, was it when CMS elected to add  
6 it to capital? Has something changed? Or was there  
7 something -- does it have implications for the adequacy of  
8 the capital PPS that it's missing some things that somebody  
9 -- I'm putting it crudely -- decided to do a little bit of  
10 a plug. Teaching hospitals with the highest intensity  
11 would tend to have more elaborate capital infrastructure,  
12 and I'm just wondering if there's no empirical  
13 justification today whether that has other implications for  
14 the accuracy or adequacy of the capital PPS.

15 MS. BINKOWSKI: So I have not been able to look at the  
16 data that far back to test if we would have found an  
17 empirical relationship then. The Secretary did -- I would  
18 -- there have been several changes since that point,  
19 including the addition of DSH payments, which I think could  
20 have affected the relationship between costs and maybe some  
21 of it was loaded onto the IME before. But I don't know for  
22 sure.

1 MS. WANG: A DSH adjustment to capital? Oh, okay.

2 DR. STENSLAND: In the DSH adjustment to Medicare  
3 payments in general. I think the other thing that's  
4 happened over time is there's a lot better risk adjustment  
5 now than there was when the system first started. So I  
6 wouldn't be surprised if when the system first started you  
7 looked at the empirical relationship and you said, oh, it  
8 does look like these teaching hospitals have higher costs  
9 than can be explained by whatever, how we're paying them  
10 then for their inpatient DRGs. But part of that might have  
11 been that they were dealing with some of the more difficult  
12 cases. But over time we have more risk adjustment. When  
13 we started -- now we even have adjustment for CCs and major  
14 CCs get you different payments that didn't before. So to  
15 the extent that teaching hospitals historically have had  
16 more difficult cases and were better at measuring how much  
17 more difficult those are and adjusting the DRG payments  
18 accordingly, there may be even less of a need for some of  
19 the IME payments, which in the past may have served as kind  
20 of a real crude risk adjuster.

21 MS. WANG: But you're referring to the IPPS. What  
22 about capital? I'm really not familiar with how the

1 capital is reimbursed. Is that risk-adjusted, too?

2 MS. BINKOWSKI: There is the same DRG weight to the  
3 base capital payment.

4 MS. WANG: I see. Okay.

5 The second question I had was: Would you mind going  
6 through again how you would -- what kind of formula you  
7 would put for outpatient activity? Which I assume would  
8 include anything that is paid under OPPS? Okay. Can you  
9 go through that again?

10 MS. BINKOWSKI: So it would follow the same broad  
11 formula. So teaching intensity would be the same across  
12 the three settings, this measure of potentially resident to  
13 average daily total equivalent census. The IME percentage  
14 add-on would come from our setting-specific model, and it  
15 would retain the same kind of log-log relationship that is  
16 under the current model. So I could go into more details,  
17 but essentially one plus this measure of teaching intensity  
18 to a power.

19 MS. WANG: Okay.

20 MS. BINKOWSKI: And it would be multiplied by the base  
21 rate for APC. Maybe this is too easy.

22 MS. WANG: No, it's okay. But just, you know, forgive

1 me, to me "log-log" is like what you put in the fireplace.

2 [Laughter.]

3 MS. WANG: But to start, you wouldn't use a resident-  
4 to-bed ratio. You would use average daily census to --

5 MS. BINKOWSKI: Right. So it's saying that the  
6 measure of teaching intensity is something that the  
7 Commission could discuss, but we think we'd need to move  
8 away from an inpatient-centric measure of teaching  
9 intensity, such as residents to inpatient beds, and we  
10 proposed one, and then it would follow the same kind of  
11 broad formula as under the inpatient operating, but it  
12 would be a different exponent.

13 DR. STENSLAND: [off microphone].

14 DR. CROSSON: Jeff, mic.

15 DR. STENSLAND: It's roughly the volume of outpatient  
16 services you're doing measured by how much you're getting  
17 paid for those outpatient services. So, you know, if  
18 you're getting paid X for a CT scan and you're getting paid  
19 one-half of X for an office visit, then that would be kind  
20 of the magnitude of those things. And so calibrating it to  
21 the inpatient would be based also on the relative prices  
22 that you're getting for those two things. That's how that

1 could be done, and that's the broad general idea of how it  
2 would be computed.

3 Now, there's details inside there, which I think is a  
4 level for way beyond this meeting. But I don't want people  
5 to go away and think, oh, everybody's dead set on saying  
6 it's going to be all outpatient. For example, you might  
7 say we think that having residents running around can  
8 affect your costs for lots of your outpatient services, so  
9 we're going to have that adjustment for your therapy  
10 services and your visits and all this. But we're not going  
11 to make an adjustment on your Part B chemo drugs because we  
12 don't think just because you have a resident there means  
13 it's going to cost you a lot more to buy the Part B chemo  
14 drug.

15 So there's some details which could go into it later  
16 which I think are, you know, for a later meeting.

17 DR. CROSSON: Okay. Now, Jim, did you want to jump in  
18 on this?

19 DR. MATHEWS: No.

20 DR. CROSSON: No. Okay. All right. So then we've  
21 got Marge and then Bruce and Amol. Is that it?

22 MS. MARJORIE GINSBURG: Based on something that Jaewon



1 referenced about specialty had me thinking. You haven't  
2 today or the current system doesn't look at compensation  
3 based on the specialty level, I assume? A resident is a  
4 resident. It would occur to me -- and maybe this goes into  
5 the second part of the session -- that in our interest to  
6 encourage more primary care physicians, would it make sense  
7 to try to orient payment according to the specialty with  
8 regard to the need of certain specialty areas more than  
9 others? So, anyway, that may be part of the next  
10 discussion, but mainly I wanted to know whether this ever  
11 looked at the differences between the intensity of the  
12 specialty.

13 MS. BINKOWSKI: These analyses did not. As we noted  
14 before, there's not the great data that we would like to be  
15 able to look at the level of how costs vary by specialty,  
16 but that's something we'll continue to look into.

17 MS. MARJORIE GINSBURG: Certainly not -- I mean,  
18 learning what the teaching hospitals now focus on and the  
19 number of residents that focus on orthopedic surgery versus  
20 oncology, those data are there, right? They just haven't  
21 been accumulated?

22 MS. BINKOWSKI: There's data on the number of

1 residents and their distribution by specialty. Trying to  
2 tie that to their effect on costs is where it's more  
3 lacking.

4 DR. STENSLAND: A two-part decision to be made. The  
5 one part is: Do we think maybe we should make some  
6 adjustment, depending on what kind of resident it is? And  
7 then there's a question of where do we do that. Do we do  
8 it in this indirect medical education portion which is  
9 supposed to account for the extra costs the hospital has  
10 because the residents are running around? Or do you do it  
11 in the direct payment where you're having some direct  
12 payment for their salaries and this kind of thing? I think  
13 it's a two-part question.

14 MS. BINKOWSKI: Or is it part of the performance  
15 program?

16 DR. STENSLAND: Yes.

17 DR. MATHEWS: And, Marge, just to add a little bit of  
18 clarification to that, I agree with Jeff that there are two  
19 ways you could do it, but this conversation is focused  
20 purely on IME and having a direct GME conversation is going  
21 to be for another time. But if you wanted to contemplate a  
22 policy that would favor programs that produce, you know, a

1 certain type of resident, you know, more primary care  
2 focused, we're coming back to the pipeline issue later this  
3 cycle, so you'll have an opportunity to hear a couple of  
4 other different ways to do that.

5 But the second thing is that, to the extent we are  
6 going to be talking about a performance-based component to  
7 redistributing some IME dollars now, you know, a  
8 consideration of the level of production of primary care  
9 type residents might be a factor in the development of that  
10 performance-based idea.

11 DR. CROSSON: Okay. Bruce.

12 MR. PYENSON: I've got a question on the recent news  
13 that Hahnemann Hospital's residency program is apparently  
14 being purchased by a consortium of other entities, and I  
15 don't know if this is an appropriate question for you  
16 because it's such recent news. But it's interesting that  
17 the bankruptcy of Hahnemann, apparently the residency  
18 program is one of the assets of the bankrupt institution,  
19 and a consortium of organizations has seen value and the  
20 bankruptcy court has apparently made some decision on the  
21 appropriateness of the value. I understand, just from not  
22 much more than the headlines, that CMS has some concerns

1 over that. That strikes me that you then surround that and  
2 maybe even the numbers might be relevant to this  
3 discussion, and I wonder if you have any thoughts or  
4 comments on that.

5 MS. BINKOWSKI: I don't have any comments on the  
6 specific numbers as they are, you know, a moving target and  
7 have just come out. But, yes, the cap on residents has  
8 made residency slots valuable, and one of the changes in  
9 the ACA was to allow slots of closed hospitals to be  
10 redistributed as opposed to lost, and the sale of  
11 Hahnemann's slots is a result of that change. We can talk  
12 more afterwards.

13 DR. CROSSON: Okay. Amol.

14 DR. NAVATHE: So I just had a question and then  
15 perhaps a suggestion going forward. One of the other big  
16 changes that's happened over the last several years is duty  
17 hour reform and its impact on sort of the economics of  
18 these slots may actually be something that's evolving. And  
19 so I was curious, if we haven't already looked at, perhaps  
20 we should look at how duty hour reform has impacted the  
21 economics of those slots in some sense and on the  
22 downstream financial health of hospitals. And then

1 secondly would be in an ongoing fashion, as duty hour  
2 reform continues or likely continues to evolve, that might  
3 be another factor for us to just keep in mind to ensure  
4 that we're not --

5 MS. BUTO: What kind of reform, Amol? Sorry.

6 DR. NAVATHE: The reform that we're talking about  
7 there is just the number of hours that residents can work,  
8 so 80 hours per week. My sense is that would  
9 disproportionately be impacting the inpatient care;  
10 therefore, the institutions that are heavily focused on  
11 inpatient care would be more impacted. The general sense  
12 is that has caused the variable cost structure of these  
13 hospitals to go up because as residents have been capped,  
14 they've been hiring PAs and other hospital physicians and  
15 whoever else to fill those hours, because obviously those  
16 hours were needed for patient care. So just another  
17 variable here that we might want to make sure we keep in  
18 this discussion.

19 DR. CROSSON: Okay. Thank you.

20 Seeing no further clarifying questions, we'll move on  
21 to the discussion period, and Paul I think is going to  
22 begin.

1 DR. PAUL GINSBURG: Yes. Well, first, thank you for a  
2 really good job on the presentation, and I think the issue  
3 was a very important one. You know, in context, in payment  
4 for IME, the policy was created in 1983 in conjunction with  
5 the Inpatient Prospective Payment System. It has not  
6 really been revisited much since then, and the context has  
7 changed so much because outpatient care is so much larger a  
8 portion of the activities of teaching hospitals, and that's  
9 where a lot of the teaching is done. It's not just the  
10 primary care residencies, but there are lots of specialty  
11 residencies where that specialty rarely sees an inpatient,  
12 so much of the training for those specialties does take  
13 place in teaching hospitals, but in their outpatient  
14 departments.

15 So one other aspect of the history is that, of course,  
16 MedPAC and its predecessor, ProPAC, has been concerned  
17 about the excess payments for IME for a long time, and that  
18 was not a failure of policy analysts in setting because  
19 HCFA and CBO came up with the right number, and Congress  
20 deliberately decided to go for a much higher IME add-on  
21 because it wanted to make sure that the AAMC supported the  
22 Inpatient Prospective Payment System. And they succeeded

1 at that, and then they have been stuck with it ever since.

2 But, you know, it was very compelling, the point you  
3 made, about how to train residents in outpatient  
4 departments is expensive, and I gather you're saying it's  
5 actually more expensive on a percentage basis than training  
6 them in inpatient settings. So the result is that, you  
7 know, we have a situation where, for not only primary care  
8 but for many specialties, you know, it becomes a losing  
9 proposition to train -- to have these residencies because  
10 they're not getting any of the IME type support. It's all  
11 going to the inpatient residencies.

12 So I don't know the degree to which this has been  
13 decisive in having hospitals change the mix. You know, the  
14 fact that so much of it is tied to numbers back in the  
15 1980s with the DME probably prevents that from happening.  
16 But I think unfunded residencies have been growing, and so  
17 it could be a factor.

18 So, you know, I think this would make the system  
19 fairer. It certainly would improve the incentives although  
20 I'm not ready to say that it will make a big difference  
21 because I think the DME and IME payment is perhaps  
22 overwhelmed by other factors, you know, some of the

1 attractiveness of providing residents in some specialties  
2 that are very profitable for the hospitals. And even when  
3 it comes to primary care, the need to have the primary care  
4 resident often overwhelms the fact that they might not be  
5 profitable.

6 I think it's intriguing to devote some of the  
7 resources to performance-based, although I worry a little  
8 bit that unless we can fairly quickly make a compelling  
9 argument that, you know, these things that we can measure  
10 are really important and really -- you know, it could  
11 undermine the bigger part of the proposal to me, which is  
12 to shift the payment toward the outpatient departments.

13 DR. CROSSON: Okay. Let's focus on the last slide,  
14 the discussion points, the questions the staff has. I see  
15 Brian, Warner, Jonathan, Kathy, Pat.

16 Brian.

17 DR. DeBUSK: Well, first of all, again, thank you for  
18 a great chapter. I really, really support the work. I  
19 think re allocating the funding is an outstanding idea. So  
20 I think you guys are off to a great start. Shifting it to  
21 the outpatient setting, I'm completely on board with.

22 Also, introducing a performance-based component, I



1 think that's an excellent, excellent idea.

2 I guess, in summary, I'm wildly supportive of what I  
3 see in this chapter and really look forward to the next  
4 iteration of this work. I hope it comes sooner rather than  
5 later.

6 The one passing comment I would like to make, I'd like  
7 us to look at performance a little bit holistically because  
8 it's not -- I realize there are some performance standards  
9 on the quality of the teaching and what's being done, but  
10 it would also be nice to look at performance within the  
11 context of what do we need in the workforce. What skills  
12 sets, what specialties do we need?

13 The other thing I do hope we can take into  
14 consideration is the relative profitability of the  
15 different specialties, because I think that's an element of  
16 performance too. I think one teaching center that's  
17 producing a lot of primary care physicians and a lot of  
18 psychiatrists and things that Medicare really needs versus  
19 a -- and, obviously, we need all specialties, but versus  
20 something that's, say, in relatively greater supply, a  
21 specialty that's in relatively greater supply that has a  
22 better revenue stream attached to it, say, to those fourth-

1 and fifth-year residents, I think those are fundamentally  
2 different needs.

3 I guess my whole point was I love the work. I think  
4 this is a material amount of spending, but I think more  
5 importantly, it's a material amount of spending that's  
6 shaping our entire work force. So I think there's some  
7 leverage here in this area. So I hope the work continues.

8 But performance to me means so much more than did they  
9 make it through the program. Performance to me is how  
10 effectively is this money shaping our workforce into  
11 training physicians that Medicare and their beneficiaries  
12 need.

13 DR. CROSSON: Okay. Warner.

14 MR. THOMAS: So I think this has obviously gone a long  
15 time without being looked at and needs to be looked at and  
16 evaluated.

17 I would say, at the same time, I think we've got to be  
18 mindful of the magnitude of change we have because, once  
19 again, I think more shifts should be to outpatient. I  
20 think that makes a lot of sense. I mean, care has changed  
21 a lot in the last three decades, so we get that.

22 But, at the same time, a lot of care done in large

1 academic medical centers is inpatient, and if you look at  
2 outcomes, it's in the Health Affairs articles. We've seen  
3 it over and over. Outcomes in large academic medical  
4 centers for high-acuity patients especially is better than  
5 what you see in other organizations. So I think we have to  
6 be mindful of that and just kind of balance that look.

7 I agree that more should be shifted to the outpatient  
8 area, and I think that that makes a lot of sense.

9 On the Figure 4, where you kind of did the chart  
10 looking at the analysis by entity, kind of the percentage  
11 change, I'd actually like to see that broken into kind of  
12 dollars as percent because I think it's important to know  
13 and the magnitude of dollars that would move around. These  
14 could have material impacts on major programs. So it would  
15 be helpful to understand that piece.

16 On the performance, I agree. I always think all of  
17 our patients should be tied to performance. I think the  
18 question is, What is that performance going to be?

19 I do think looking at unfunded positions, especially  
20 if they're in areas that we need to train more folks, like  
21 primary care, psychiatry, other places where we have a  
22 shortage, medical subspecialties that are more in the

1 cognitive nature, I mean, there's just a tremendous  
2 shortage of these folks. I think we ought to be looking at  
3 perhaps more of those dollars ought to be redistributed in  
4 that way, and maybe there should be higher payments for  
5 these types of specialties that we want to train more  
6 people in going forward.

7 I'm concerned about how are we going to actually  
8 develop the performance metric. What are they going to  
9 look like?

10 I think Jay's point about are we putting out people  
11 that are trained in quality, that are trained in value-  
12 based payments is great, but I'm kind of going back to how  
13 are we going to evaluate that. I think that's the thing  
14 I'm challenged with.

15 I like the idea of modification. I think we need to  
16 be mindful, and I think we also should think about, if  
17 we're going down this road, some sort of transition to give  
18 people time to adjust to these types of things.

19 I wouldn't totally discount the importance of funding  
20 this through proportion of inpatient care and looking at  
21 that carefully because, I mean, we want to make sure these  
22 centers are good at inpatient care and they are taking all

1 the high-acuity transfers. More and more, they are coming  
2 from places that can't take care of folks because they  
3 don't have the medical staff in more rural areas. People  
4 are getting transferred to places like this. We need to  
5 make sure they can do it.

6 So I just would kind of use that as a caution as we  
7 look at it.

8 DR. CROSSON: Just on Warner's point, I want to  
9 emphasize that you gave those two examples as just  
10 examples.

11 MR. THOMAS: Yeah.

12 DR. CROSSON: I think the commission's position at the  
13 time was that we were not equipped, and we were not at all  
14 certain that CMS was equipped to be able to design the  
15 right way to measure performance, outside of the question  
16 of the specialty issue, but that the industry itself should  
17 do that --

18 MR. THOMAS: Yeah.

19 DR. CROSSON: -- because I think it's kind of hard to  
20 imagine that we would accept the position that there is no  
21 way to measure the success of training programs, that we  
22 ought to just accept the fact that as long as someone, a

1 resident, is put out of a training program, then they're  
2 all the same in terms of their capabilities to meet the  
3 needs, in this case, the Medicare beneficiaries going  
4 forward. It would be, I think -- I still think it would be  
5 incumbent on the industry to address that question.

6 MR. THOMAS: Jay, I think that's a great point, and I  
7 think there's good training programs and ones that are not  
8 as excellent. So I think that's a great point.

9 I have no issue with that. I think the question is it  
10 would be a good challenge to the industry to think about  
11 how they come back and provide new feedback around that.  
12 So I think that would be great to hear ideas about that.

13 DR. CROSSON: Okay. Jonathan.

14 DR. JAFFERY: Yeah. Thanks, Jay.

15 So, first of all, thanks, Alison. It was a great,  
16 clear presentation. Jeff, it's good to see you finally  
17 doing some work around here.

18 DR. STENSLAND: [Speaking off microphone.]

19 [Laughter.]

20 DR. JAFFERY: So echoing a lot of the support that  
21 others have already given, I think some of the concerns  
22 about how this would impact individual teaching hospitals,

1 I think there's an opportunity to do some modeling. I  
2 think somewhere you talked about how 18 different hospitals  
3 would have greater than 5 percent of their payments, and  
4 you could just imagine that every single teaching hospital  
5 is assuming they're one of those 18, and that grade of 5 is  
6 going to be significantly greater than 5. So that could  
7 just be important going forward.

8 I think Amol's comments, suggestion about looking at  
9 Medicare margins and overall margins is actually a really  
10 interesting idea. If you think about the initial purpose  
11 of IME to sort of cove some of the inefficiencies that we  
12 might get from having resident care and then you combine  
13 that with what we've seen and observed around how more  
14 efficient hospitals and organizations may have -- less  
15 efficient ones may lead to lower Medicare margins, and  
16 maybe because they're getting higher overall payments, and  
17 how that all connects, I think we want to make sure that  
18 those payments are rewarding the right things.

19 I wonder if we can -- on page 17 of the report, you  
20 talk about how IME policy doesn't reflect the contemporary  
21 spectrum of settings in which hospital care occurs, and I  
22 just wonder if there's any reason or ability to consider

1 even more broadly where all care occurs. We're making all  
2 these shifts to value-based care, and if we're interested  
3 in training more of a workforce, including maybe a focus on  
4 primary care that's going to spend time in nursing homes or  
5 -- we're launching a home-based primary care program this  
6 fall. So we'll actually have people, hopefully, at some  
7 point helping care for people in their own home. How do we  
8 measure that exactly, and how is that accounted for?

9 I think in terms of the performance-based payments, I  
10 really appreciated Jay's context about the 2010 report. I  
11 worked for Senate Finance shortly after that report came  
12 out. I remember it coming out, and we talked about it a  
13 lot and thinking about how maybe this would create  
14 opportunities to shift more slots towards primary care then  
15 and just reflecting on the fact that now it's basically a  
16 decade later and we're still having the same conversation.

17 And I appreciate the idea that maybe the industry is  
18 best positioned to come up with some metrics that would  
19 make sense, but maybe there is an opportunity for us -- and  
20 this is maybe a later conversation, but to frame, even in  
21 broad strokes, what that might look like, to try and align  
22 with the commission's principles and goals around improving



1 care for Medicare beneficiaries and creating a good  
2 stewardship of taxpayer dollars.

3 Resource utilization, for example, and affordability  
4 was not something that was nearly in the front of the  
5 conversation as it is now, I think.

6 I think there may be some opportunities to push the  
7 industry to think about other things. What about workforce  
8 diversity and matching that to populations, the populations  
9 served by a particular teaching hospital?

10 Again, I'm not sure that I would know right now how to  
11 measure that exactly or that we would be equipped as a  
12 commission, but we could put that out there as something  
13 we'd like to see.

14 Thanks.

15 DR. CROSSON: Thank you, Jonathan.

16 Kathy.

17 MS. BUTO: So, first of all, I support the  
18 recommendations that you have laid out wholeheartedly. I  
19 think it's definitely an improvement.

20 I would ask -- I think others have brought this up --  
21 that we actually do an impact analysis by large teaching  
22 hospitals, by geography, by other things that we think are

1 important, so we can see where the impact actually is.

2 For some hospitals, even though the impact overall in  
3 terms of Medicare payment is relatively small, for some  
4 hospitals, it could be significant. So I think we really  
5 want to understand where that's happening, and it could  
6 have to do with distribution of low-income beneficiaries  
7 versus not, et cetera.

8 So one thing -- I think Marge brought this up -- I  
9 really think it's important for us to separate and yet  
10 bring together both the GME direct medical education and  
11 this IME component, which is more -- it was always  
12 envisioned as the extra intensity related to teaching  
13 programs and recognizing where that intensity adds cost and  
14 so on.

15 The ability to actually influence sort of these  
16 specialties that are being trained, I think, really resides  
17 more directly in direct medical education. If we could  
18 tie, somehow, this performance-based payment element back  
19 to payment direct costs for those interns and residents, I  
20 think that would be important or at least to acknowledge  
21 that we want to have some connection there.

22 The performance-based payment looked to me like trying

1 to do that light, sort of the light version of can we make  
2 policy preferences and influence decision-making at the  
3 hospital level by having this pot of money, which isn't  
4 very big.

5 So the other thought I had was maybe it needs to be  
6 bigger if we really want that to be significant, but I  
7 actually think it has to be tied more to the actual slots.

8 Then I started thinking about performance-based  
9 payment in a teaching program, where the time frames are  
10 very long, I think we have to think about that. How would  
11 you do performance-based payment? You would probably not  
12 want to change the performance metrics or things you're  
13 measuring year to year.

14 Let's say it was something like directly providing  
15 more opportunities or training around treatment disparities  
16 by race and ethnicity, something like that. You're not  
17 going to do that one year and not do it the next year.

18 So I just really think we need to think about that  
19 element with a little more granularity and see how much we  
20 can tie these performance metrics back to direct medical  
21 education.

22 Then, last, I thought when we do get around to doing

1 our chapter, our analysis on direct medical education or  
2 maybe even in the next iteration of this one, I think it  
3 would be really helpful for us to have a refresher or an  
4 update on sort of the supply of physicians by specialty.  
5 What are we seeing? What's the trend? I know we've done  
6 this before, but I just think it would be helpful as we  
7 think about where we think there are shortages, we all say  
8 primary care. I'm now concerned there are specialty care  
9 shortages that we tend to not focus on, especially in the  
10 area of Medicare beneficiary treatment.

11 So I'd like to see us update that analysis of impact  
12 or, rather, what the pipeline looks like, even though it's  
13 not directly related to IME, per se.

14 Thank you, Kathy.

15 Pat?

16 MS. WANG: So I echo what others have said. I think  
17 this is a very important paper, and that the concept is  
18 very, very attractive. It's time to have this  
19 conversation.

20 I agree with what others said about the need for sort  
21 of much more information disclosure, I guess, and  
22 transparency. When we were right at the start of this, I

1 understand about what the impacts are and where they fall.

2 To Amol's suggestion about looking at impacts on  
3 margins, my recollection is that teaching hospitals in  
4 general have higher Medicare margins but lower all-payer  
5 margins, and I think that we have to be very sensitive  
6 about any impact on both of those and the viability of  
7 access to Medicare beneficiaries to excellent teaching  
8 hospitals. I think that's been part of the historical  
9 concern around calibrating these teaching programs.

10 You kind of touched on it. I just don't know, but in  
11 the next round of this, what the operational issues would  
12 be about extending to the OPPS settings. That's a lot of  
13 claims. That's a lot of shadow bills. I don't know  
14 whether there's some complexity there that would need to be  
15 addressed and operationalizing anything.

16 I do want to say that even if not to Jaewon's point  
17 earlier, even if not a dollar shifted from hospital to  
18 hospital, I still think the value of the concept here is to  
19 sort of unshackle or equalize the value of all settings in  
20 a hospital to get paid for what is owed for IME, so that  
21 it's not such a heavy burden, like you got to put the head  
22 in the bed in order to get the IME payment, whatever the

1 level of payment is, and that you can still get what you  
2 are supposed to get by treating people irrespective of the  
3 setting and find the most appropriate.

4 I'm not saying the teaching hospitals unnecessarily  
5 admit, but there is a handcuff to the bed in some ways in  
6 order to get your full IME budget.

7 So I think that even if dollars don't move, just  
8 equalizing the value of the settings to get paid for IME is  
9 a good thing.

10 For capital, honestly, I didn't even know that there  
11 was an IME adjustment on capital. It's a relatively small  
12 amount. I guess I'm a little concerned about whether  
13 there's a reason that it's there, and if you take it away,  
14 whether you're busting a hole in the adequacy of capital  
15 payments. So I wouldn't start with taking IME off of the  
16 capital PPS. I probably would just leave it alone.

17 As far as the performance pool is concerned, I really  
18 understand the impulse here, but I think that some of the  
19 things that people have mentioned as performance goals,  
20 which have to do with competencies of the physician  
21 workforce are more effectively done through the  
22 accreditation bodies. I think program directors will be

1 much more sensitive to accreditation standards of how the  
2 skills that physicians -- that residents need to have when  
3 they emerge from a residency program, I'm not sure that  
4 IME, which was supposed to be part of the operating payment  
5 structure, is the way to do that.

6 Others have pointed out -- so I feel like payment  
7 policy from Medicare is more appropriately -- if we were  
8 going to target money, it's really around workforce supply,  
9 and as far as that's concerned, I do think that DGME is an  
10 important component there, and that even if you were --  
11 it's less about IME, and it's more about DGME.

12 Just a very crude example would be we need more  
13 geriatricians. We're going to weight the DGME payment for  
14 a geriatric resident at 1.2, and then you have to down-  
15 weight some. You know, it's that kind of thing that I  
16 think Medicare payment policy is more equipped to handle as  
17 opposed to some of the important nuances that Jay was  
18 describing.

19 I think Jon raises a good point. As care even moves  
20 out of the OPSS setting, hospital at home, all these  
21 innovative things, at some point, IME will have to catch up  
22 with that. But I think even just starting with outpatient

1 is a positive thing.

2           Then, finally, because of what I just said about the  
3 performance pool, if you leave capital alone, there's less  
4 kind of access. I would just use it for transition, and I  
5 would use it to prevent untoward gaps and impacts on  
6 teaching hospital programs.

7           DR. CROSSON: Paul, on that point?

8           DR. PAUL GINSBURG: Pat, on this, the capital,  
9 initially, under prospective payment, capital was paid on a  
10 cost basis. I think it's because they weren't sure how to  
11 do it. I guess then when they went to prospective payment,  
12 they had to do one for capital. I mean, once they put  
13 capital on prospective payment, they did an IME,  
14 presumably, because of an argument that having residents  
15 means more capital cost.

16           That's probably valid. I could see looking into it,  
17 but I wouldn't just blow it away, which I think you're  
18 suggesting and kind of make it a slush fund for other  
19 things.

20           So I'd be very cautious on doing anything other than  
21 to make it consistent with operating cost IME in the  
22 capital area.



1 DR. CROSSON: Karen.

2 DR. DeSALVO: Actually, a quick point about that. I  
3 suspect that the utility of it on the ground, the capital,  
4 is call rooms and conference rooms and IT necessary to  
5 webcast grand rounds, all those things that probably aren't  
6 part of a normal hospital's infrastructure. So there's  
7 probably some real use to the resource.

8 Let's see. I think this is a really great step to  
9 move in from a sickness model to going upstream, to  
10 thinking about how to create a workforce that can  
11 understand how to care for patients and populations in a  
12 variety of settings and not just in the hospital.

13 My own experience in training was pretty sickness  
14 hospital-based and that we've tried to evolve that over the  
15 course of the last 100 years, that it's still really  
16 difficult on the front lines to get agreement on having  
17 training opportunities in the clinic environment. There  
18 are residents running around and it creates a mess. So I  
19 really appreciate the idea of giving the hospitals the  
20 flexibility, even if it's just a message rather than any  
21 major financial shift.

22 But I want to agree also, though, with Jonathan's

1 point, which is that what this does is it kind of moves  
2 money around in a very hospital-centric model, and there  
3 are other places that we want to train residents. He  
4 mentioned some of the settings. It might be post-acute  
5 care settings. It might be models that are primary care at  
6 home. It might be telehealth. It might even be in  
7 federally qualified health centers or in non-hospital-  
8 affiliated community environments, rural clinics.

9       And these are real impediments every day to making  
10 sure that there is a way to support our partners that want  
11 to train residents and they don't fall under our tax ID, so  
12 it doesn't necessarily allow that this kind of a shift to  
13 support new sites of training. It just may be worth  
14 thinking about are there ways to -- instead of a  
15 performance-based pool, is there a way to do some piloting  
16 of a different model of payment? It was kind of mentioned  
17 here, it's definitely mentioned by NAM, but thinking of  
18 bringing together DME and IME, as an example, rather than  
19 having separate payments. Is there a way to more directly  
20 drive the development of certain skills and categories of  
21 doctors, based upon leveraging both pools of money but  
22 thinking of new ways to combine them, and trying to free

1 ourselves from this -- sorry, this hospital-centric model,  
2 the way that we've been paying for resident training.

3         And the last point does also relate back to the  
4 question I asked earlier and the strategy that was  
5 mentioned in the NAM report, which is they are a set of  
6 medical education experts and they need to be a part of  
7 this development of new workforce that they're going to be  
8 responsible for on the front lines. On the other hand,  
9 people have equities, other entities like the VA. There  
10 are experts at places like HRSA. And so this idea of a  
11 council, a DME council.

12         Again, I know that's beyond the scope, potentially, of  
13 MedPAC, but I think as we're considering this I would like  
14 for us to just make sure that we're not -- we're asking the  
15 Secretary to really think about how to put Medicare IME,  
16 DME, any other pilots, demonstrations, performance  
17 standards in alignment with other programs. And they could  
18 do that in a structured way with some sort of a council,  
19 because I wouldn't want us to only use the -- I'd like for  
20 our levers to be more strategically aligned with other  
21 folks' levers, because the stakes are high.

22         I do have one more small thing, which is just to say I

1 do think that Jay -- I don't want to speak ill about  
2 medical education. We're all right now, too, being a part  
3 of it. But there's a lot that we know in med ed, but  
4 there's a lot that we don't know. And I think where Jay is  
5 going with some of his value-based care and thinking about  
6 quality improvement and other skills that you need on the  
7 other side, sometimes there are things around technology,  
8 team-based care, social determinants of health, that  
9 horizontal view of what we need to train physicians for  
10 that probably there would be some benefit add to having  
11 stakeholders help define the new workforce skill sets  
12 beyond just the current medical education community. Does  
13 that make sense?

14 DR. CROSSON: It does to me.

15 DR. DeSALVO: Or we can just pitch it all over to med  
16 ed. I think that there needs to be a broader array of  
17 folks thinking about how to build a future workforce,  
18 because it goes beyond, I think, what even the med ed  
19 community has currently got in their portfolio of things  
20 they're trying to think about. I'm being ginger about  
21 this, but I could be a little more direct afterwards if you  
22 want.

1 DR. CROSSON: Karen, just on your first point. When  
2 we looked at this in 2010, we did, as part of our proposal,  
3 consider more than the hospital outpatient department in  
4 terms of training sites should be included in that. In  
5 this particular proposal we're sort of going back and  
6 starting with the first part, and then I think, Pat, you  
7 mentioned, or someone, that at some point later that could  
8 be extended. But the concept that you have in mind was, in  
9 fact, part of our initial thinking.

10 MS. BUTO: Does this require legislation? I think it  
11 does, doesn't it?

12 DR. CROSSON: I would imagine so.

13 MS. BUTO: I think that's another reason to think  
14 about eventually linking it up to DGME rather than a  
15 standalone, because it really doesn't make sense not to  
16 have the two together at some point.

17 DR. CROSSON: Okay. Bruce.

18 DR. PYENSON: I think we have a terrific opportunity  
19 here because of the data analytics that we've done, and  
20 it's interesting for me to hear the history of IME and to  
21 read about it, and the history of medical education. I  
22 think not only are the formulas we're using old but I think

1 the narrative probably needs updating. You know, when the  
2 narrative that says, well, residents do more procedures and  
3 order more labs, that's been around for a while and it sort  
4 of sounds kind of counter to what we'd expect of evidence-  
5 based medicine and all the investments in electronic  
6 medical records and other kinds of things.

7 But I think through the data that we have we could  
8 actually parse out better what those extra costs are, where  
9 they're coming from, which cost centers and maybe which  
10 revenue centers, maybe also look at the connection to the  
11 inpatient Part B side perhaps, to get some insight into  
12 that. So I think that one of the benefits of this is it  
13 would update the narrative that we have.

14 DR. CROSSON: Thank you, Bruce. Jaewon.

15 DR. RYU: Yeah. I'll be brief. I think a lot has  
16 been said. I think this makes sense to revisit. It's  
17 shocking to me that it hasn't been revisited really  
18 meaningfully in quite some time.

19 I like the concepts of what this is setting out to do.  
20 I think the place where I struggle a little bit is it's  
21 tough for me to decouple this from the payment adequacy  
22 conversation. And I get that, you know, when we have the

1 annual payment adequacy session we do it in an all-in, all-  
2 hospital way. And maybe the impact analysis that Kathy  
3 referenced, or the margin question that Amol referenced, I  
4 think that will help inform this a little bit.

5 But it feels like those two lanes converge, for me at  
6 least, as far as, you know, this particular proposal and  
7 then the payment adequacy discussion that we have. So to  
8 the extent that we can tease that out a little bit, through  
9 that impact analysis, and just understanding what the  
10 implications are I think that would be helpful.

11 And then to Karen and Jonathan's point, what I like  
12 about this is that it does get us out of the inpatient  
13 environment and incenting through the actual formulas --  
14 not even incenting but properly reflecting where the cost  
15 of education may be, but it still doesn't get us to  
16 untethering from, or distethering, whatever the word is --

17 [Laughter.]

18 DR. RYU: -- disconnecting from the hospital  
19 institution-associated programs. I mean -- and that's why  
20 it still feels a little bit like squeezing toothpaste,  
21 because the dollars, I think, still land in fundamentally  
22 the same kinds of organizations, and it feels like there's

1 more we might be able to do to actually get into those  
2 other sites and other organizations.

3 DR. CROSSON: Thank you, and Dana, once again you have  
4 the last word.

5 DR. SAFRAN: Okay. I'll be brief. I like the  
6 direction that you're going. I like the concepts so would  
7 echo a lot of what's been said.

8 The only two incremental adds I have are, one, as we  
9 think about the beginning of including outpatient care, I  
10 wonder if we are not going far enough in terms of some of  
11 the shifts that others have pointed to in health care since  
12 this formula was developed and whether we should be looking  
13 at payments related to at least certain specialties for  
14 community-based work in order to encourage that work.

15 So I think the point I want to make there is both  
16 let's think broadly but let's also think about where do we  
17 want the emphasis to be, in terms of residency training,  
18 and how do we use these payments to help get it there.

19 And then on the performance question, I don't have an  
20 easy, good answer to that. I just wanted to suggest that  
21 maybe it's helpful to think about what are the areas of  
22 performance, both inpatient hospital, outpatient hospital,



1 and community, that we think are supported by having  
2 residents, and then create accountability for those things.  
3 In other words, by paying for performance on the things  
4 where residents really can be a value-add, do we start to  
5 create the right emphasis on the use of residents in the  
6 settings where we want to see them?

7       So that's just a thought that's a different way to  
8 think about the performance-based component of this, from  
9 what I've heard so far, where it was more like what are the  
10 skills we're trying to teach, and are we teaching them, and  
11 so forth. You may have already thought of this, probably  
12 have, but I wonder whether also conferring with the boards  
13 could be helpful here on how they would think about it.

14       So that's all I have.

15       DR. CROSSON: Thank you very much, Dana. Yeah, I'm  
16 sorry. Marge, I didn't see you.

17       MS. MARJORIE GINSBURG: Several people have looked at  
18 the performance-based issue and are sort of questioning it,  
19 and I wanted to actually come right out and say I think we  
20 should dump it. I think this whole plan is a really major  
21 change, and I think everything we can do to make it as easy  
22 as possible for this to get incorporated means that maybe

1 we ought to try to simplify it somewhat. And I think we  
2 can always come back in five years, after this is all in  
3 place, everything is perfect, and then add the performance-  
4 based measure then. But I think it complicates something  
5 that's already pretty big as it is, and I'm just not sure  
6 the benefit is worth the risk of adding it.

7 DR. CROSSON: Okay. I think then we're done. Again,  
8 Alison and Jeff, thanks for the presentation. This is work  
9 that we're going to be doing over some time, and I think  
10 you've given us a great start here.

11 So we now have time for a public comment session. If  
12 there are any of our guests who would like to make a  
13 comment please come to the microphone. I will ask you, in  
14 a minute, to begin. Please identify who you are and what  
15 organization you're affiliated with, although I have a good  
16 sense of that already.

17 [Laughter.]

18 DR. CROSSON: And I would ask you to keep your remarks  
19 to two minutes, and when this light comes back on the two  
20 minutes will have expired.

21 Please proceed.

22 DR. ORLOWSKI: Thank you and good morning. I'm Dr.

1 Janice Orlowski. I'm the Chief Health Care Officer at the  
2 Association of American Medical Colleges. The AAMC  
3 represents medical colleges and teaching hospitals.

4 Four quick comments. One, we truly appreciate the  
5 work and the proposal by the MedPAC staff to keep total IME  
6 dollars intact. Number two, we agree that an outpatient  
7 IME payment should be studied as more care moves to the  
8 ambulatory setting and the complexity in the teaching  
9 environment rises, and so we support this.

10 Number three, we question the statement that Medicare  
11 overpays, as both inpatient and outpatient Medicare margins  
12 are negative. And we need to keep in mind, as a number of  
13 folks have said, that recent studies continue to  
14 demonstrate that Medicare patients enjoy a significant  
15 mortality benefit when treated at a teaching institute.  
16 Any proposal change in the resources need to be carefully  
17 studied.

18 And four, finally, we respectfully ask the MedPAC  
19 staff to not only study the IME, but we need to also study  
20 the continued issue with the 22-year freeze on the GME  
21 slots, so that we look at payment in a holistic manner.

22 And with that I appreciate very much the opportunity.

1 DR. CROSSON: Thank you very much for your comments.  
2 Seeing no one else at the microphone we are adjourned until  
3 October 3rd. Safe travels, everyone. Bye-bye.

4 [Whereupon, at 11:33 a.m., the Commission was  
5 adjourned.]

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22