

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 10, 2015  
10:40 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
SCOTT ARMSTRONG, MBA, FACHE  
KATHERINE BAICKER, PhD  
KATHY BUTO, MPA  
ALICE COOMBS, MD  
WILLIS D. GRADISON, JR., MBA, DCS  
WILLIAM J. HALL, MD, MACP  
JACK HOADLEY, PhD  
HERB B. KUHN  
MARY NAYLOR, PhD, FAAN, RN  
DAVID NERENZ, PhD  
RITA REDBERG, MD, MSc  
CRAIG SAMITT, MD, MBA  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
CORI UCCELLO, FSA, MAAA, MPP

B&B Reporters  
701 Copley Lane  
Silver Spring, MD 20904  
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P R O C E E D I N G S

[10:40 a.m.]

1  
2  
3 DR. CROSSON: Okay. I'd like to welcome  
4 everyone, including the public, to the 2015-2016 season of  
5 MedPAC meetings. As some of you in the public are aware,  
6 I'm not Glenn Hackbarth.

7 [Laughter.]

8 DR. CROSSON: I am privileged, though, to have  
9 become Chairman after Glenn's extraordinary 15-year career.  
10 I just spoke with him last night, and for those of you who  
11 have known and loved Glenn, he's doing very well. He's  
12 still engaged in health policy, and he's enjoying his home  
13 and family in Oregon at the same time. So he's a happy man  
14 and well deserves to be.

15 I thought it might be useful to talk a little bit  
16 about how the Commission from my perspective sees its role  
17 and talk a little bit about some of the priority issues  
18 that we have dealt with, particularly during my time on  
19 MedPAC, which is now 7 years, as well as an indication of,  
20 in generic terms, where we want to go in the future.

21 I think as everyone understands, MedPAC was  
22 created by and charged with serving the needs of Congress,

1 and that is, in the words of "Star Trek," our prime  
2 directive. That's as far as I'm going with --

3 [Laughter.]

4 DR. MILLER: Thank you.

5 DR. CROSSON: We do research, we elaborate  
6 information, and we, when appropriate, make  
7 recommendations, and those recommendations, as you know,  
8 can be made either to the Secretary or to the Congress or  
9 both.

10 As envisioned by the Congress, one primary goal  
11 of MedPAC -- not the only one but an important one -- is to  
12 obtain the greatest possible value for the program's  
13 expenditures, which means maintaining beneficiaries' access  
14 to high-quality services while maintaining their efficient  
15 use and encouraging their efficient use.

16 This goal should not put MedPAC at odds with the  
17 health care industry because their long-term goal, in fact,  
18 should be and in most cases is the same. In fact,  
19 beneficiary access to quality care requires a healthy,  
20 robust insurer world and delivery system.

21 But MedPAC also recognizes that government and  
22 beneficiary resources are finite and that health care cost

1 increases significantly higher than inflation and the  
2 growth of GDP over time can squeeze out other important  
3 societal needs, such as job creation outside of health  
4 care, education of the young, infrastructure repair, and  
5 mitigation of the national debt.

6 Our job is to balance these sometimes contesting  
7 values through our prioritization of agenda issues, our  
8 deliberations, and the nature and force of our  
9 recommendations.

10 As we continue to advance the body of MedPAC's  
11 work, well grounded in previous deliberations, it may be  
12 useful at this time to reiterate a few basic positions that  
13 the Commission has stated in recent years, all related to  
14 our fundamental stated goal.

15 Because we recognize the importance of physicians  
16 and other health professionals in advancing high-quality  
17 affordable care, we are concerned and we remain concerned  
18 that the Physician Payment System is not perfect and it is,  
19 in fact, unbalanced by specialty to the detriment of  
20 primary care as a choice of career for young physicians and  
21 it needs adjustment.

22 In general, we question the argument that

1 Medicare payment rates force certain providers -- for  
2 example, hospitals -- to cost shift to commercial payers.  
3 Costs, in fact, are not immutable, and efficient providers  
4 find Medicare payment rates adequate.

5           However, we're also aware that the hospital  
6 industry in particular is facing significant change in the  
7 next decade and will need time and support to properly  
8 adjust to those changes, and we intend to take that into  
9 consideration.

10           We adhere to the principle that payment for  
11 Medicare-covered services should be as equivalent as  
12 medically reasonable across sites of service, and as  
13 observers of MedPAC know, this is part of our continuing  
14 work.

15           We are quite concerned about the recent  
16 escalation of pharmaceutical costs and its impact on the  
17 Treasury and on beneficiaries. And we believe that  
18 improvement in pharmaceutical affordability in the United  
19 States is needed.

20           We see delivery system and payment reform as  
21 complex but essential to the long-term improvement in  
22 quality, care coordination, and mitigation of unnecessary

1 cost increases based on the creation of a robust market  
2 environment.

3           We support the provision of beneficiary choice in  
4 how to access Medicare coverage, including the existence of  
5 a robust Medicare Advantage program and the evolution of  
6 ACOs and other innovative delivery systems. To the  
7 greatest degree possible, these choices should be cost  
8 neutral to the Treasury, transparent to and affordable for  
9 beneficiaries, and incorporate a range of incentives for  
10 the efficient provision and use of care.

11           We continue to be concerned that Medicare  
12 expenditures on graduate medical education are provided to  
13 institutions without concomitant accountability for  
14 educational outcomes and needs of a modern workforce. And  
15 we reiterate our previous position, similar to that of the  
16 IOM, that this issue needs to be addressed.

17           So, with that preamble, Julie will take us  
18 through the traditional context for Medicare policy  
19 presentation. Julie, the floor is yours.

20           DR. SOMERS: Thank you, Jay.

21           Good morning. Part of the Commission's mandate  
22 in law is to consider the budgetary impacts of its

1 recommendations and to understand Medicare in the context  
2 of the broader health care system. As one of the ways of  
3 meeting these elements of its mandate, the Commission's  
4 March report to Congress includes an introductory chapter  
5 that places the Commission's recommendations for Medicare  
6 payment policy within the context of the current and  
7 projected federal budget picture and within the broader  
8 health care delivery landscape. The chapter is valued by  
9 MedPAC's committees of jurisdiction, and it is intended to  
10 frame the Commission's upcoming discussions regarding  
11 payment updates. While there are no policy recommendations  
12 in the chapter, we are seeking your comments today on its  
13 scope, substance, and tone.

14           In today's presentation I'll discuss the main  
15 topics of the chapter, which include: health care spending  
16 growth and the recent slowdown; Medicare spending trends in  
17 detail; Medicare spending projections; Medicare's effect on  
18 the federal budget; the next generation of Medicare  
19 beneficiaries; and evidence of inefficient spending in the  
20 health care delivery system and challenges faced by  
21 Medicare to increase its efficiency.

22           For decades, health care spending has risen as a

1 share of GDP, but recently its growth rate has slowed. As  
2 shown by this graph, that general trend is true for health  
3 care spending by private sector payers as well as by  
4 Medicare. As a share of GDP, total health care spending  
5 (the top line) more than doubled from 1973 to 2009,  
6 increasing from about 7 percent to a little over 17  
7 percent.

8 Over that same time period, private health  
9 insurance spending (the middle line) more than tripled, and  
10 Medicare spending (the bottom line) more than quadrupled.  
11 Then from 2009 to 2013, health care spending as a share of  
12 GDP remained relatively constant, as highlighted by the  
13 shaded portions of the spending curves.

14 However, government actuaries estimate that  
15 spending modestly accelerated in 2014 driven in part by  
16 health insurance expansions under PPACA and increases in  
17 prescription drug spending mainly on new treatments for  
18 hepatitis C. The actuaries project that over the next  
19 decade, health care spending will continue to gradually and  
20 modestly increase. Growth rates are projected to be higher  
21 than the lows of the recent slowdown, but lower than the  
22 historic highs of the past.

1           Taking a closer look at Medicare, growth slowed  
2 in traditional fee-for-service and in Medicare Advantage,  
3 or MA, but has held steady in Part D. This chart shows  
4 average annual growth rates for the last decade (from 2005  
5 to 2014) in three-year periods. In the last period (from  
6 2011 to 2014), growth averaged 0 percent annually in fee-  
7 for-service and MA. The lower growth rates were generally  
8 due to both decreased use of health care services and  
9 restrained payment rate increases. For fee-for-service,  
10 beginning in 2012, PPACA reduced annual payment rate  
11 updates for many types of providers, and for MA, in 2011,  
12 PPACA began lowering payments to MA plans to bring payments  
13 more in line with fee-for-service spending. In Part D,  
14 growth averaged 3 percent annually.

15           However, the three-year annual average masks a  
16 substantial increase in per beneficiary drug spending in  
17 2014. In 2014, per beneficiary drug spending increased 11  
18 percent due to increased spending on high-priced specialty  
19 drugs to treat hepatitis C. From the slide, we also see  
20 that fee-for-service growth and MA growth increased in  
21 2014. The increase in fee-for-service growth was due to an  
22 increase in per beneficiary spending on outpatient

1 services, such as services received in hospital outpatient  
2 departments and physician services.

3           And now taking a closer look at fee-for-service,  
4 generally we see a slowdown across all settings over the  
5 past decade; however, the impact is not uniform. For  
6 example, for inpatient hospital care, the average annual  
7 growth in per beneficiary spending fell from 2 percent in  
8 the first period to minus 1 percent in the last period.  
9 The growth in outpatient hospital and lab services came  
10 down, but was still growing robustly in the last period at  
11 7 percent annually, in part because of shifts in site of  
12 care from both the inpatient hospital setting and physician  
13 offices to the outpatient hospital setting.

14           Despite the recent slowing of annual growth  
15 rates, cumulative growth in per beneficiary spending over  
16 the last decade has increased in almost all settings and  
17 increased substantially in some settings.

18           Per beneficiary spending on outpatient hospital  
19 and lab services, skilled nursing facilities, hospice, and  
20 some other lab services all grew by more than the growth in  
21 GDP.

22           What do these current trends portend for

1 Medicare? As shown by the blue portion of the bars, per  
2 beneficiary spending growth has fallen from average annual  
3 rates of 9 percent in the 1980s and 6 percent in the 1990s  
4 and 2000s to 1 percent over the last four years. However,  
5 that average annual growth over the last four years  
6 averages some zero-growth years with growth of about 2  
7 percent in 2014.

8           For the next 10 years, as shown by the right side  
9 of the graph, the Trustees and the CBO project that growth  
10 in per beneficiary spending will be higher than the recent  
11 lows, but lower than the historic highs, with an average  
12 annual growth rate of 4 percent for the Trustees and 3  
13 percent for CBO. However, the aging of the baby-boom  
14 generation is causing an increase in enrollment growth.  
15 Enrollment growth increased from about 2 percent per year  
16 historically to 3 percent. That increase occurred over the  
17 last few years and is projected to continue throughout the  
18 next decade. So despite the slowdown in spending per  
19 beneficiary, the Trustees project growth in total spending  
20 to average 7 percent annually over the next decade, and CBO  
21 projects 6 percent.

22           At those rates, the size of the Medicare program

1 will double over the next 10 years, rising from about \$540  
2 billion today to \$1 trillion in the coming decade.

3           As Medicare enrollment rises, the number of  
4 workers per beneficiary is projected to decline. Workers  
5 pay for Medicare spending through payroll taxes and taxes  
6 that are deposited into the general fund of the Treasury.  
7 However, the number of workers per Medicare beneficiary has  
8 already declined from about 4-1/2 around the program's  
9 inception to 3.1 today. By 2030 -- the year by which all  
10 baby boomers will have aged into Medicare -- the Trustees  
11 project there will be just 2.4 workers for every  
12 beneficiary. These demographics are creating a financing  
13 challenge for the Medicare program. As well reported in  
14 the news, the Trustees project that the Hospital Insurance  
15 Trust Fund, or HI, will become insolvent by 2030, but that  
16 date doesn't tell the whole financial story.

17           HI covers less than half of Medicare spending, or  
18 44 percent. It covers Part A services, like hospital  
19 stays, and is financed by a dedicated payroll tax. Since  
20 payroll tax revenues are not growing as fast as Part A  
21 spending, the HI Trust Fund is projected to become  
22 insolvent by 2030.

1           The Supplementary Medical Insurance Trust Fund,  
2 or SMI, accounts for over half of total Medicare spending,  
3 or 56 percent. It covers services under Part B, like  
4 physician services, and under Part D, which helps pay for  
5 prescription drug coverage. Parts B and D are financed by  
6 general tax revenues, covering three-quarters of spending,  
7 and premiums paid by beneficiaries, covering one-quarter of  
8 spending.

9           General tax revenue transfers from the nation's  
10 Treasury and premiums are reset each year to match expected  
11 Part B and Part D spending. Since general tax revenue  
12 transfers and premiums are set to grow at the same rate as  
13 Part B and Part D spending, the SMI Trust Fund is expected  
14 to remain solvent.

15           This slide puts spending and income from the two  
16 Trust Funds together for a more complete financial picture.

17           The black line at the top depicts Medicare  
18 spending as a share of GDP. The layers below the line  
19 represent sources of Medicare funding.

20           As we just discussed, the three primary forces of  
21 funding are payroll taxes in orange, premiums paid by  
22 beneficiaries in yellow, and general revenue transfers in

1 green. The white space below the Medicare spending line  
2 represents the Part A deficit created when payroll taxes  
3 fall short of Part A spending.

4           The takeaway here is that the Part A deficit is a  
5 financing challenge, but the large and growing share of  
6 Medicare spending funded through general revenues is also a  
7 financing challenge. General revenues accounted for 42  
8 percent of Medicare funding today and are projected to grow  
9 to 48 percent by 2030. And keep in mind here that general  
10 revenue includes both general tax revenue as well as  
11 federal borrowing since with few exceptions federal  
12 spending has exceeded federal revenues since the Great  
13 Depression.

14           Here is a look at our situation from the  
15 perspective of the federal budget. The black line at the  
16 top of this graph represents total federal spending as a  
17 percentage of GDP. The yellow line represents total  
18 federal revenues. Year-over-year, we spent more than we  
19 collected in revenues and have increased our debt to levels  
20 not seen since World War II. The layers below the black  
21 line depict federal spending by program.

22           Medicare spending, the bottom layer, is projected

1 to rise from 3.5 percent of our economy today to a little  
2 over 6 percent of our economy in 25 years, or by 2040. In  
3 fact, in 25 years, spending on Medicare, Medicaid, the  
4 other major health programs, Social Security, and net  
5 interest will reach about 20 percent of our economy and by  
6 themselves exceed total federal revenues.

7           So the takeaway here is that Medicare has great  
8 and growing competition for the general tax dollar.

9           Now I'd like to shift gears and take a closer  
10 look at the next generation of Medicare beneficiaries.

11           The baby-boom generation began aging into  
12 Medicare in 2011 at a rate of about 10,000 boomers per day,  
13 a rate that will continue until 2030, increasing Medicare's  
14 enrollment by almost 50 percent, from 54 million  
15 beneficiaries today to 80 million beneficiaries by 2030.  
16 The older population is, and will be for some time, less  
17 racially and ethnically diverse than the under-age-65  
18 population. By 2030, minorities will make up 49 percent of  
19 the under-age-65 population but only 28 percent of the  
20 Medicare population. The health outlook for boomers is much  
21 more uncertain. What is known is that the baby-boom  
22 generation has longer life expectancies and much lower

1 rates of smoking than previous generations.

2           And while they appear to have higher rates of  
3 chronic conditions, they are much more likely to have those  
4 conditions under control. However, baby boomers have  
5 higher rates of obesity and diabetes than previous  
6 generations. The obesity rate of baby boomers is about 40  
7 percent compared with an obesity rate of about 15 percent  
8 for previous generations.

9           Also of interest are the baby boomers'  
10 experiences with private health insurance coverage before  
11 they become Medicare eligible. Those experiences may  
12 affect enrollment decisions for Medicare Advantage and  
13 Medigap, and preferences about tradeoffs between cost  
14 sharing and limitations placed on choice of providers.  
15 Baby boomers likely began their working years in  
16 conventional plans, but over the course of their working  
17 lives, many experienced the disappearance of conventional  
18 plans and the rise and fall of managed care in the 1990s.  
19 Over that time, the share of workers in preferred provider  
20 organizations, or PPOs, also grew steadily. However, those  
21 PPO plans likely had broad provider networks supported by  
22 rapidly rising premiums, deductibles, and co-payments.

1           Finally, all but the youngest boomers are not  
2 likely to have had much experience with narrow-network  
3 PPOs, high-deductible plans, and the ACA health insurance  
4 exchanges because those types of plans have only recently  
5 arrived on the scene.

6           Given the aging of the baby-boom generation, even  
7 if Medicare's recent low growth in spending per beneficiary  
8 is sustained -- and the experience of 2014 suggests it may  
9 not be -- total Medicare spending will increase. However,  
10 there is strong evidence that a sizeable share of current  
11 health care spending in Medicare -- and nationally -- is  
12 inefficient, providing an opportunity for policymakers to  
13 reduce spending, extend the life of the program, and reduce  
14 pressure on the federal budget.

15           For example, research on Medicare spending shows  
16 that areas with higher spending or more intensive use of  
17 services do not have higher quality of care or improved  
18 patient outcomes. Services that have been widely  
19 recognized as low value continue to be performed regularly.  
20 The U.S. also spends significantly more on health care,  
21 both per capita and as a share of GDP, than any other  
22 country in the world, but studies consistently show it

1 ranks poorly on indicators of efficiency and outcomes. And  
2 while life expectancy in the U.S. has increased, it's  
3 increased at a slower rate than in other OECD countries.

4           The Medicare program as well as the health care  
5 system more generally faces challenges in achieving  
6 efficiency gains. Medicare has a fragmented payment system  
7 across multiple health care settings reducing incentives to  
8 provide patient-centered and coordinated care. It has  
9 limited tools to restrain fraud and overuse. Medicare's  
10 benefit design consists of multiple parts, each covering  
11 different services and requiring different levels of cost  
12 sharing. Medicare can pay different prices for the same  
13 service depending on where the service is delivered.

14           And finally, in the process of setting prices for  
15 thousands of services, some services are undervalued and  
16 others are overvalued, providing incorrect incentives for  
17 their use.

18           The Commission's approach to overcoming these  
19 challenges has been to pursue accurate prices that promote  
20 the efficient provision of services, to develop policies  
21 that encourage high-quality care and the coordination of  
22 care across settings, to support policies that improve the

1 information that beneficiaries and providers receive, to  
2 advocate for medical education and training that focuses on  
3 team-based approaches to care coordination, and finally, to  
4 engage beneficiaries in the decision-making about their  
5 health care.

6           So with that, I'll conclude and welcome your  
7 questions or corrections and look forward to your  
8 discussion.

9           DR. CROSSON: Thank you, Julie, for a very nice  
10 presentation.

11           Let's see hands for clarifying questions. Let's  
12 start down at this end on the right with Bill Gradison, I  
13 think.

14           MR. GRADISON: On slides 8 and 9, which have the  
15 projections by CBO and by the trustees, there are  
16 indications or numbers that reflect that in the out-years,  
17 their views differ, and the CBO expenditures show a higher  
18 projection than the trustees. I think it might be useful  
19 to add two sentences, maybe a paragraph explaining what the  
20 principal differences are in the assumptions used by those  
21 two groups in reaching those numbers.

22           It doesn't look like a big difference between 6

1 and 7 percent until you project it out far enough, and then  
2 it becomes a really big deal. And that's the context in  
3 which I suggest -- I'm not asking for an immediate answer,  
4 but I suggest that might be a useful addition to the  
5 document.

6 Thank you.

7 DR. SOMERS: So I could say -- oh, do I -- can I  
8 say things?

9 DR. CROSSON: Go ahead.

10 DR. SOMERS: So I can say a little bit. So,  
11 generally, the CBO has had a lower projected per-  
12 beneficiary spending, growth rate projection. I think they  
13 have tended to put a little more weight on the recent  
14 slowdown; and the trustees, rather than thinking it's so  
15 much persistence, think that it's more about the economy,  
16 and as the economy recovers, spending will recover.

17 It actually doesn't make too much difference in  
18 the out-years. Then CBO has their long-term budget  
19 projection, and they actually cross at some point there in  
20 the out-years where CBO becomes a little bit higher than  
21 the trustees. But it keeps the two projections fairly  
22 close together.

1           MR. GRADISON: It is why they're crossing. I am  
2 trying to understand better. There must be some difference  
3 in their assumptions. I have seen some analytical articles  
4 that have been written about this, and so I don't think it  
5 would be hard to find out and put it in there.

6           DR. SOMERS: Mm-hmm, will do.

7           DR. MILLER: Cori, it depends on how far out we  
8 are talking about? Doesn't it sort of get to -- and,  
9 Julie, this is to you. You, too. I'm sorry. Doesn't it  
10 kind of get to once you get past a certain set of years,  
11 what you -- oh, yeah, you're involved in this too, now that  
12 I think about it.

13                   [Laughter.]

14           DR. MILLER: There's actually a ton of people  
15 around the room who probably -- what the kind of  
16 equilibrium growth is relative to -- on a per capita basis.

17                   And the actuaries revised their assumptions, but  
18 they did kind of come to a place that I think --

19           MS. UCCELLO: And it's also an issue of it's just  
20 not -- their kind of equilibrium long-term growth is not  
21 fixed. It changes over time, so that number that they pick  
22 is the average, but it's the way they get there. So each

1 year varies. Well, I am not explaining this well.

2 DR. MILLER: Well, I'm not sure I knew that.

3 MS. UCCELLO: And I'm not sure what CBO does.

4 DR. MILLER: All right. We will look at this.

5 We will write a paragraph.

6 [Laughter.]

7 DR. MILLER: All right. Never mind.

8 DR. CROSSON: On this point, or another  
9 clarifying question?

10 [No audible response.]

11 DR. CROSSON: All right. So let's start again.

12 David and then Bill Hall.

13 DR. NERENZ: Thanks, Julie. Slide 11, please.

14 The out-year projections here -- oops. Sorry. I  
15 guess their things are numbered differently. It's the one  
16 that -- I don't know how to describe it without the number.  
17 That one.

18 The projections imply sort of separate future  
19 projections about inpatient and outpatient because we got  
20 Part A and Part B distinct here. How is that done?  
21 Because it seems like there's a separate set of assumptions  
22 that you'd have to put in about how much is inpatient going

1 to grow, how much is outpatient going to grow, that sort of  
2 thing. Can you talk just briefly how that's done?

3 DR. SOMERS: Well, I can say inpatient isn't --  
4 the assumptions are that it isn't growing as fast. Part A  
5 is not growing as fast as Part B, and it used to be that  
6 Part A -- average per-beneficiary spending for Part A was  
7 higher than average per-beneficiary spending for Part B. I  
8 think now they're about equal on average, and Part B is  
9 overtaking Part A. I think that has to do with the  
10 trustees use historical volume and intensity in use trends  
11 as well as the payment updates that are in law for each,  
12 for each individual service.

13 DR. NERENZ: I was just curious. Okay. And that  
14 makes sense, and that's what I presumed to be the case. I  
15 was just curious if any overlay was there, for example, any  
16 assumptions about the effect of ACO-type initiatives, the  
17 effect of medical home initiatives that are designed to  
18 have a limiting effect on inpatient care specifically, or  
19 is that just left out?

20 DR. SOMERS: No. They do include -- what's the  
21 right terminology here? Where the ACOs were certified to  
22 be allowed to expand and that the actuaries did say that

1 they reduce cost, they incorporate that into their  
2 projections. Yeah.

3 DR. CROSSON: Thank you.

4 Bill Hall?

5 I'm sorry. On this, Cori?

6 MS. UCCELLO: I just want to clarify that this 44  
7 or 56 is a point in time. That's not a projection, right?

8 DR. SOMERS: Okay.

9 MS. UCCELLO: Oh, I'm sorry. I'm on a different  
10 page. I don't know what I'm thinking. Just strike all of  
11 that.

12 [Laughter.]

13 MS. UCCELLO: In my own little world.

14 DR. CROSSON: Let's see. It's the event horizon  
15 problem. I know.

16 Bill Hall.

17 DR. HALL: Cori, we'll get back to you.

18 [Laughter.]

19 DR. HALL: On Slide 15, you present what is  
20 almost the mantra that we have been using for a long time,  
21 that the U.S. spends more on health care than any other  
22 country in the world. I think it's 15 -- geographic

1 variation -- 15 in my handout. I understand that.

2 I have been talking to some people recently who  
3 say that this great disparity that we are seeing, where a  
4 percentage of our GDP is not producing the expected  
5 outcome, would be very different if we included if we  
6 included in these comparisons the amount of money in a  
7 disparity in money that is spent on social programs for  
8 older people. So Scandinavia would be one of the most  
9 obvious examples of that where the great burden of taxes is  
10 to promote social welfare programs.

11 And if we put those together, the U.S. would  
12 actually, relative to GDP, kind of fit more in the middle,  
13 not in the Ezekiel Emanuel curve, way above. It might  
14 reflect the fact that while we spend more on health care,  
15 we may be spending less on health than other countries, in  
16 developed countries. Is that just total fiction, or is  
17 there some validity in that?

18 DR. CROSSON: Well, thank you, Bill, for getting  
19 a question in there at the end.

20 [Laughter.]

21 DR. CROSSON: Julie?

22 DR. SOMERS: That is a counter-argument that

1 social spending in other countries is much higher, and then  
2 there's just also folks point to lifestyle factors in the  
3 U.S., more sedentary. Just the way we live is just  
4 different and causes the differences in those outcomes, but  
5 yeah.

6 DR. HALL: Okay.

7 DR. CROSSON: Clarifying questions? Mary.

8 DR. NAYLOR: On Slide 9, I think it's -- that's  
9 10. Oh, no, that's the one I want. All right. Great.  
10 Perfect.

11 DR. CROSSON: The numbers are different between  
12 the papers.

13 DR. NAYLOR: Oh, they have different numbers.  
14 Sorry. So, can you provide us with a sense of what it  
15 means in terms of contributions when we move from, at the  
16 start of the program, 4.6 workers supporting the Medicare  
17 program to a projected 2.4 in 2030? What does it mean in  
18 terms of actual payroll contributions and the -- can we --  
19 I mean, I think this is a really powerful and important  
20 statement, given that we rely on workers to pay the taxes  
21 to support the program, and I'm wondering if we could add  
22 some numbers to that to help us to understand and make that

1 more robust.

2 DR. SOMERS: Let's see --

3 DR. NAYLOR: I mean, one way I was thinking about  
4 is --

5 DR. SOMERS: Dollars per worker?

6 DR. NAYLOR: Dollars per beneficiary. You know,  
7 what is it that they have paid in lifetime contributions,  
8 maybe even just starting with the 3.1 we have today and  
9 projecting out what implications that might have as we rely  
10 on fewer and fewer workers to support the program. So,  
11 anyway, I think it's a really important concept and am  
12 wondering if we could help to explicate it by saying what  
13 are the implications in terms of payroll support from the  
14 beneficiaries --

15 DR. SOMERS: So -- okay. So, I see a couple of  
16 different threads, and one I thought you were asking about,  
17 what is the impact on workers, and so you could think of,  
18 basically, if 2.4 workers are supporting a Medicare  
19 beneficiary, what is the Medicare beneficiary's spending  
20 and what is the average spending over the worker, or what  
21 is each worker --

22 DR. MILLER: Kind of the burden that the worker

1 is carrying.

2 DR. NAYLOR: Exactly. That's what I was  
3 interested in --

4 DR. CROSSON: And are you asking what the  
5 implication would be for the payroll tax?

6 DR. NAYLOR: Yes. What would it have to -- what  
7 adjustments are going to have to be made, or if we made no  
8 adjustments, what are 2.4 --

9 DR. SOMERS: Oh, and that, the actuaries will  
10 say, like, how much does the payroll tax have to increase  
11 to extend -- again, but this is just Part A -- to extend  
12 Part A for 25 years, to 2039, or for 50 years, and, let's  
13 see, it's in the paper. I can't quite remember. It's a 16  
14 percent increase in the payroll tax, I think --

15 DR. REDBERG: It's on page 21.

16 DR. SOMERS: Ah, thank you. So, say the payroll  
17 tax right now is 2.9 percent. If you want to make sure the  
18 HI Trust Fund is solvent for 25 years, until 2030, you  
19 would need to increase it to 3.4 percent, a 16 percent  
20 increase, or you would need to reduce Part A spending by 11  
21 percent.

22 But, again, what I tried to emphasize here is

1 that is just Part A, which --

2 DR. CROSSON: The smaller -- the smaller part of  
3 the projected increase.

4 DR. SOMERS: Right. And then, Mary, I heard you  
5 say one other thing, kind of what does a worker pay in over  
6 their lifetime versus what do they get out.

7 DR. NAYLOR: [Off microphone.] Yes.

8 DR. SOMERS: And, that, I've seen estimates.  
9 Others -- CBO has done that. It really all lies in the  
10 assumptions. It's a difficult calculation, but we can look  
11 through that again.

12 DR. CROSSON: Thank you.

13 Scott.

14 MR. ARMSTRONG: So, this may be a little bit more  
15 than a clarifying question, but it is a question and we can  
16 just kind of put it off --

17 DR. CROSSON: As long as your voice rises at the  
18 end.

19 MR. ARMSTRONG: Okay. All right.

20 [Laughter.]

21 MR. ARMSTRONG: So, if you go to the previous --  
22 actually, it's Slide, I believe it would be 8 on your

1 slides, the one before this. So, I'm looking at the  
2 projections, the Trustees' projections versus CBO  
3 projection, and I get how these inflation rates are a  
4 combination of new enrollment versus spending per  
5 beneficiary, and what I am assuming is that all of our  
6 work, and I'm thinking about our work plan for the coming  
7 year as an example, is really to influence whether it's  
8 four or three or some bigger or smaller number around that  
9 spending per beneficiary.

10           And, I guess that's my question, and is that the  
11 right way of thinking about this chart and its relationship  
12 to the work that MedPAC does?

13           DR. MILLER: Do you want me to do it? Yeah, I  
14 think probably most of our work is aimed at ultimately what  
15 the per capita expenditure rate as opposed to the gray part  
16 of the chart, which is somebody becoming eligible at 65 or  
17 somebody becoming eligible as a result of their disability  
18 status. That's driven more by the fact that more people  
19 are now 65 years old. The blue part is, you know, payment  
20 rates, how you manage care, that type of thing.

21           Is that -- Julie, is that causing you heart  
22 attack?

1 DR. SOMERS: That sounds great to me.

2 DR. MILLER: Okay. We're going to work with  
3 that.

4 MR. ARMSTRONG: All right. So, again, to try to  
5 take this picture that you're painting and apply it to our  
6 agenda, our challenge is to move four or three down to one  
7 or zero or negative-four or negative-three, because on the  
8 next chart, that's the only way you are going to change the  
9 curve of those lines. Okay. Got it.

10 DR. SOMERS: That's right.

11 DR. CROSSON: Jon.

12 DR. CHRISTIANSON: So, I like the fact that in  
13 the report chapter, starting with page 35, you have some  
14 discussion of quality indicators and population health  
15 indicators and so forth, and it's for the -- they relate to  
16 the future, to the Baby Boom generation, so, basically, the  
17 future.

18 So, I would love to see in the final version of  
19 this chapter trend lines related to some general measures  
20 of value, just like we see trend lines related to  
21 historical costs up to the present. Now, I know data is an  
22 issue. I don't know that you can get the data for the 65-

1 and-over population so you can look at what's happening to  
2 diabetes care over time and outcomes.

3           The reason I think it would be useful to have at  
4 least some stuff like that in there is this is a context  
5 paper. It's put into context for the work of the  
6 Commission. A lot of the work of the Commission the past  
7 few years and going forward is going to be focusing on  
8 paying for value. So, that's a -- not just, let's hold  
9 costs down, but what are we getting for the money. So, to  
10 provide a context for that, it seems to me to be reasonable  
11 in this chapter to try to talk about value and what's  
12 happening historically to value.

13           Now, I know we do some value measures when we  
14 talk about payment adequacy and some other -- and other  
15 analysis that we do, where we survey beneficiaries and we  
16 talk about what's happening to access, you know, one  
17 measure of value, or clinical measures of value.

18           So, I guess I would like you to think about that  
19 and whether there are any similar lines to this. This  
20 looks like the context for our work is totally what is it  
21 costing Medicare, and yet in a lot of our discussion, we've  
22 shifted to what's the value of what Medicare is purchasing.

1 So, it would make sense to me to have a similar kind of  
2 dynamic in this concept chapter if we could. I understand  
3 the issues in terms of trying to find the right data sets,  
4 but at least where it's possible.

5 DR. CROSSON: Jack.

6 DR. HOADLEY: So, I have two, I think, pretty  
7 straightforward questions. On Slide 3 in our pack, when  
8 the National Health Expenditure Accounts do their analysis,  
9 how do they count the subsidies for exchange insurance  
10 under the ACA? That's federal dollars, but it's buying  
11 private insurance. Do you know where that comes out?

12 DR. SOMERS: I don't.

13 DR. HOADLEY: Okay.

14 DR. SOMERS: I can look into that, unless -- I'm  
15 looking at my colleagues. Okay.

16 DR. HOADLEY: It would be useful to know, maybe.  
17 I mean, it's not a huge number of dollars in the big  
18 picture, but it could be something that is changing the  
19 trend lines a little bit and how to count it.

20 STAFF: [Off microphone.]

21 DR. CROSSON: Sorry. Where are we?

22 DR. MILLER: We'll come back to this.

1 DR. CROSSON: Jack, do you have another --

2 DR. HOADLEY: My second -- so, the second  
3 question, on Slide 10, on the split that Cori was talking  
4 about earlier, the 44 percent Part A and 56 percent Part B,  
5 it actually -- it seems like it would be interesting to see  
6 that over a period of time. I mean, we know that many of  
7 the spending on the Part A side has been growing more  
8 slowly or even going down. So, it would just actually be  
9 interesting to see the trend line on that over a longer  
10 period -- including projections into the future, if they're  
11 available.

12 DR. CROSSON: Thank you, Jack.

13 Warner, and then Craig.

14 MR. THOMAS: So, on your chart where you showed  
15 the per beneficiary cost, you show for a decade period of  
16 time, Chart 4. Is it possible to get similar information  
17 for, with the same time period or a longer time period,  
18 similar to Chart 3 that you have, just so we can understand  
19 the broader context of what the historical has been and  
20 what you anticipate it being going forward?

21 DR. SOMERS: [Off microphone.] Slide 4?

22 MR. THOMAS: Yeah. So, you have -- on Slide 3,

1 you're showing kind of total costs of the shared GDP. We  
2 don't have kind of the total per member per beneficiary,  
3 per member per year, you know, trended out over a period of  
4 time. Is that information available?

5 DR. SOMERS: Yes, that's available.

6 MR. THOMAS: So, I think that would be helpful to  
7 have, just to look at. You know, one you have here, fee-  
8 for-service versus MA in Part B, I think it would also be  
9 helpful, going back to Jack's point of looking at it for  
10 the different components of the program underneath fee-for-  
11 service so that we understand, you know, what are the  
12 bigger drivers kind of over time, getting back to we want  
13 to try to impact the payment policy.

14 As a comment to Scott's point, and I don't know  
15 if this is -- this isn't exactly clarifying, but I guess a  
16 question I would have for us is do we think that we can do  
17 enough on the payment side to impact the overall trend?  
18 Should we be taking a broader approach to this? I just  
19 would leave that as a -- I don't know if that's a  
20 clarifying question or a broader question, but it's a  
21 question.

22 [Laughter.]

1 DR. CROSSON: Oh, yes.

2 DR. MILLER: Just before we move, did you end up  
3 clear on the first part of what he was looking for?

4 DR. SOMERS: Well, I think so. You want a per  
5 beneficiary --

6 MR. THOMAS: Yes --

7 DR. SOMERS: -- spending, broken out by fee-for-  
8 service --

9 MR. THOMAS: And then --

10 DR. SOMERS: -- in MA Part D over time.

11 MR. THOMAS: Right, and under fee-for-service,  
12 could you look at the broader components of fee-for-service  
13 so we could understand the per beneficiary cost there, as  
14 well.

15 DR. SOMERS: You mean, and then look at all it's,  
16 like, inpatient hospital --

17 MR. THOMAS: Not in -- well, I don't know what  
18 the right components are. I mean, you could look at  
19 inpatient, outpatient, I mean, you could look at the pieces  
20 --

21 DR. SOMERS: Look at a few of the --

22 MR. THOMAS: -- yeah, to try to understand what

1 the trend is --

2 DR. SOMERS: -- the health care settings --

3 MR. THOMAS: -- because I think we understand  
4 that we continue to see a flattening or decreasing in  
5 inpatient. We know the outpatient fees, the trend which is  
6 not surprising, kind of given the incentives in the payment  
7 system. So, I think we need to understand that as we  
8 contemplate our payment policy thinking going forward.

9 DR. SOMERS: Mm-hmm. Okay.

10 DR. CROSSON: So, Warner, on your second point,  
11 because I think I've heard you make the same point before,  
12 a good portion of our work, as you say, is directed at how  
13 much Medicare pays for services and whether those are  
14 appropriate or not and the rest. As you say, there are  
15 other issues affecting the expenditure of the program. Age  
16 of eligibility. I think I've heard you mention the issue  
17 of disability, as well. I think during a period of time  
18 when both of us were off the Commission a couple of years  
19 ago, as I understand it, and having gone back and read it,  
20 the Commission did take on at least an information-based  
21 analysis of the disability issue. But, there are larger  
22 questions, and to the extent that, I think, over time, we

1 feel that those fall within the purview of this Commission,  
2 they're certainly on the table.

3 MR. THOMAS: And, I think, really, my broader  
4 question is, as a Commission, I think we have to ask  
5 ourselves, are there enough modifications we can make to  
6 the payment mechanism to realign these lines, these trend  
7 lines, from a cost perspective. You know, if we're  
8 bothered enough by what the future cost trend lines look  
9 like, then I think we ought to ask ourselves, can we get  
10 enough in the payment side of this, or do we have to  
11 broaden our thinking, or at least make comments about  
12 others that ought to basically take a broader look at the  
13 program overall. So, that would really just be my comment.

14 If on Slide -- where we show the projection --  
15 Slide 8, we show the projection. I mean, I think we would  
16 probably all sit here and agree that it's unsustainable to  
17 see that happen. So, then, the question is, we're sitting  
18 here. We know it. We understand this is a problem. So,  
19 what can we do as a Commission? What recommendations  
20 should we be making, if it's not in our purview, that  
21 others take on those issues to try to impact this  
22 unsustainable future scenario.

1 DR. CROSSON: And, as I said, I believe that some  
2 of those areas are within our purview. If you have  
3 specific ideas, then certainly bring them forward.

4 MR. THOMAS: [Off microphone.] Okay.

5 DR. CROSSON: Craig.

6 DR. SAMITT: On Slide 4, my question is about  
7 what's included in the Part D bucket. I assume that PDP is  
8 included in there, but where does MAPD sit? Is it in Part  
9 D or is it in MA for the purposes of this --

10 DR. SOMERS: It's in Part D. So, both PDP and  
11 the MA plans are in there -- are in Part D.

12 DR. SAMITT: And, can we distinguish between fee-  
13 for-service, the PDP trend versus the MAPD trend? Is that  
14 distinguishable?

15 DR. SOMERS: I cannot --

16 DR. SAMITT: Especially in the recent year, with  
17 the 11 percent spike.

18 DR. SOMERS: I'm going to look at my drug  
19 colleagues.

20 DR. SCHMIDT: [Off microphone.] We do have some  
21 information about this and the trend. We do have some  
22 information on per capita spending trends, MAPD versus PDP

1 enrollees, in our latest data book. We don't have a  
2 breakout for the Hep C drugs in the last year. Maybe in  
3 the future, we'll be able to look at the claims in a little  
4 more detail. We don't have claims for 2014 yet.

5 DR. CROSSON: Okay. Thank you. Thank you.

6 DR. REDBERG: Yes. I have three short clarifying  
7 questions.

8 DR. CROSSON: All right.

9 DR. REDBERG: On page 7, I just wanted to get the  
10 numbers right for the estimates for Medicare and Medicaid,  
11 because for 2014 there were 54 million for Medicare, 65  
12 million for Medicaid, and then 11.5 million duals. Are the  
13 duals also included in the Medicare and Medicaid numbers?  
14 Are they listed twice?

15 DR. SOMERS: Right, they're in the Medicare and  
16 the Medicaid numbers, so they're not distinct.

17 DR. REDBERG: So the total number of people  
18 covered would be 54 plus 65 minus 11.5.

19 DR. SOMERS: That's right.

20 DR. REDBERG: Okay. And then can you say what  
21 percentage of the duals are over 65?

22 DR. SOMERS: All duals --

1 DR. REDBERG: All duals are--

2 DR. SOMERS: -- are over 65. Right?

3 DR. NERENZ: No. It's about half. It's half.

4 DR. REDBERG: About half? Because some are in  
5 Medicare because of the SSI.

6 DR. SOMERS: Oh, oh. Yes, okay. We're going to  
7 get back to you on that.

8 DR. REDBERG: Okay. You'll get back to --

9 DR. MILLER: [off microphone] It's a knowable  
10 fact. It's sitting, I'm sure, on somebody's shelf. We'll  
11 get that.

12 DR. NERENZ: Just for what it's worth, because of  
13 a demonstration project in Michigan, we looked at this  
14 closely. At least in our setting, it's half. And I think  
15 that's reasonably close to the national number. But  
16 somebody could check.

17 DR. REDBERG: Okay. That's close.

18 DR. NERENZ: But in our setting, it's half.

19 DR. REDBERG: That sounds close enough for me.  
20 Thank you.

21 And, last, what percentage of Medicare  
22 beneficiaries have supplemental insurance?

1 DR. SOMERS: I think we say around 90 percent.

2 DR. MILLER: Yes, and just to be clear, you know,  
3 that can be employer, that can be Medigap, and then we put  
4 Medicaid in there, when you're saying the world  
5 "supplemental," if that's what you're meaning.

6 DR. HOADLEY: And MA.

7 DR. MILLER: And MA. I'm sorry. That's correct.

8 DR. REDBERG: That would be 90 percent.

9 DR. MILLER: Right.

10 DR. CROSSON: Okay. So we have kind of leaked a  
11 little bit in terms of the clarifying question issue, and I  
12 think there have been already a number of suggestions put  
13 on the table beyond questioning. But can I get a sense of  
14 how many people have additional points they'd like to make  
15 with respect to this report? I see three -- four. Is that  
16 right? Let's start with Scott.

17 MR. ARMSTRONG: Yeah, I just briefly would build  
18 on the clarifying sort of question I had before and  
19 Warner's comments, too. This chapter I think is really  
20 interesting and, frankly, kind of depressing. And I'm  
21 trying to think about, well, what do I do with this? And  
22 it's really meant, I think, at least in some way, to create

1 context for the work that we do during the course of the  
2 next couple of years. And so that's why I was asking, you  
3 know, what part of these trend lines do the policy issues  
4 we have on our agenda really influence? And it feels like  
5 it's a remarkably small adjustment to what those trend  
6 lines might be, but I don't really know.

7           And so I think my point would just be it would be  
8 really interesting -- I know future cost trends are not our  
9 only agenda, but I would argue it is probably the most  
10 important agenda, assuming you maintain a level of quality  
11 and access and so forth. But I think it would be really  
12 interesting for us as we go forward with our agenda in the  
13 coming year to occasionally ask the question: What kind of  
14 impact do we think this policy question will have on these  
15 longer-term trends?

16           And then, second, I do think when you look out  
17 several years, more to what Warner was saying, some part of  
18 that trend we can affect and big parts of it we can't. But  
19 we ought to be asking, you know, what is the expectation we  
20 have of payment policy in future years to have an impact on  
21 those trends? I just have no sense for that at all, and I  
22 would think I's knowable, but maybe that's where my

1 question would come in.

2 DR. CROSSON: No, I think it's a very good point,  
3 and it is similar to the point that Warner made a few  
4 minutes ago. As you know, when we come up with  
5 recommendations, they carry with them an estimate of the  
6 economic cost or savings to the program. But they're often  
7 not -- as you say, they're not in a larger context, you  
8 know, or in aggregate, like if we took all the  
9 recommendations that were made in a given year, what  
10 percentage of the problem would that likely address if  
11 those recommendations were to be implemented?

12 I mean, as you say, I think there are aspects of  
13 this, particularly the demographic things that we see on  
14 the chart, that probably we can't influence. There are  
15 probably some things that are even beyond Congress' power  
16 to influence. But having a sense of proportionality I  
17 think is an excellent point.

18 Mark, do you think -- what's your thought on  
19 that?

20 DR. MILLER: I think there's a couple of trap  
21 lines that we have to be a little bit careful of. So if we  
22 are considering a specific policy and you guys are going to

1 vote, we try to put together our best range estimate of its  
2 impacts. And the reason we do that range thing is because  
3 there are two estimation houses in Washington -- the  
4 actuaries and CBO -- and they govern that process; and us  
5 throwing another estimate into the middle of that has  
6 issues, and particularly since we're not a real estimation  
7 house. So we tend to do ranges.

8           And a direct answer to your question sort of  
9 needs to say here's the point estimate; now I took the  
10 point estimate out multiple years, and it has this much  
11 effect. So there's a little bit of -- we'd have to be a  
12 little bit careful about how we did it, and certainly point  
13 by point or policy by policy, which is the other point I  
14 wanted to make.

15           I think sometimes you guys will have something in  
16 front of you, and you'll be saying, you know, why am I  
17 spending so much time on this, and in the larger scheme of  
18 things, maybe it doesn't move that line. But Kathy's  
19 earlier comments in another session of, well, what does it  
20 look like cumulatively when you look across sets of  
21 recommendations, you could actually get some movement on  
22 the needle there. And I wonder if it's more a way to try

1 and address your point is to kind of look at the  
2 Commission's work, body of work more broadly and  
3 categorical; that way I don't get into the point estimate  
4 problems of other people saying, "But you said it was this;  
5 CBO says it's something else." And I do need to be  
6 institutionally very careful of that. But to say, when you  
7 think about what the Commission has done over multiple  
8 years and kind of look at it broadly, this is how much it  
9 would move the needle. I think that gives me enough room  
10 that I don't cross institutional lines and maybe gives you  
11 some sense -- and you might actually see the needle move,  
12 because if you take one update, you know, the needle might  
13 not move all that much. Then you might ask, "Well, why am  
14 I paying attention to it?"

15 MR. ARMSTRONG: I just would say I'm really not  
16 interested in degrees of precision. It's more that, you  
17 know, part of our responsibility is to have an impact on  
18 the needle and to just bring that into our dialogue. I  
19 mean, there are moments I kid myself, and I believe our job  
20 is actually to save Medicare from those trends, and maybe  
21 just every once in a while to get a little real about,  
22 well, what do we think our contribution around these

1 payment policies could be to that future. It's not a  
2 degree of precision that I'm really looking --

3 DR. CROSSON: Just a sense of aggregate  
4 proportionality, given the problem.

5 MS. BUTO: Same point. I just wanted to say I  
6 guess the way I think about it, Scott, is to the extent  
7 Medicare remains a largely fee-for-service program, I think  
8 it's hard to move the needle except by degrees through  
9 updates and through better payment policy. So I think the  
10 big issue is: Can that change and how can we influence  
11 something more like -- I don't want to use -- it's sort of  
12 like a per beneficiary spending, you know, constraint, if  
13 you will. And if we can't get there, it's moving in that  
14 direction that I think will really begin to change the rate  
15 of growth, not -- in the meantime, I think we have to do  
16 our jobs, which is to look at the payment systems. But to  
17 keep in mind that as long as it's a hugely fee-for-service  
18 system, it's difficult to really move that needle, I think.

19 DR. CROSSON: Personally, I could not agree with  
20 you more.

21 DR. NAYLOR: On this point, just -- and I'm not  
22 sure that this follows the trend, but I think that this

1 context chapter provides us with an opportunity to develop  
2 a little bit more some of the tools or the ways that we  
3 talk about these tools. So, for example, engaging  
4 beneficiaries, which you've identified as a really  
5 important strategy, has really focused on engaging  
6 beneficiaries at the individual level, shared  
7 decisionmaking and so on. But I think the beneficiaries  
8 need to know the dimensions of the challenge that the  
9 program is experiencing a lot more clearly than I think  
10 that they do. And it then could help us think about ways  
11 to move the needle, engaging in the kinds of conversations  
12 about how people want to live high-quality lives and die  
13 with dignity.

14           You know, so I think we have some opportunities  
15 to further develop the strategies that you've outlined in  
16 the end of this chapter in a way that, say, this is more  
17 than just us and Congress -- which is, I know, our mandate  
18 -- but also really a chance to really engage beneficiaries  
19 in coming up and helping to offer the solutions.

20           DR. CROSSON: Thank you, Mary.

21           DR. BAICKER: This is just a brief follow-up  
22 linking this conversation back to the point that Jon

1 raised, that I think it's -- having a sense of the overall  
2 magnitude of the things we're talking about is really  
3 important, but I think we want to be careful not to suggest  
4 that our goal is to stick within a certain budget or that  
5 spending less per beneficiary is always the answer or that  
6 our job is to move that line without thinking about the  
7 implications for health. And, you know, with people living  
8 longer, that's good news. That means we may be spending  
9 more on health care, and that's all great, as long as we're  
10 getting our money's worth and it's high-quality care and  
11 we're not spending money on stuff that's not producing the  
12 outcomes we want. So that's not to say we can get into all  
13 this in this chapter but, rather, being careful not to  
14 imply inadvertently that we're all about the dollars, which  
15 are important -- I'm an economist; the dollars are  
16 important.

17 DR. CROSSON: I was going to say.

18 DR. BAICKER: But bringing in Jon's point about  
19 what do we know about the context about what we're getting  
20 for those dollars. And the problem of spending a ton of  
21 money is spending a ton of money and not getting as much  
22 health as you think you ought to when there are all these

1 budget pressures.

2 DR. CROSSON: Kate, I agree with that, and I also  
3 think, as I mentioned earlier, that we also have to -- and  
4 maybe this isn't part of our charge, but we also in that  
5 context as well need to understand that there are societal  
6 tradeoffs inherent in that additional discussion to spend  
7 more of GDP on health care.

8 DR. COOMBS: I think the chapter was excellent,  
9 and you can get overwhelmed with the Mount Everest graph.  
10 I think that just throws me for a loop every time. But I  
11 wanted to say something about one of the graphs. I guess  
12 this would be Graph 7 or 6, the per beneficiary spending,  
13 and the trends with the breakout.

14 Kathy, as I think about fee-for-service, we have  
15 fee-for-service. Unfortunately, fee-for-service is here  
16 and it's here in a lot of sectors. But the one entity that  
17 I think would really lend us some information is what does  
18 an ACO look like with their breakout in terms of growth of  
19 spending. And I'll tell you why that's important: because  
20 the ACOs that I've seen in some of the areas where I  
21 practice do have a goal that is an inherent population  
22 health where they take on a lot of the patients that are in

1 their area because of this notion of an ethos change, where  
2 they say, okay, we contract with Gillette and we're going  
3 to take care of everything, we're taking the whole hot dog,  
4 we've got it all. And so they don't have -- it's not as  
5 much selection per se because it's a community. The people  
6 in the village will be cared for by this ACO.

7 I think when you have an entity like that, you  
8 could actually do a breakout here. My bias is -- and it's  
9 solely a bias -- that you may have a different look in  
10 terms of growth of spending. So I would be very interested  
11 in what an ACO, which is still fee-for-service, looks like,  
12 especially as I look at the breakout for labs performed in  
13 physician offices and independent laboratories. There's  
14 going to be a shift, and I can't name you the private  
15 laboratory that charges so much more, you know, and maybe  
16 there will be a shift in the utility. You'll say that I  
17 don't -- maybe the volume won't be driven up if you have  
18 on-site access.

19 So I think that would teach us a lot if we had  
20 that kind of breakout with ACOs, because it more likely  
21 reproduces what a fee-for-service might have an option to  
22 move toward in terms of a better goal and benchmark,

1 because they might look at MA plans and say, oh, they've  
2 got the best patients, and the biases are there in terms --  
3 there's implicit biases about who the MAs are caring for.  
4 But it might be that the ACO is more tangible for the other  
5 doctors, influence the culture, to drive the culture in  
6 regional areas.

7           So I think it's a possibility. I agree with Jon  
8 on this whole issue of quality. I think there's some  
9 things that I'm constantly looking at in terms of if this  
10 was avoided, then I would see someone -- I wouldn't see  
11 this person in the ICU. I wouldn't see them with the  
12 Gorillacillin antibiotic that they've got to take for the  
13 next six weeks for endocarditis.

14           So I think that notion eludes us when we're still  
15 at this high-altitude 747 jet rolling around in the sky.  
16 But I think there are microscopic changes where there have  
17 to be interventions and you have to move the culture, and  
18 moving the culture means there's commercials, there's like  
19 this Pioneer ACO does an incredible job with this. And I  
20 don't know if that data is available, but I would say that  
21 would be a commercial that would move culture, more  
22 providers.

1 DR. CROSSON: Thank you, Alice. A number of good  
2 points in that. I don't want to complicate the point  
3 you're making, but I think one of the issues we need to  
4 think about in doing that with respect to fee-for-service  
5 payment is how the ACO is paid, but then how the individual  
6 providers are paid, because you can have any combination,  
7 depending on which ACO model you're talking about, how it's  
8 paid, but also how it then determines to pay its individual  
9 providers, whether those providers are paid a salary, a  
10 partial capitation, or fee-for-service as well.

11 And, you know, I don't think we know right now,  
12 first of all, the range of models that will work and those  
13 that won't work or what the level of performance is going  
14 to be.

15 DR. COOMBS: I think there's some great  
16 references. Harold Miller produces, you know, a Webinar,  
17 and he does a great job with the different kinds of -- the  
18 diversity of how the relationship is, and we call it  
19 "inter-ACO governance" because it controls all of the  
20 providers, nurse practitioners and docs, everyone within  
21 the entity, and also the capacity to contract with  
22 consultants that are under your umbrella of an ACO or

1 outside.

2           So it might be that, you know, you have this --  
3 you're financially responsible, quality you're responsible  
4 for, and you're saying, "I'm not getting inappropriate  
5 consults."

6           The other piece of it is, when I consult an  
7 orthopedic surgeon, I'm going to get the one that has the  
8 least complication, and when they go to the PAC, they're  
9 going to a PAC that has the best outcome. And so, I mean,  
10 it's a trickle-down effect all the way around quality  
11 because of the governance structure.

12           DR. CROSSON: Thank you.

13           DR. HOADLEY: My comment has to do with  
14 beneficiary income and assets, and I think after the  
15 discussion we had around Scott's point, it just feels even  
16 more relevant as part of the context. I know you had a  
17 little bit of a discussion at one point on sort of share of  
18 Social Security income and some of that in the chapter, but  
19 it does seem like as part of the context for our discussion  
20 on what changes we're looking at over the future, and  
21 particularly when we get into some of the bigger changes  
22 that we've often talked about, having a better sense of

1 where beneficiary incomes and assets fall. We often just  
2 talk about sort of averages, but really needing to get into  
3 distributions, you know, how many are down at the lower  
4 levels versus upper levels, and particularly as we think  
5 about this next-generation discussion that's in this  
6 chapter, sort of where's that headed. You know, you get  
7 all these statements made and sort of public  
8 pronouncements, "Oh, you know, the next generation are  
9 going to be much better off." And then you heard about,  
10 "Well, the recession has caused wages to stagnate, and  
11 people have had to spend their retirement money."

12           So I don't even know what the accurate story is,  
13 but it seems like as part of how we want to understand what  
14 anything we do is going to mean for the Medicare  
15 beneficiary, we ought to have a better sense of not just  
16 their insurance experience, their ethnicity, and some of  
17 the things we do have here, but what's their financial  
18 picture going to look like.

19           DR. CROSSON: And when we've looked at it in the  
20 past, it's quite sobering to us around the table, I have to  
21 say.

22           Warner and Craig, and then we're going to move to

1 the public session.

2 MR. THOMAS: I'll be very brief. I think, as I  
3 look at this, the other question I have is are we providing  
4 enough incentive around the ACO model and the global  
5 payment model to continue to have providers and systems  
6 move in that direction, which I think we've seen some  
7 results, that it certainly has shown positive results  
8 compared to the fee-for-service. And once again, is there  
9 enough financial incentive there? Is there enough clarity  
10 around the structure for providers who want to go in that  
11 direction, which is -- it would help us avoid this idea  
12 that basically the utilization moves from category to  
13 category based upon where we change health care policy or  
14 payment policy, so that would be something I think we need  
15 to continue to seriously consider and think about do we  
16 have the right and enough financial incentives in the ACO  
17 model.

18 DR. CROSSON: Okay. Craig?

19 DR. SAMITT: So when I read the chapter, beyond  
20 the motion that it feels like we are perpetually pushing a  
21 boulder up uphill unsuccessfully, it makes me wonder what  
22 our action plan should be in response to this chapter. So

1 what does the data suggest should be our priority focus  
2 over the course of the next year, and should we be  
3 redeploying additional time and energy to discussion of  
4 alternative payment approaches that work or specialty drug?  
5 Does the data suggest we should be adding an analysis of  
6 laboratory since there are spikes there? I am curious to  
7 know what this tells us and guides us to in terms of where  
8 we can make an impact, either directly or indirectly, to  
9 suppressing the trend.

10 DR. CROSSON: That's a fair question. I mean,  
11 it's an informational chapter. It's one that we do every  
12 year to say, "Here's the trend now." We look at the trend  
13 again. We'll look at the trend again.

14 I think, in general, it suggests to us the  
15 importance of our efforts. I mean, to me, one of my  
16 takeaways was, although Medicare spending may have  
17 moderated in the last few years, that's not a reason to  
18 take our eye off the ball.

19 In terms of choices that we make, as you suggest,  
20 maybe there are things we should look at that we haven't  
21 looked at before in that regard.

22 Okay.

1 DR. MILLER: Can I do one?

2 DR. CROSSON: You can.

3 DR. MILLER: One minor clean-up.

4 DR. CROSSON: Yeah.

5 DR. MILLER: Rita, you asked the proportion of  
6 dual eligibles who are aged. 56 disabled, 44 percent.

7 Thank you, Emily.

8 DR. CROSSON: Does that mean there are e-mails  
9 going on here while we are having a meeting?

10 DR. MILLER: No, no.

11 DR. CROSSON: Okay.

12 DR. MILLER: You didn't see her stand up with the  
13 flags?

14 [Laughter.]

15 DR. CROSSON: Okay. Thank you very much for the  
16 discussion. Julie, very nice presentation and chapter.

17 We now open for the Public Comment period. So  
18 I'd like to see any individuals who would like to make a  
19 public comment, stand up at the microphone so we can  
20 determine how many we have.

21 [No response.]

22 DR. CROSSON: Seeing none, we are recessed for

1 lunch, and we reconvene at 12:45.

2 [Whereupon, at 11:53 a.m., the meeting was  
3 recessed, to reconvene at 12:45 p.m., this same day.]

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1 presentations you'll see over the coming months as the  
2 Commission works to fulfill its mandate.

3           This slide lays out our expected timeline. Today  
4 we will lay out our approach to designing a prototype PAC  
5 PPS. At future meetings, the Commission will discuss  
6 additional PPS design features that might be needed to  
7 properly align payments with costs and other policy  
8 considerations such as changes to regulatory requirements.  
9 We will also review estimates of the financial impacts of  
10 implementing a unified PAC PPS. And in the spring, the  
11 Commission will discuss draft recommendations.

12           So today I will first review the Commission's  
13 longstanding concerns about Medicare's current payment  
14 systems for post-acute care. Then I'll review the path to  
15 PAC reform and the challenges that lay ahead. Then,  
16 turning to our mandate, I will outline the key components  
17 of a prospective payment system. Then Carol will provide  
18 an overview of our approach to designing a unified PAC PPS  
19 and present our initial findings.

20           PAC providers offer important recuperative and  
21 rehabilitation services to Medicare beneficiaries  
22 recovering from an acute-care hospital stay. The services

1 provided in skilled nursing facilities, home health  
2 agencies, inpatient rehabilitation facilities, and long-  
3 term care hospitals are similar, but Medicare pays  
4 different prices depending on the setting in which the  
5 services are delivered.

6           The Commission has long been concerned that  
7 Medicare's siloed approach to payment for PAC does not  
8 encourage appropriate care and creates inefficiencies that  
9 result in wasteful spending. The problems with this  
10 approach are well documented. The need for post-acute care  
11 is not well defined. There are few evidence-based  
12 guidelines for PAC, so it's not always clear when care is  
13 needed, where it is best provided, how much care is  
14 required, or when more care is likely to result in better  
15 outcomes. There are some regulatory requirements that  
16 guide placement decisions, but generally providers have  
17 considerable latitude in admission of cases. PAC placement  
18 decisions often reflect nonclinical factors such as local  
19 practice patterns and the availability of PAC providers in  
20 a market. As a result, there is substantial overlap of  
21 patients across PAC settings.

22           At the same time, Medicare's payment systems and

1 regulatory requirements for post-acute care include  
2 elements that create incentives for inefficient care. For  
3 example, the SNF PPS encourages providers to furnish  
4 unnecessary therapy services and to avoid patients who need  
5 costly nontherapy ancillary services. The requirement that  
6 LTCHs maintain an average length of stay of more than 25  
7 days for certain patients may encourage providers to keep  
8 patients longer than necessary.

9           In addition, the fact that Medicare pays more for  
10 certain types of cases in some PAC settings than in others  
11 encourages growth in the supply and use of certain types of  
12 providers.

13           Given all these issues, it is not surprising that  
14 Medicare spending varies more for post-acute care than for  
15 other covered services.

16           These problems are exacerbated by the lack of a  
17 common patient assessment instrument in PAC settings.  
18 Without a common assessment tool, it is difficult to  
19 evaluate the cost and outcomes of the care that  
20 beneficiaries receive across settings.

21           MedPAC has been calling for post-acute care  
22 reform for many years. The Commission first recommended

1 the use of a common patient assessment tool in PAC settings  
2 in 1999 and called for a unified PAC classification system  
3 in 2001. More recently, in 2014, the Commission again  
4 called for the collection of common assessment information.  
5 And last March, the Commission recommended site-neutral  
6 payments for IRFs and SNFs for selected conditions.

7 In response to MedPAC recommendations, the  
8 Deficit Reduction Act of 2005 required CMS to conduct a  
9 demonstration to understand the costs and outcomes across  
10 post-acute care settings. CMS's PAC Payment Reform  
11 Demonstration, or PAC-PRD, developed a common patient  
12 assessment tool that measured medical, functional, and  
13 cognitive complexity. The CARE tool was used to compare  
14 patient resource use and outcomes in the four PAC settings.  
15 An RTI evaluation of the PAC-PRD suggested that a unified  
16 PAC PPS for routine and therapy services was possible,  
17 although RTI found that including home health care might  
18 present some challenge because agencies' costs are very  
19 different from those of other PAC providers.

20 As I mentioned at the outset, the data collected  
21 using the CARE tool during the PAC-PRD will be the basis  
22 for the Commission's work on a unified PAC PPS for our

1 mandated report.

2           Since the PAC-PRD was completed in 2011, progress  
3 toward PAC reform has slowed. The IMPACT Act was enacted  
4 to further advance reform. In addition to the report  
5 MedPAC is required to submit next June, the act requires  
6 the Secretary to collect patient assessment data from PAC  
7 providers using a uniform assessment tool beginning in  
8 2018. After the Secretary has collected two years of data,  
9 she is required to submit a report to the Congress  
10 recommending a uniform payment system for post-acute care.  
11 The Commission will then be required to submit a second  
12 report on PAC payment reform.

13           As we begin our work on the mandated report for  
14 June 2016, we should be cognizant of our objectives. The  
15 goals are to develop payments that are based on patient  
16 characteristics, not site of service, and to better align  
17 payments with the costs of care.

18           As we move towards a unified PAC payment system,  
19 it will be important to remember that the current system  
20 does not reflect efficient delivery of care. A unified PPS  
21 in which payments are properly aligned with costs will  
22 shift payments from some types of cases, providers, and

1 settings to others. That will likely result in changes in  
2 how and where PAC services are furnished.

3           So what do we need to do to design a PAC PPS?  
4 This slide shows the basic components of any prospective  
5 payment system. As you see in the green boxes, we have a  
6 base rate per unit of service, which is adjusted for case  
7 mix and sometimes for other factors -- like rural location  
8 -- to get a payment amount. Additional payments may be  
9 made for cases that are extraordinarily costly.

10           The orange boxes show how the current PAC payment  
11 systems differ. The systems have different units of  
12 service and different base rates. They also use different  
13 patient assessment tools and have different methods of  
14 adjusting for case mix. The other adjustments to payment  
15 differ as well. Some PAC settings have reduced payments  
16 for very short stays. And high-cost outlier payments apply  
17 in some settings but not all.

18           As shown in the blue boxes, the Commission's task  
19 will be to model a payment system that has a common base  
20 rate and unit of service, with adjustments for patient  
21 characteristics based on common assessment information.  
22 We'll talk about other adjustments to payment at future

1 meetings, but any that are included would be standardized  
2 as well.

3           So now I'll turn it over to Carol to go over the  
4 details of our methodology and present our initial  
5 findings.

6           DR. CARTER: The first task of the mandate is to  
7 use data from CMS's PAC-PRD to design a unified PPS using  
8 patient characteristics. To help complete this work, we  
9 contracted with researchers from the Urban Institute. The  
10 common unit of service will be a stay or, in the case of  
11 home health, the 60-day episode. We developed a common  
12 case-mix adjustment method that uses information from the  
13 demonstration along with information from claims and MA  
14 risk scores. The case-mix adjustment includes patient age,  
15 clinical conditions and comorbidities, functional status,  
16 and other aspects of care, such as wound and ventilator  
17 care and difficulty swallowing. The case-mix method will  
18 raise or lower a base rate to predict the stay's actual  
19 costs. The idea is to design a model that reasonably  
20 accurately predicts the actual costs of stays using patient  
21 characteristics. These predicted costs would form the  
22 basis for a common payment under a unified PPS, and the

1 details of the method are in the paper.

2           The PAC-PRD data has unique advantages for  
3 designing a PPS. It is the only source of data that  
4 includes uniform patient assessment information, such as  
5 functional status. It also includes patient-level  
6 information about routine services, such as nursing.

7           While the PAC-PRD data are uniquely suited to  
8 designing a PPS, a key limitation is the size of the  
9 sample. Though designed to be illustrative of PAC stays,  
10 the sample is small and not representative of PAC stays  
11 nationally. This is a particular concern as we go to the  
12 second task of the mandate: estimating the impacts of  
13 moving to a unified PPS.

14           So to address the limitations of the PAC's  
15 sample, we devised the following strategy: First, we will  
16 take the model built using the PAC-PRD stays and replicate  
17 it as best we can using information available for all PAC  
18 stays. Then we will apply this revised model to all PAC  
19 stays in 2013 to estimate impacts. We'll compare actual  
20 costs and actual payments to the predicted costs -- that  
21 is, that would become the new payments under a unified PPS.  
22 At a future meeting, we will present our estimates of the

1 impact results. For the rest of this session, we'll be  
2 talking about the first task: developing models to predict  
3 the costs of stays using the PAC-PRD data.

4 We're required to develop a PPS that spans the  
5 four PAC settings, but currently, the home health benefit  
6 does not cover nontherapy ancillary services such as drugs,  
7 ventilator care, and respiratory services. For our work,  
8 we assumed that the home health benefit would remain the  
9 same. Therefore, we developed one model to predict routine  
10 and therapy services across four settings and a separate  
11 model that uses the same patient characteristics to predict  
12 NTA costs across SNFs, IRFs, and LTCHs. The predicted cost  
13 would form the basis for a common payment.

14 In practice, the models would establish one  
15 payment for routine and therapy services and a separate  
16 payment for NTA.

17 This figure illustrates how the models could be  
18 used. In green, you see the routine and therapy model  
19 would be used to establish a payment for these services,  
20 and in yellow would be the NTA model, and that would  
21 establish payment for NTA services. The two payments would  
22 be made for patients admitted to SNFs, IRFs, and LTCHs, and

1 that's shown on the left. On the right, for patients  
2 admitted to home health, only a payment for routine and  
3 therapy services would be made.

4           To evaluate how good the prediction models are,  
5 we look at two features. First, we'll estimate how much of  
6 the variation in costs across stays is explained by the  
7 models. Second, we'll assess whether the models would  
8 establish an average payment that equals the stay's average  
9 cost, assuming the new payments would be based on predicted  
10 costs. We will focus on results for groups of  
11 beneficiaries because the goal of the PPS is to establish a  
12 single base payment, or rate, that covers the costs of care  
13 regardless of the setting.

14           To evaluate our results, we created eight  
15 beneficiary groups. The clinical groups are on the left,  
16 and these four groups are mutually exclusive. Stays were  
17 assigned to one group using the hierarchy that follows the  
18 order of the groups listed. Later, when we report impacts  
19 on the 2013 data, we will provide further breakout of the  
20 "other medical" group.

21           We also evaluated the model for disabled, dual  
22 eligible, chronically critically ill patients as defined by

1 law, and patients admitted directly from the community. So  
2 let's turn to our results, and first we'll look at the  
3 model that predicts routine and therapy service costs.

4           The routine and therapy model predicted a high  
5 share -- that is, 56 percent -- of the variation in costs  
6 per stay across all stays. This model includes an  
7 indicator that the stay was treated in a home health  
8 agency. Otherwise, given the very large differences in  
9 costs per stay between home health agencies and other  
10 institutional PAC, the model would result in large  
11 overpayments to home health agencies and large  
12 underpayments to the other PAC settings. For almost all of  
13 the groups we examined, the model explains a high share of  
14 the variation in cost per stay. Furthermore, the average  
15 predicted costs that would be used to establish payments  
16 would be equal to or close to the average stay's actual  
17 costs.

18           Our second model predicts the costs of nontherapy  
19 ancillary services. As background, NTA services make up 13  
20 percent of SNF costs, 17 percent of IRF costs, and 44  
21 percent of LTCH costs. Because a patient's need for NTA  
22 services is often known before a PAC provider accepts the

1 patient for admission, a PAC provider can selectively admit  
2 or avoid certain types of patients based on whether  
3 payments are likely to be too high or too low.

4           The NTA model predicts costs well, explaining 47  
5 percent of the variation across all stays. Looking at the  
6 broad patient groups we examined, the model explained  
7 between 22 and 49 percent of the differences in costs.

8           Looking at our other criterion, the model's  
9 predicted costs are very close to actual costs for five of  
10 the eight beneficiary groups. If payments were based on  
11 these predicted costs, providers would have little  
12 incentive to admit certain types of cases over others.

13           However, I want to remind you that the NTA costs  
14 need to be put in broader context: providers consider  
15 their total payments to cover their total costs, not just  
16 their payments for one component of their care. So we  
17 wanted to look at the combined effects of both of the  
18 models together.

19           The models together explain a large share -- 36  
20 percent -- of the variation in routine and therapy and NTA  
21 costs across all stays. And here I'll remind you, we're  
22 looking at SNFs, IRFs, and LTCHs because we have included

1 NTA and so home health do not get those payments. Our  
2 ability to predict differences in stays across the various  
3 subgroups of beneficiaries is good, varying across the  
4 groups from between 22 percent and 38 percent. For most of  
5 the beneficiary groups we examined, the average predicted  
6 costs are close to the average actual costs, indicating  
7 that average payments would equal the average stay's costs.  
8 Providers would not have strong incentives to selectively  
9 admit some patients over others. Unlike the current SNF  
10 and home health PPSs, providers would not favor  
11 rehabilitation care over treating medically complex cases.

12 Our results suggest that it is possible to design  
13 a unified payment system that uses a common unit of service  
14 with a common risk adjustment method to establish a common  
15 rate for a stay. Using the demonstration data, the models  
16 explain a high share of the variation in costs across stays  
17 and would establish average payments that equal the average  
18 stay's costs.

19 Payments to home health agencies would need to be  
20 adjusted to account for the very large differences in costs  
21 between them and other PAC providers. Otherwise, payments  
22 would be too high for home health agencies and too low for

1 the other providers.

2 A unified PPS will shift payments across  
3 different types of patients, across providers within a  
4 setting, and across settings.

5 Our results inform the design of payment policy  
6 in the following way. The uniform base payment for routine  
7 and therapy services needs to be adjusted downward for  
8 stays treated in home health agencies to account for this  
9 setting's considerably lower costs. For the three  
10 institutional PAC settings, a separate model could be used  
11 to establish payment for NTA services.

12 As Dana mentioned, you will be seeing more on  
13 this project over the coming months. We would like to do  
14 more analysis by additional patient groups. We will also  
15 want to discuss possible payment adjusters and outlier  
16 policies for exceptionally high-cost or short stays. Much  
17 like the site-neutral work, we will want to consider  
18 changes to the regulatory requirements for the different  
19 PAC settings and a transition period to give providers time  
20 to adjust their practices and  
21 cost structures to the unified PPA.

22 And last, a unified PPS is still fee-for-service.

1 Other policies will be needed to move away from volume-  
2 driven patterns of care. We will want to discuss what  
3 companion policies should be considered to dampen the  
4 incentive to refer patients to unnecessary post-acute care.

5 That concludes our presentation, and we have  
6 suggested a couple of discussion topics. First, are there  
7 any particular beneficiary groups you would like us to  
8 include in our analysis? The second is, Are there  
9 particular payment adjustors that we should be looking at?  
10 And third, what policies should we consider to dampen the  
11 fee-for-service volume incentives?

12 DR. CROSSON: Okay. Thank you, Dana and Carol.  
13 This is a wonderful beginning to a rather complex and long-  
14 term, I think, engagement here at MedPAC.

15 So we're going to start with clarifying  
16 questions, and I'm going to start on this end. I'd just  
17 like to ask one myself. On page 18, I think. Right. So  
18 where it says include an indicator, this stay was treated  
19 in a home health agency, what does that mean? It's  
20 extracted, or it's the actual number has changed in some  
21 way? What does that mean?

22 DR. CARTER: So, when we were doing the modeling,

1 we included a lot of different patient characteristics, but  
2 we also included whether the stay had been treated in a  
3 home health agency.

4 DR. CROSSON: Okay. But that doesn't change the  
5 numbers. That doesn't change the numbers. That's just a  
6 qualitative indicator; is that right?

7 DR. CARTER: Well, it's -- I'm not sure I  
8 understand the question.

9 DR. BAICKER: [Speaking off microphone]

10 DR. CROSSON: Okay, all right.

11 DR. BAICKER: I think they mean an indicator  
12 variable, meaning a zero, one, binary --

13 DR. CARTER: Yeah. I mean, all of the  
14 coefficients are being estimated at the same time that  
15 we've also included in the model that the stay was treated  
16 in a home health agency. So all of the model coefficients  
17 would change if that indicator weren't in there.

18 DR. CROSSON: All right. Thank you.

19 DR. MILLER: And just to give you, maybe, the  
20 reason for it, because the estimation, the dummy variable  
21 is how it was done, so you are taking three settings where  
22 average stay costs are in the 10,000-plus range and one

1 setting where your average --

2 DR. CROSSON: 4,000.

3 DR. MILLER: Yeah -- or two and a half, 3,000,  
4 somewhere in there --

5 DR. CARTER: Yeah.

6 DR. MILLER: -- but I'll defer to them on the  
7 actual facts. But the point is taken.

8 And so you're trying to say, "I want to have a  
9 prediction for the cost of the patient where one of these  
10 things is very different." You would like that to actually  
11 be taken care of by all the patient characteristics, but  
12 it's so different, you had to enter an actual measure of --  
13 in the way that Kate said.

14 DR. CARTER: Right. And we actually ran the  
15 model first without it to kind of look at how out of  
16 alignment payments would be, and it was probably -- would  
17 not have been acceptable policy.

18 DR. CROSSON: Because it gave you a net number  
19 that was just too low.

20 DR. CARTER: Well, for all of the PACS?

21 DR. CROSSON: Combined.

22 DR. CARTER: The institutional PAC would have

1 been too low, and the home health stays would have been way  
2 over payment.

3 DR. CROSSON: Okay.

4 DR. CARTER: Yeah.

5 DR. CROSSON: All right. Thanks.

6 Clarifying questions? Starting over here.

7 Sorry?

8 DR. MILLER: [Speaking off microphone] -- Round  
9 2. Never mind.

10 DR. CROSSON: Yeah, yeah.

11 Clarifying questions? Over here starting with  
12 Cori.

13 MS. UCCELLO: I'm pretty sure I know the answer  
14 to this, but I'm going to ask it, anyway. So this is  
15 focusing on the provider cost side. It's not related to  
16 payments. So our concerns in the past about certain sites  
17 need to be rebased and that kind of thing, that's not  
18 relevant for this because we're going after just the cost  
19 side. Is that right?

20 DR. CARTER: I would think when we start looking  
21 at impacts, we are -- that would be a natural place to  
22 compare. All right. We're estimating what new payments

1 would be, and we should be comparing them to current  
2 payments.

3           Now, we have standing recommendations that money  
4 should be taken out of a couple of the payment systems, and  
5 at a future meeting, we are going to want to hear from you  
6 about how to think about sort of what do we want to do with  
7 those recommendations. We've done work on efficient  
8 providers in the past. So there are lots of ways of  
9 thinking about the base rate that might not reflect kind of  
10 the world as is, and that's part, I think, kind of what's  
11 behind your question.

12           DR. CROSSON: Jack?

13           DR. HOADLEY: The non-therapy ancillary services,  
14 you mentioned at some point drugs, and you mentioned, I  
15 think, ventilator services. Is that most of the dollars  
16 involved in that area? Is there quite a scattering of  
17 other kinds of services involved?

18           DR. CARTER: There is a scattering, but those are  
19 the big-ticket items. I mean, labs would be in there,  
20 radiology, but those are small dollars compared to the  
21 things I mentioned. Yeah.

22           DR. HOADLEY: Okay. Thank you.

1 DR. COOMBS: Thank you very much.

2 I notice this is not a random group in terms of  
3 the PAC-PRD, but I remember we went over the care, too, I  
4 think in past meetings. Was there some element of looking  
5 at readmission rates in the PAC-PRD, specifically how one  
6 fared with the other with the demonstration?

7 DR. CARTER: So now you're testing my memory. It  
8 was one of the outcome measures that the PAC-PRD looked at,  
9 and I think I am remembering correctly that we did not see  
10 differences across settings in the readmission rates except  
11 for LTCHs, which in a way sort of makes sense because  
12 they're a much higher level intensity provider, anyway, so  
13 they had different readmission rates. But there were not  
14 significant differences across the other three settings.

15 DR. COOMBS: So you did make a comment in the  
16 paper regarding the community setting, and I just wanted to  
17 ask if you saw some -- if you were able to hone in on that  
18 and look and see if there were some differentials between  
19 them, between the three entities.

20 DR. CARTER: I didn't catch what the question  
21 was. I'm sorry.

22 DR. MILLER: I was right with you up to the last

1 thing you said.

2 DR. CARTER: Yeah.

3 DR. COOMBS: So you made an exception with  
4 certain communities that there was differential in terms of  
5 looking at the final conclusion, and I was wondering if  
6 there was any differentials with the readmission rate or  
7 any of those things with specific subgroups.

8 DR. CARTER: We haven't looked at that.

9 When we were looking here in this work, we did  
10 look at patients directly admitted from the community  
11 without a prior hospital stay. I think you're asking about  
12 whether the readmission rates were different for community  
13 admits, and we haven't looked at them.

14 DR. CROSSON: Kate.

15 DR. BAICKER: I have a really basic question, and  
16 apologies for taking us so far back to square one. But I'd  
17 love clarification on what the goal of the model is in the  
18 sense that -- we know costs differ across these different  
19 settings, supposedly cost twice as much for a given patient  
20 in one setting to achieve the same outcomes as another  
21 setting.

22 Presumably with enough variables on the right-

1 hand side, enough flexibility on the functional form, even  
2 throw in a dummy variable, you can generate something with  
3 a really high R-squared that's going to match the observed  
4 pattern of costs across settings. And rather than saying  
5 we're paying each of these five settings on a different  
6 schedule, I wrote down a really complicated formula that  
7 replicates that, but it's just one formula.

8 I'm not sure what problem that solves. If it's  
9 not addressing the issue, we could achieve the same  
10 outcomes at a lower cost in a different place. Maybe we  
11 should do that. Then I'm not sure what the -- what's our  
12 measure of success of this exercise? What's the -- I'll  
13 stop there. What's our goal?

14 DR. MILLER: I could definitely get in on this,  
15 but if you want to start, it's up to you.

16 DR. CARTER: Well, we were mandated to design a  
17 common payment system, so let's start there.

18 I think you raise a really good question, which  
19 is if we don't think we like the patterns of care, why are  
20 we trying to predict them? And I think that that's a fair  
21 question, but it is -- we are trying to develop a common  
22 payment system, and so we're using the best characteristics

1 we have to predict cost. But your point is well taken, and  
2 we talk about sort of what is our measure of success, and I  
3 think that's fair.

4 DR. BAICKER: Well, in a common -- developing a  
5 common formula or a common system doesn't necessarily mean  
6 developing a common system that does as best as possible to  
7 replicate the system that we have right now. So I am not  
8 questioning the goal of having a common payment system, but  
9 there are an infinite number of common payment systems.  
10 How are we choosing which ones we think are performing  
11 better or worse, and is the benchmark -- it matches what  
12 we're doing the best, the right way to choose among those  
13 options?

14 DR. MILLER: Okay. So here's what I would say,  
15 and some of this answer of when we know we're at the right  
16 place is going to have to come from you guys. We're going  
17 to roll information through you, and over several meetings,  
18 we're going to have to get down to a solution. And I'm  
19 going to give you a little bit more on that.

20 But one other thing to keep in mind, our job is  
21 to put a prototype together that will help guide the  
22 formulation when the real data comes in and then CMS is

1 going to build a model, and then we're supposed to then  
2 turn around and comment on that. So there is some latitude  
3 here that if this doesn't turn out to be perfect, the train  
4 doesn't leave the tracks.

5           But here is what I would say about your question  
6 -- and we've had this conversation in so many different  
7 ways, maybe not exactly the way she said it. Part of this  
8 exercise is going to be saying, "Is this PAC-PRD functional  
9 data helpful in predicting the needs of the patient?" And  
10 we had this very exchange. If you went through and just  
11 stuck dummies in for every setting, you could completely  
12 replicate the current system, and it's sort of "What is the  
13 point?"

14           And so I think what we're up to here is we're  
15 trying to get the best patient prediction that we can based  
16 off of the patient characteristics and the data that we  
17 have and then look at the fall-out across patient groups  
18 and across setting and ask ourselves, using transitions,  
19 outlier payments, adjustors to that model to say, "Which of  
20 these differences would think are legitimate to capture in  
21 a payment system?" and that there will be two forms of  
22 thought, "Do I have a really good patient-level predictor?"

1 By the way, what other policy adjustments should I make to  
2 end up with an outcome where I'm at a different place, but  
3 I'm not doing damage to patients and all that?" So that's  
4 the way.

5           There's going to be two sets of conversations. I  
6 think trying to get the predicted model as well as we can  
7 get it, but then what does the rest of the policy look like  
8 to support the transition and to put adjustors in, where  
9 legitimate differences might want to be captured as opposed  
10 to your giant equation, which is "I stuck all these  
11 variables in, and I'm right back where I started," which  
12 would be kind of a pointless exercise."

13           DR. CARTER: So some of what Mark is saying also  
14 is I think it's important for us to focus on beneficiary  
15 groups as opposed to settings because we know that putting  
16 all of the patients across the settings is going to change  
17 things. That's the point, and so we are trying to focus  
18 more on doing the best job estimating cost for patients and  
19 looking at how different groups of beneficiaries -- and we  
20 picked eight to start with, but we really anticipate doing  
21 many more than that, and so we're seeing how the model does  
22 with different cuts at patient groups.

1 DR. BAICKER: So I can come back then in Round 2  
2 to -- I think all of this discussion, which was very  
3 helpful and clarifying for me, does have implications for  
4 what it is you want on the left as well as what you want  
5 the right to look like. And we can get to that in Round 2.

6 DR. MILLER: I haven't been thinking through the  
7 left, so I'll be curious to hear what you said.

8 DR. CROSSON: Mary?

9 DR. NAYLOR: So just a question in terms of also  
10 stepping back a little, but how did you define post-acute,  
11 or how did the legislation define post-acute? In other  
12 words, why would community home health populations who are  
13 not post-acute be included at all in this?

14 DR. CARTER: Well, we included it because it is  
15 covered under the current home health benefit.

16 DR. NAYLOR: Covered under the benefit.

17 DR. CARTER: Right.

18 DR. NAYLOR: So there wasn't a specific  
19 definition of post-acute that got in?

20 DR. CARTER: No. I think the legislation defines  
21 the settings.

22 DR. NAYLOR: Okay.

1 DR. CARTER: Yeah.

2 DR. NAYLOR: And second, it might link a little  
3 to what Kate has asked. Does the legislation requiring --  
4 asking for the prototype prevent thinking about the key  
5 features of a post-acute benefit as a whole rather than  
6 home health, long term, IRF, et cetera?

7 DR. CARTER: It doesn't ask us about the benefit.

8 DR. NAYLOR: It doesn't ask about the benefit --

9 DR. CARTER: Right.

10 DR. NAYLOR: -- but it doesn't preclude thinking  
11 about key features of what is optimal post-acute care?

12 DR. CARTER: It does not.

13 DR. NAYLOR: It does not.

14 DR. MILLER: It does not, and you can imagine a  
15 report where we say, you know, "The ideal world would look  
16 like this. You have asked us to look at this, given that.  
17 Here is what we say." So I don't think it precludes your  
18 kinds of statements.

19 And also, if we think there's some roll-out  
20 comment -- I mean, we do have to respond to the mandate,  
21 but it doesn't preclude us talking about other things, and  
22 if there's some roll-out comments that says, "You know,

1 there's a population over here that maybe we ought to think  
2 about differently as we go down the road," it doesn't  
3 preclude that either, if you wanted to chase the community  
4 population.

5 DR. NAYLOR: It wasn't just chasing the  
6 community, but outcome.

7 DR. CROSSON: Kathy?

8 MS. BUTO: I'm just curious whether the four  
9 clinical groups that you chose -- I don't know how to put  
10 this, but are they evenly distributed amongst the different  
11 settings, or are they very different, depending on which  
12 setting you look at, including home health?

13 And then what did you do about weighting costs to  
14 account for that? I don't know whether I'd say you'd want  
15 to give more weight. If they're being concentrated in one  
16 setting, it could be because they're being overpaid in that  
17 setting, but I'd just be curious to see how you made an  
18 adjustment for the distribution of the clinical groups and  
19 the other groups that you looked at.

20 DR. CARTER: So we used a weighting just by  
21 setting. So, in the sample, the mix of cases doesn't  
22 reflect the PAC mix nationwide. The IRF and LTCH stays are

1 way overrepresented, and so we reweighted the sample to  
2 reflect the IRF mix, the LTCH mix, the home health mix, and  
3 the CNF mix broadly. We did not reweight each group for  
4 each analysis.

5           You're right that the groups are not evenly  
6 distributed across the settings, even given that LTCHs are  
7 small and there are only -- I don't know -- 150,000 stays  
8 per year, and there are 2.5 million stays of SNF. But the  
9 share of event cases in LTCHs is much higher than any of  
10 the other settings, as an example.

11           DR. CROSSON: Sue.

12           MS. THOMPSON: On that question, in these  
13 clinical groups, did I understand you to say you looked at  
14 them mutually exclusive of each other?

15           DR. CARTER: Yes. And they're defined mutually  
16 exclusive. So if you're in the event bucket, you're not in  
17 the other ones. If you're in the wound care, you're not in  
18 the others.

19           MS. THOMPSON: For the clinical.

20           DR. CARTER: For the clinical group.

21           MS. THOMPSON: For the clinical group.

22           DR. CARTER: Yep.

1 MS. THOMPSON: Thank you.

2 DR. CROSSON: David.

3 DR. NERENZ: Yes. Just to follow on Kate's  
4 question and Mark's response, there was a variable in the  
5 model for home health location. Was there intentionally  
6 not a corresponding variable or variables for the other  
7 settings --

8 DR. CARTER: Right.

9 DR. NERENZ: -- because you did not want that  
10 effect in the model?

11 DR. CARTER: Right.

12 DR. NERENZ: Okay, good. I thought that was  
13 implied. I just wanted to make sure. Okay.

14 DR. CROSSON: Other clarifying questions?

15 [No audible response.]

16 DR. CROSSON: So if the question is how do we  
17 dive into this, I think Dana and Carol have presented three  
18 specific questions, and we need to address those, but  
19 before we do that -- and I'd like to take them one at a  
20 time, so start thinking about which beneficiary groups  
21 might be added, adjustors, et cetera.

22 But before we do that, we answer the questions

1 directly, let's hear, because I've already heard some,  
2 other more global points that folks want to make that they  
3 haven't made, or are there any?

4 Oh, wait a minute. I'm sorry. Violation. I  
5 already violated my own new policy.

6 [Laughter.]

7 DR. CROSSON: That didn't take long. That didn't  
8 take long. So Alice and Bill Hall have -- Bill Gradison.  
9 Bill Gradison. Sorry. Alice and Bill Gradison have  
10 volunteered to kick off. So I would ask you, if you want  
11 to talk about these three questions, that's fine. If you  
12 have another point, I suspect you might do that. And then  
13 we'll have Round -- starting at Rita's end, to ask  
14 questions which are broader or not related to these three  
15 questions, and then we will return and try to answer these  
16 three questions, okay?

17 So, Alice.

18 DR. COOMBS: Thank you. Thank you very much,  
19 Dana and Carol. Excellent work.

20 First of all, one of the things that I thought  
21 about in reading this chapter was the dilemma that we got  
22 into when we looked at CCI cases back in the day, because

1 it was clear that some of the same diagnosis across each of  
2 the venues were being housed in SNFs versus IRFs versus  
3 LTCH, and the criteria used for how those patients got  
4 there seemed not to be consistent, and so that was a piece  
5 of it.

6 But, even with the home health, there are cases  
7 of people who have total joints who don't go to IRFs and go  
8 straight home. And, so, I think home health was included  
9 as a part of that because a large population that is shared  
10 in common with those other entities are actually being  
11 cared for in the home health sector, as well. So, that was  
12 one of the reasons why it's reasonable for us to consider  
13 home health agencies in light of the IRFs and the SNFs and  
14 LTCHs.

15 With the LTCHs, one of the things that we talked  
16 about in the past was looking at the serious comorbid  
17 conditions that occur in the LTCH population. However,  
18 LTCHs in some areas have patients that are basically  
19 identical to some of the SNFs and IRFs. So, we needed to -  
20 - and I think this actually gets to the point of not  
21 necessarily the diagnosis, but the conditions which require  
22 the resources, inputs into those patients and their care to

1 yield a consistent outcome.

2           So, I think we're going in a right direction.  
3 However, the piece of the puzzle is the readmission rates  
4 and looking at those outcomes that are those big outcomes  
5 that really result in -- and I'd like to -- I know the PAC  
6 demo probably has this somewhere embedded in it, but to  
7 look at that and to say, okay, this is a good job, how can  
8 we better say that -- reaffirm that we're going in the  
9 right direction, even though we have a mandate to go in  
10 this direction anyway? And, so, lessons learned in terms  
11 of whether or not there are some differences with the  
12 different groups based on the PAC demo. I know that  
13 there's probably information embedded in --

14           DR. CARTER: We can bring back to you -- I know  
15 that there were some broad clinical groups that were looked  
16 at more specifically than, like, the overall readmission  
17 rate, and I'll see what's there.

18           DR. COOMBS: Okay. And then your second question  
19 -- actually, your first question was additional beneficiary  
20 groups of interest. So, in the chart on -- in the chapter,  
21 let's see, it's Table 2, the second line of severe wound.  
22 So, the patient that I would have a hard time placing from

1 the ICU would be a patient who's vented, dialysis, with a  
2 wound vac, and it's not just a wound vac from a diabetic  
3 who has a wound vac for, say, a decubitus. You know, a lot  
4 of times it's not the diabetic, necessarily. It's the  
5 post-operative wound vac. That wound vac is very different  
6 because a lot of those patients will require weeks of  
7 therapy, and the area where you have such large denuding of  
8 tissue and what needs to be done. And then the input into  
9 that patient, a lot of times, those vacs are actually  
10 changed by the physician and not by a nurse. So, and  
11 there's all these specialists in wound treatment, but long  
12 term is these patients actually will recover and do very  
13 well. Most of them aren't going to LTCHs. So, wound vac,  
14 dialysis, and vent patients, I think.

15           And, so, the model doesn't take into  
16 consideration the cross-over between -- it's those  
17 idealistic, that you just got respiratory failure, but  
18 there's a large overlap and I don't know how this  
19 reconciles that if there's modifiers to look at. What  
20 happens when you have all three of the majors there?

21           DR. CARTER: So, the model has many features in  
22 it --

1 DR. COOMBS: Okay.

2 DR. CARTER: -- and so your patient, if we had  
3 variables, which I think for the three things that you  
4 indicated, we do have --

5 DR. COOMBS: Okay.

6 DR. CARTER: -- and, so, we're already including  
7 that in the model. We're simply categorizing patients for  
8 reporting purposes. But in terms of the way we're trying  
9 to predict costs, we have a lot of comorbidity indicators.  
10 We have the primary reason they were treated, three  
11 different indicators of wound care, ventilator care, bowel  
12 impactment. I mean, it sort of goes on and on and on, and  
13 we only had 6,000 cases, so we don't have that many  
14 variables. But, we were trying to have a spare model that  
15 -- we were actually particularly concerned about the  
16 medically complex cases that are treated in LTCHs and kind  
17 of high-end SNFs.

18 So, at least narrowly to answer your question, I  
19 think we're trying to capture that dimension and multiple  
20 dimensions of a patient.

21 DR. COOMBS: And, so, the other piece of it is  
22 how you calculate the NTA for the different diagnoses. So,

1 there's a wide range of respiratory failure, people on  
2 trachs, the chronic trachs walking around their house and  
3 stuff, you know. So, I know it's probably hard to get at  
4 this, but there are some vents that are different than  
5 other vents in terms of severity of illness, and that would  
6 be the other piece that I would have a problem with, you  
7 know, the same thing we talked about with strokes. You  
8 know, you have a stroke who needed TPA and all of a sudden  
9 they're walking around and they're fine. You have another  
10 stroke who's devastated with severe comorbid kind of  
11 consequences and hemiparetic.

12           So, that would be the other issue, looking at  
13 diving down into the beneficiaries in terms of what kind of  
14 advanced disease that they may have, not just labels of  
15 comorbid conditions, but within a comorbid condition, you  
16 may have a severity that goes pretty -- that could be  
17 pretty devastating. So, thank you very much.

18           DR. CROSSON: So, Alice -- I'm sorry -- it sounds  
19 to me like your principal concern is that the model is  
20 specific enough to deal with a number of clinical variables  
21 that you see.

22           DR. COOMBS: But it doesn't have to deal with it

1 in a label fashion, because you'd get a thousand, you know,  
2 entry points, but maybe if it dealt with it in terms of  
3 resource utilization. This diagnosis with this thing  
4 causes type A resources to be poured into a patient. And I  
5 think that's very different than what providers are used  
6 to, is just labeling something and getting a DRG. This  
7 says that the diagnosis in and of itself is not enough. It  
8 really is the care utilization, you know, the resource  
9 requirement.

10 DR. CROSSON: Right. But as Carol indicated, a  
11 lot of -- if I've got this right -- a lot of those  
12 situations or factors are indicators in the model, is that  
13 right?

14 DR. CARTER: Yes.

15 DR. CROSSON: Right. So, there's --

16 DR. CARTER: What you're seeing here are just  
17 reporting categories. It's not the model.

18 DR. CROSSON: Right. I would just ask one  
19 question deriving from Alice's comments, is with the size  
20 of the -- the existing --

21 DR. COOMBS: Demo.

22 DR. CROSSON: -- demo, thank you --

1 DR. CARTER: The demo, mm-hmm.

2 DR. CROSSON: With the size of the demo, 6,000  
3 patients, do you, in fact, have enough numbers to be  
4 confident that you've addressed the major types of issues  
5 that Alice talked about?

6 DR. CARTER: It's the sample we have to work  
7 with. I think that --

8 DR. CROSSON: Well, there's that.

9 DR. CARTER: -- the providers were selected to be  
10 illustrative. I think they were really trying to look at  
11 all different types of providers and, you know, types of  
12 providers within SNFs, different mixes. So, I think they  
13 were trying to get a mix of cases to be illustrative of  
14 care. But, you know --

15 DR. CROSSON: Right. I'm not being critical of  
16 the design, but I'm just saying --

17 DR. CARTER: Yeah --

18 DR. CROSSON: -- in retrospect, then, how  
19 confident are you that there's enough --

20 DR. CARTER: Well, I think that's why we want to  
21 move to 13 --

22 DR. CROSSON: Yeah. Okay.

1 DR. CARTER: Once we've built this sort of  
2 prototype, we want to move to 13, because this isn't the  
3 sample you would want to estimate impacts off of.

4 DR. CROSSON: Okay.

5 DR. MILLER: Yeah, and that's the point I was  
6 going to make, is remember, the next step is to -- you  
7 know, in a sense, this has a small group of people where  
8 you have the data you really want. Then the next step is  
9 we're going to move to a larger model where it's a large  
10 group of people without the data that you really want and  
11 we're going to start to try and triangulate. And then I  
12 would just ask you to keep in mind, you know, prototype,  
13 we're looking for kind of major errors and major  
14 directional error. The data will flow in over a few years  
15 to CMS and then they'll have to construct a model which  
16 will actually be everybody with this data on it, and then,  
17 hopefully, the precision starts to get better when they  
18 actually get down to building their models.

19 DR. CROSSON: And then a different Commission in  
20 2020 will finally resolve those problems.

21 DR. MILLER: I don't even want to talk about  
22 that.

1 [Laughter.]

2 DR. CROSSON: So, on this topic --

3 MS. THOMPSON: On this topic, and I think Alice's  
4 point that a trach is not a trach and a ventilator is not a  
5 ventilator is important, and the sample size can grow, but  
6 the question will remain.

7 So, what about the functional assessment? Within  
8 the functional assessment, are there criteria that help us  
9 differentiate and be able to be predictive about resources  
10 that likely will be needed for a patient that gives us  
11 greater confidence, even with the sample you have?

12 DR. CARTER: So, the care data has many  
13 dimensions of function. We're using sort of a composite  
14 score that looks at, I forget how many different -- I'm  
15 going to guess nine different self-care and mobility and  
16 sort of into a composite measure. So, I don't know. For  
17 any given case type, you might care about one thing over  
18 another, but it is a composite measure we're using for  
19 everybody.

20 MS. KELLEY: We can -- we can look at some -- in-  
21 depth into more patients, for example, not just vent, but  
22 we could look at vent with multi-organ failure. We might

1 be able to dig down a little bit deeper to look at certain  
2 types of cases, particularly the highly resource intensive  
3 ones that we would be concerned about.

4 DR. CARTER: We've run all the patients through  
5 an MS-DRG grouper that assigns severity of illness. So,  
6 one group that we definitely will want to look at are the  
7 level fours to see -- and compare to the level ones, right,  
8 because you want things to work out at both ends of the  
9 spectrum. So, that's one thing we'll definitely be doing.

10 DR. CROSSON: Okay. Bill Gradison.

11 MR. GRADISON: One minor thing, and then one  
12 somewhat more complicated. I would suggest that when  
13 you're looking at payment adjustors, you take a look at  
14 direct admits. Maybe you would anyway. But, I can see how  
15 that might conceivably be a group that's in better health  
16 and lesser severity than those that have been referred  
17 elsewhere. It also is obviously not a post-acute care  
18 category anyway, but -- I'm not saying exclude them, but  
19 just to see if it makes any difference.

20 My more important point has to do with home  
21 health care. We've emphasized quite properly in the  
22 discussion to date and so far the issue with regard to non-

1 therapy ancillaries, but there's another difference in  
2 payment for home health care and that's there's no copay.  
3 It's something we talked about in the past. And, I  
4 understand why you've constructed this way, and this may be  
5 in the real world what has to happen in the end. But, I  
6 would like to see at least some numbers that would give  
7 some idea of how much could be raised through copays and  
8 how much it would cost to add the non-therapy ancillaries  
9 for the home health agencies and, therefore, have the  
10 benefit package much more comparable, particularly with  
11 regard to SNFs versus home health care, than trying to  
12 adjust around it.

13 I know, of course, the politics of the copay  
14 issue, but I don't remember ever suggesting giving  
15 something in return. And so it's in that context that I  
16 simply would ask you to take a look at that and we'll talk  
17 about it another time.

18 DR. CROSSON: So, it sounds like that's a bit  
19 outside of the charge we got, but is this doable, do you  
20 think?

21 DR. MILLER: It's definitely outside the charge.  
22 We can definitely run you through, Bill, get back into --

1 one part of your question was how much revenue could be  
2 brought in through a copayment, I think was part of your  
3 question --

4 DR. CROSSON: And would that pay for the non-  
5 therapy --

6 DR. MILLER: Well, that's the part that is harder  
7 for me to think through, and I'd rather not do it in public  
8 off the top of my head because it will embarrass me and  
9 everyone else. We can definitely give you revenue senses  
10 of copayment here, copayment there. That's not a hard  
11 thing to do. What it means to say, I'm going to take the  
12 NTA and put it in home health, I would want to spend some  
13 time thinking about it. I just need to back up. We know  
14 that it's drugs and ventilators and certain kinds of  
15 things, and exactly what's going to be going on in home  
16 health, that just strikes me as a more complicated question  
17 than I would want to answer on the fly.

18 MR. GRADISON: I totally agree with that. Just  
19 in reading this over, I asked myself, why are they -- why  
20 are non-therapy ancillaries excluded from this one group,  
21 and I realized I don't know. There may be a perfectly good  
22 reason, but I'd just like to have some thought given to

1 this. Maybe it's a historical accident. Maybe there were  
2 some very solid clinical reasons, and that's what I would  
3 like personally to learn more about. Thank you.

4 DR. CROSSON: Yes. I don't -- Bill, you're not  
5 asking for a response from Mark right now --

6 MR. GRADISON: [Off microphone.] No, no.

7 DR. CROSSON: You're just saying, is this some  
8 work that could be done in the course of what is going to  
9 be a rather significant set of analyses, I think --

10 MR. GRADISON: [Off microphone.] Absolutely.  
11 That's what I had in mind.

12 DR. CROSSON: Right. And, I think since it's  
13 relatively easy for me as Chairman to say, yeah, we'll do  
14 that, and I don't feel anything kicking me under the table  
15 --

16 [Laughter.]

17 DR. MILLER: We can arrange that --

18 DR. CROSSON: Right.

19 [Laughter.]

20 DR. MILLER: Yes, we will certainly put in front-  
21 line thought of how did we get here and is there a good  
22 argument. We can definitely do that and then try and pick

1 up the thread from there.

2 MR. GRADISON: [Off microphone.] Thank you.

3 DR. CROSSON: Okay. So, before we go to  
4 suggestions in response to the three questions, starting  
5 down here with Rita, are there other broad points that  
6 people want to make.

7 DR. REDBERG: Thank you.

8 DR. CROSSON: Go ahead.

9 DR. REDBERG: I would like to make some broad  
10 points. It was an excellent chapter, but I wanted to bring  
11 it back to what we were talking about before lunch, sort of  
12 the whole picture of how much we're spending and what we're  
13 getting for it, and also add the patient preferences part,  
14 because there are clearly big differences in the cost of  
15 this care. You know, we've talked about in the past that  
16 there weren't such big differences in outcomes between a  
17 lot of these different settings.

18 And then in terms of patient preferences, in  
19 general and my experience taking care of patients the last  
20 30 years, most people want to go home. They always want to  
21 go home if that is a reasonable option. And, so, I think  
22 it's good to be able to incorporate, because certainly for

1 a lot of these patients, they're able at home to get some  
2 of the services that they can also get in the inpatient  
3 facilities, you know, for physical therapy, other kinds of  
4 therapy, and for some reasons that aren't necessarily their  
5 choice, they're not sent home with home health aides.

6           So, I think, just sort of looking at the big  
7 picture is good, to try to incorporate the value part  
8 that's sort of the outcomes and patient preferences.

9           The other point, which is kind of related to the  
10 bigger picture but not to that last comment, is the other  
11 sort of post-acute care option that we don't include is  
12 hospice. You know, we've looked before, but there are  
13 people that go to hospice after they leave the hospital.  
14 We've looked at sort of LTCHs before and talked about them.  
15 We sometimes consider -- I mean, we know the mortality rate  
16 is very high in those. Those are very sick patients. But,  
17 that certainly, I suspect, some of those patients, if given  
18 an informed choice, would have preferred to go to hospice  
19 and have less of that intensive care and spent their last  
20 months in a more compassionate sort of environment.

21           And, so, I just wonder if there's some way to  
22 include the other options in the post-acute care, mainly

1 home hospice or inpatient hospice.

2 DR. CROSSON: So, we've not traditionally -- I  
3 mean, we've traditionally looked at hospice as a separate  
4 issue.

5 DR. MILLER: We have traditionally, and here, I  
6 would go back to invoking the mandate. The Congress has  
7 said they want us to focus on these four. I do think that  
8 if there is overlap in these populations, and I think you  
9 said this, and I apologize if you didn't, it's probably  
10 between the LTCH and the hospice. I mean, I've been out in  
11 the field enough where many medical directors have said  
12 those populations overlap.

13 How to think about it in the presence of the  
14 other three, you know, home health, SNF, and IRF,  
15 complicates my mind a little bit. So, for myself, I guess  
16 I'd like again to say I'd probably want to go back and  
17 huddle with the crew before I thought about how to do this,  
18 or whether to do it. But, I do want to say the mandate,  
19 the Congress has separated it in their mind, for sure.

20 DR. REDBERG: Sure. I understand, and I did say  
21 it would be LTCH patients that were --

22 DR. MILLER: And I thought you did, but I just

1 wanted to make sure.

2 DR. CROSSON: Craig.

3 DR. SAMITT: So, my comments are also about home  
4 health, and in particular Slide, I don't know if it's 22 or  
5 23 in the deck. You know, I'm assuming, to go back to the  
6 prior discussion we had about goals, that what we're trying  
7 to achieve here is for like patients with like conditions,  
8 how do we assure that they're getting the highest quality  
9 care, the highest value of the various post-acute care  
10 alternatives that also meet their preferences. And, so,  
11 I'm concerned a bit about the methodology where we create  
12 this payment adjustor for home health, because it feels  
13 like we're creating two separate categories by having three  
14 of the post-acute in one category and the last through a  
15 very separate payment-adjusted scenario.

16 And, so, I'm most curious about the like patient  
17 with the like condition that should probably receive home  
18 health as opposed to skilled nursing, and the methodology  
19 does not discount the payment sufficiently through this  
20 approach to create and warrant an incentive to assure that  
21 those patients do go home as opposed to go to a skilled  
22 nursing facility.

1           So, that would be my only concern. I recognize  
2 the dangers of a blended methodology, where you create  
3 overpayment for home health and underpayment for the  
4 others, but I'm still a little bit worried that there's  
5 going to be a category of patients that for SNFs, the  
6 reimbursement should go significantly lower because we  
7 really would want those patients at home if at all  
8 possible, and if they prefer. So, that's -- otherwise, the  
9 chapter is fantastic and the methodology seems sound, but  
10 that's the piece of it that worries me.

11           DR. CROSSON: Craig sort of connected to what I  
12 was saying before. I think -- I felt what I was hearing  
13 was that what you're concerned about is not in the model.  
14 Is that -- Kate looks like she wants to say something.

15           DR. BAICKER: I know, I do look like I want to  
16 say something. My understanding is you're trying to  
17 predict costs that are actually realized by patients who  
18 happen to be treated in whatever settings they're treated.  
19 You put in a whole bunch of patient characteristics,  
20 indicators for various conditions, demographics, et cetera.  
21 And if you do that in a reasonably parsimonious way,  
22 without putting in, you know, age and age squared and age

1 cubed and every possible thing you could, if you put a  
2 reasonably parsimonious model down, home health still costs  
3 much less than the other settings. So you stick in a dummy  
4 variable, an indicator variable for home health.  
5 Presumably that bangs in with a big negative coefficient.  
6 And then you've got one model that's predicting costs where  
7 you have this home health indicator. And the challenge in  
8 my mind there is, yes, it costs much less to treat a  
9 patient in a home health setting, and we're saying even  
10 holding all else equal that we can control for, you know,  
11 in this multivariate regression, you have controlled for a  
12 bunch of other stuff when you have this home health dummy.

13           So then what we're implicitly saying is that  
14 patients who look the same in all these dimensions that  
15 we've measured, some of them are getting treated in home  
16 health, and some of them are getting treated in inpatient  
17 or these other settings, and in these other settings it  
18 costs way more. And so if we were to pay the same rate,  
19 we'd be paying way more for home health than it really  
20 costs and too little for these other settings, and that  
21 goes back to the fundamental question of why do patients  
22 who look very much the same and, let's say for the sake of

1 argument, have very similar outcomes get treated in  
2 settings that have very different costs? And is that  
3 something that we want the payment model to propagate? Or  
4 is that something that we think if we pick a different  
5 model it might push back against?

6           And you could say, well, actually the type of  
7 patient for whom it's appropriate to be treated through  
8 home health care is a very different type of patient from  
9 the patient for whom it's appropriate to be treated in an  
10 LTCH, in which case those other patient characteristics on  
11 the right-hand side should be pushing people into the  
12 setting in which they get treated. The fact that we're  
13 sticking in -- that we need to stick in a home health dummy  
14 is either telling us that our covariates on the right are  
15 inadequate, so differentiate among patients who should be  
16 in one setting versus those who should be in the other; or  
17 that some patients who could very well be treated in one  
18 setting are being treated in the other, and that's  
19 potentially something that we don't want to facilitate.

20           So I go back to my original question. If our  
21 goal is to write down a payment model that is in the spirit  
22 of site-neutral payments, you say, okay, we don't want to

1 pay places more than it costs to treat the patient, so step  
2 one, let's not overpay relative to costs. And so you're  
3 predicting costs on the left, which is better than  
4 predicting payments. But then step two is even if places  
5 are not making any margins on the costs, do we want to be  
6 neutral with respect to that, or do we want to say patients  
7 should be treated in the lowest-cost setting in which they  
8 can achieve the quality of care and the health outcomes  
9 that we're looking for, in which case something else should  
10 be on the left. It should be how much does it cost -- it  
11 should be more of a prospective payment type framework  
12 where you're thinking how much does it cost to treat this  
13 patient in the most efficient setting for this patient, and  
14 that might suggest a very different modeling exercise  
15 altogether, which goes back to where I started.

16 DR. CROSSON: All that is what I really wanted to  
17 say.

18 [Laughter.]

19 DR. CHRISTIANSON: Well said.

20 DR. CROSSON: Okay. So let's continue on --

21 DR. BAICKER: Ignore the woman in the corner [off  
22 microphone].

1 [Laughter.]

2 DR. CROSSON: No, let's continue on. Cori, do  
3 you want to continue on this point?

4 MS. UCCELLO: Yeah, what she said.

5 [Laughter.]

6 MS. UCCELLO: But I'm trying to think about this.  
7 Our concern is that we're modeling the left-hand side based  
8 on costs that we think may be not the most appropriate  
9 settings. So I guess two questions.

10 One, are there any geographic area indicators on  
11 the right-hand side?

12 And, two, are there certain geographic areas that  
13 we know are really over or under sending people to certain  
14 settings that could be skewing the results? And can we do  
15 a sensitivity analysis that would exclude patients in that  
16 area to see kind of how much difference we're talking  
17 about?

18 DR. CARTER: So when -- I know this isn't what  
19 you asked. So all the -- well, all the costs are  
20 standardized, which is different than are there different  
21 regional practice patterns, and we haven't controlled for  
22 that. We certainly could look at -- I think your idea of

1 sensitivity is an intriguing one. I know when Evan worked  
2 with the guys from Urban, they were looking at, you know,  
3 can we build a better PPS, and if you exclude the outlier  
4 counties that have really aberrant home health, can you  
5 build a better model? And the answer is marginally, yes,  
6 not great. It's not the magic bullet there.

7           But I think your idea is an intriguing one in  
8 that I think we could put some thought into, in addition to  
9 slicing this by clinical groups, would we want to kind of  
10 characterize markets and sort of look at sort of if that is  
11 getting at what you're thinking about. I mean, presumably,  
12 you know, there are markets with -- lots of markets without  
13 LTCHs, and so how is that substitution going? I know in  
14 our IRF/SNF work, we looked at markets with both types of  
15 facilities to make sure that we could see where patients  
16 were being treated where they had the option to go to both.  
17 And so we might be -- I'd have to -- I don't want to think  
18 -- like Mark, that would be scary to think in public, but I  
19 think your idea of trying to get at what is the sensitivity  
20 of the model given we know that there are different  
21 practice patterns, or how could we do that? And I think  
22 that's worth spending some time on.

1 DR. MILLER: And the thing I want to say -- and I  
2 was following what Kate said really carefully. I'd like  
3 maybe to have a separate -- or some follow-up on this,  
4 because in a hypothetical or theoretical sense, I  
5 completely follow how you got back over on the left-hand  
6 side and what you were saying. But I feel like that's  
7 precisely the problem that we don't know, like these people  
8 go to different settings, they often have similar needs,  
9 and how I construct the left-hand variable that  
10 operationalizes that when that's the very problem we live  
11 with is what I can't think through. And so we'll talk.

12 DR. CROSSON: So maybe I'm missing something  
13 here, but if we have 100 patients with all these specified  
14 characteristics, and they're cared for in home health, and  
15 we know what that costs, why can we not say that that's  
16 what it should cost, irrespective of what side of service  
17 they're in? Right? I mean, is --

18 MS. KELLEY: I mean, one factor -- and I think  
19 it's an important one here -- is that there are  
20 characteristics of patients that we might not necessarily  
21 want to pay on that do dictate where patients go. Some  
22 patients have a spouse at home so they can go home; other

1 patients live alone, and so going home following an acute-  
2 care hospital stay is just not possible. But we may not  
3 want to pay on that factor.

4 DR. CROSSON: So it's not the providers -- it's  
5 not the provider issue that's determining that. It's --

6 MS. KELLEY: It could be. It certainly could be.  
7 But complicating it is these other patient characteristics  
8 that are not necessarily assessed, and even if they were,  
9 that we might not want to pay on.

10 The other thing is that on the left-hand side of  
11 the model, home health costs -- the costs of the home  
12 health agency are fundamentally different. They're not  
13 paying for meals. They're not paying for the heat and the  
14 lights. You know, so their costs are fundamentally  
15 different.

16 DR. CROSSON: Okay.

17 DR. HOADLEY: I don't know that I can add much.  
18 I liked this last set of conversations about, you know, the  
19 different ways to think about this. I mean, I am struck by  
20 the fact that we have to do something different in home  
21 health, and what is that really reflecting? Is it  
22 reflecting, you know, the kinds of things Dana just talked

1 about? Is it reflecting the patient differences and  
2 resources back at home? And yet the other three were sort  
3 of more able at the moment to sort of put them in one lump  
4 and say that. But are there some other things going on  
5 there with cost differences? Anyway, I think we're getting  
6 on the right set of questions. I don't know if we have a  
7 good sense of where answers are.

8           The other thing I wanted to just put on the table  
9 in terms of sort of thinking down the line and picking up  
10 on a comment I guess Bill initiated on the beneficiary  
11 side, not necessarily going all the way to where he went  
12 with it, but I do hope that in the final report on this we  
13 would have a chance to lay out, first of all, just what the  
14 differences are beneficiary cost sharing across the  
15 settings, any kind of way that -- you know, putting the  
16 home health co-pay or lack thereof aside, any way that, to  
17 the extent that there are differences in how cost sharing  
18 is structured in the other three settings, if people move  
19 across settings, what impact will it have, just make sure  
20 we're thinking about that aspect of beneficiary impact.

21           And then, obviously, you know, you've raised this  
22 sort of in statements throughout the presentation, but the

1 impact on a patient's ability to select sites, and Dana's  
2 comment I think is a really good one, the difference of  
3 having a spouse at home or not, just like we don't want to  
4 create incentives for providers to direct people to a more  
5 profitable setting, we don't want to make it hard for the  
6 person without a spouse at home to be able to use the more  
7 appropriate setting for them. And you're right, I'm not  
8 sure whether we want to throw it in as a payment parameter,  
9 but we certainly want to make sure we understand that  
10 impact and whether we've created some bad incentives in the  
11 thing from the point of view of how the patient -- and is  
12 there a way we ought to think about it. I think that's  
13 just a good -- one good example of how to think about it,  
14 presence or absence of a spouse at home. Maybe that's even  
15 something you cut your data with to see, you know, how it's  
16 playing out in terms of thinking about subgroups to look  
17 at.

18 DR. NAYLOR: This might get into the question at  
19 the end on other beneficiary groups and follows this  
20 conversation, but I think the kind of richness and case  
21 studies that help to kind of make clear to everyone who is  
22 being served in these populations, one of the major reasons

1 that people are often referred to one over another setting  
2 has, of course, something to do with the physical health  
3 problems, but often the physical health problems  
4 complicated by, and it might be social support issues, it  
5 might be cognitive impairment, it might be mental health,  
6 behavioral issues, and so on. And I think until we really  
7 are willing to get a hold of who's going where and the  
8 decisionmaking process -- well, that would help. And  
9 that's where, as you're thinking about who are the  
10 beneficiary use cases, it's not just having functional  
11 deficits. It's the nature and number and severity of those  
12 deficits that really dramatically impact where people go  
13 for what kinds of services.

14           And I wanted to just build a little bit on, you  
15 know, in a PAC design versus a home health or IRF, skilled  
16 nursing facility, you might think about the capacity not  
17 constrained by the 25 days or episode of care, to think  
18 about Mr. Smith who goes for a brief time to institutional  
19 support for whatever kinds of services and then quickly  
20 moves home. So you're thinking about an entirely different  
21 redesign, and that was my earlier point. Is there any  
22 capacity of this kind of unified payment system to lead us

1 where we've often been talking about, the most efficient  
2 use of resources, aligned with people's goals and needs,  
3 that are enabling them to come in quickly and out of  
4 services to match the changing needs over a journey.

5 MS. BUTO: As I listen to the conversation, it's  
6 almost easier to visualize that the routine and therapy  
7 services for home health are the box, and that you actually  
8 create add-ons or additional factors for the institutional  
9 providers. If, in fact, they have some of these other  
10 costs, it's more like you're adjusting for that than you're  
11 adjusting downward. I mean, it's just a visual, but it's  
12 easier to think about as a basic payment for the service,  
13 and then whatever the additional considerations are for  
14 costs on the other side.

15 And I think it would also be really helpful to  
16 have a little bit more granularity with who the patients  
17 are, because I have a feeling that that's another factor,  
18 that as people have mentioned, not just the spouse at home  
19 but the comorbid conditions or mental health issues or  
20 whatever, so that, again, would inform how you would pay on  
21 the institutional side, or it might be an adjustment or  
22 not. But just conceptually it's easier for me to think

1 about it that day than it looks like we've just whacked  
2 home health payments because they seem maybe too generous.  
3 In fact, I think what we're doing is recognizing additional  
4 costs on the left-hand side.

5 MR. KUHN: First of all, I want to thank Carol  
6 and Dana for this great work. Being part of a team myself,  
7 as I suspect Jack has and I'm sure Kathy has, and Mark, of  
8 standing up a PPS system, I know how this is an awful lot  
9 of work, and you've done a great job of getting it started  
10 down where.

11 So a couple things I just wanted to highlight.  
12 One is the focus on program vulnerabilities. We got into  
13 it a little bit today in terms of nontherapy ancillaries  
14 and, if not properly adjusted, could lead certain  
15 facilities to selectively choose patients. But, you know,  
16 when we think about program vulnerabilities, I also think  
17 about incentives that would either help or drive poor-  
18 quality care. I also think about fraud and gaming of the  
19 systems that are out there.

20 So as we continue to go forward, I'd really like  
21 us to think these different elements, as you bring them  
22 forward, how we can kind of deal with those general program

1 vulnerabilities part, and you've started that conversation  
2 today, and I really appreciate that.

3           The second is that we've talked about the data,  
4 and I know we've got a limited set from this demonstration.  
5 But I'm thinking about the operations side, the systems  
6 operations, and the fact that, you know, is this real-time  
7 data for both CMS as well as the providers so that they can  
8 bill appropriately, bill timely, and do all the things that  
9 they need for payment as part of the process. So I'm also  
10 thinking about the systems operations component of that as  
11 we go forward, or if that's something that has to play out  
12 in the future, it would be interesting to hear about.

13           When you talked about some of the features and  
14 adjustments, I think both patient level as well as facility  
15 level adjustments need to be looked at as we move forward  
16 here, as you look at your regression. And also I think it  
17 would be helpful, at least for me, to look beyond the  
18 statistical meaningful factors that you look at here so  
19 that we can understand about issues of access, particularly  
20 access in rural areas, or certain urban core areas or  
21 things like that would be helpful as we move forward in  
22 this process.

1           And then, finally, I can't remember who mentioned  
2 it, but we're talking a little bit about some regional  
3 differences and state differences and things like that. I  
4 think that would be very powerful, but also looking at  
5 rural versus urban, availability of different provider  
6 types, as you talked about, maybe even financial status,  
7 for-profit versus nonprofit, things like that I think would  
8 be very helpful for us to look at on a go-forward basis.

9           DR. CROSSON: Thank you.

10           DR. HALL: I love this analysis, and I think it's  
11 a wonderful start in a really muddy area of the river. And  
12 one of the things that I've been thinking about in this is  
13 the -- from a clinical standpoint, my experience over the  
14 years in a lot of different hospitals and settings is that  
15 the decisionmaking for picking post-acute care is very  
16 different than the methodology we use for admitting people  
17 to an acute hospital. We're pretty good at that. They're  
18 sick, they have to come in the hospital.

19           From the standpoint of the providers and  
20 sometimes the institutions, the decision as to what part of  
21 the post-acute care system is used is highly predicated  
22 upon getting people out of the hospital, and increasingly

1 that's the mantra: reduce acute length of stay, open up  
2 beds for other opportunities, more patients, and also on  
3 the receiving end, some of the incentives have to do with  
4 keeping post-acute-care beds or positions filled.

5           And it seems to me that one of the adjusters  
6 we're going to have to look at very carefully is not to  
7 assume that everybody is on the same page here in terms of  
8 I think SNF is the right place, home health care is the  
9 right place. A lot of it has to do with who has the beds,  
10 who's willing to accept the patient and get them out  
11 pronto. That doesn't mean that there's malfeasance or bad  
12 practices. It's just kind of the way it is.

13           So I'm kind of wondering, as we develop this  
14 model and get it more sophisticated, whether we might be  
15 able to take advantage of the fact that we might have data  
16 that suggests that some parts of the country, not so much  
17 regionally but maybe in terms of the dominant medical care  
18 system, are really the most efficient or the most  
19 excellent. But, conversely, there may be parts of the  
20 country that are the least efficient and less excellent,  
21 and then apply the models to that real-world situation and  
22 see what comes out of that.

1           I know that somewhere somebody's doing this, if  
2 not right, better than the rest of us are doing, and not  
3 right now but I think at some point we might be able to use  
4 that as a very powerful tool to help realign the  
5 incentives. One, for instance, might be that bundling is  
6 really the answer to this situation. But maybe not. I  
7 don't know.

8           DR. CROSSON: Thank you, Bill.

9           Sue, yes.

10          MS. THOMPSON: I, too, think this is great work  
11 and a really wonderful start to this really difficult  
12 question. However, I can't help but think about this  
13 question in the context of working in an ACO and an  
14 alternative payment level, because we have worked really,  
15 really hard to reduce the overall spend, and home health  
16 has been our best friend.

17           And so in the context of thinking about the  
18 transitioning forward, I think it's also important to look  
19 where we have come from and what has brought us to this  
20 place and keeping that in mind, so the incentives we put in  
21 place looking forward, understanding we are where we are  
22 because of some incentives that brought us here. So

1 there's lessons to be learned, I believe.

2           From a rural perspective, clearly the adjustors  
3 that need to be considered are quite different because, if  
4 you're seeing five to six patients as a home health care  
5 nurse, your patients may be 60 miles apart, so that's quite  
6 different than if you're working in the city where patients  
7 may be 15 minutes apart. So I think those sorts of  
8 adjustments are important to consider.

9           But again, I'm intrigued with the idea of  
10 incentives, and I think the incentive to have SNF  
11 organizations be party to reducing readmissions and working  
12 as partners in care, it has tremendous opportunity. And  
13 we've seen that in our work.

14           DR. CROSSON: David.

15           DR. NERENZ: This comment may end up being --  
16 addressing the second bullet on slide 25 about which  
17 adjustors, but just as an exercise, take Dana's use of the  
18 example of living alone as a variable that plays into this  
19 mix somehow, and I was thinking about whether in your  
20 current model, you could even detect an effect of that. My  
21 guess is no, but you may tell me if you can.

22           If, for example, the main effect of that variable

1 is to put people from -- I mean, not in home health, but in  
2 someplace else, and you've got a dummy variable for home  
3 health, the residual variance for living alone may not be  
4 detectable. Is that sort of tracking your experience so  
5 far, or do you even have that as a predictor to try?

6 DR. CARTER: We don't have that as a predictor,  
7 and certainly moving forward, it probably is in the PAC-PRD  
8 data and definitely would not be in the national claims  
9 that we plan to use for modeling.

10 DR. NERENZ: Yeah. And that's where I was trying  
11 to go with this. Your quick comment was maybe we wouldn't  
12 want to pay on that, but I'm thinking, well, maybe we would  
13 because it may, indeed, be a valid driver of post-acute  
14 cost.

15 Now, if that's the case, in most of the modeling  
16 you can do, I imagine you can't pick up an effect because,  
17 currently, in the payment models that exist, it is not a  
18 cost driver. And the cost data you have to model with are  
19 payer costs, not underlying provider costs. Still good so  
20 far?

21 DR. MILLER: I definitely don't understand that.

22 DR. NERENZ: Okay. The point is that if -- let's

1 just say hypothetically that matters, meaning it takes more  
2 time. It means it's more intense effort. If it's not  
3 currently built into the payment models, you won't be able  
4 to see that effect. You can't pick it up in the modeling.  
5 Okay, good.

6           And that is essentially my point, that as you go  
7 forward or we together go forward on this, we want to make  
8 sure that we don't lose track of variables that might  
9 really matter or should matter in an eventual payment model  
10 that we can't see an effect of now because they're not  
11 currently in the payment models. Did I say that any more  
12 clearly?

13           And I'm just using that as an example. You can't  
14 find now a statistical effect of living alone. You have  
15 not found it, but just hypothetically, if it's there, we  
16 just don't want to lose track of it and ignore it.

17           DR. CARTER: So I'm pretty sure that CMS  
18 considered spouse or caregiver at home when it was  
19 considering the Home Health PPS and opted not to include it  
20 as payment variable, but certainly, I understand the logic  
21 of that. I think as a payment policy, we would need to  
22 think about that. I understand what you're saying.

1           In our data, we won't have that. When the care  
2 data has been -- or the care items have been collected for  
3 all providers for two years, you will have a whole range of  
4 characteristics about patients that you can then decide  
5 whether or not to include in a payment system. We don't  
6 have that luxury right now.

7           DR. NERENZ: Right. And clearly, choice about  
8 what to include in the end is not only just empirically or  
9 statistically based. There's some policy thoughts.  
10 There's some ethics and politics thoughts, and I understand  
11 all that goes into the mix, but I just was struck by that  
12 particular example where that can very easily get lost in  
13 the shuffle in this analysis because its empirical effect  
14 is undetectable. But yet it still may really matter.

15           DR. CROSSON: Okay. Alice, one last question,  
16 and then we get to the questions.

17           DR. COOMBS: Well, Carol, how would we be able to  
18 get a different population with the care data that we -- we  
19 don't have care data that goes back far enough? I mean, do  
20 we have that kind of information on hand?

21           DR. CARTER: So we have the care data that was  
22 collected.

1 DR. COOMBS: Not with the PAC demonstration, but  
2 outside of the PAC demonstration.

3 DR. CARTER: There is none.

4 DR. COOMBS: Okay. So we are really limited to  
5 the PAC demonstration. We can't go get another population  
6 --

7 DR. CARTER: No.

8 DR. COOMBS: -- as all these recommendations that  
9 people have been making?

10 DR. CARTER: No. It will start to be collected  
11 because that now is current law, but we won't see that data  
12 for --

13 DR. COOMBS: But we won't be able to have that  
14 information to weigh in on the recommendations that the  
15 mandate would like us to, so we really have to just abide  
16 by the information that we have at hand, which is the  
17 current demonstration project.

18 DR. MILLER: Yeah. Again, the way I think about  
19 this is we're living in a really imperfect world. That's  
20 what the legislation was designed to try and overcome, to  
21 collect unified data across the population more generally.  
22 For whatever sets of reasons, they said, "Even though you

1 don't have a lot of that data, we want you to think through  
2 the prototype," and I would keep the prototype in the  
3 forefront of your mind, that we make broad-stroke  
4 statements about how to proceed. We identify areas where  
5 information is missing and things that need to be thought  
6 through when the real stuff shows up, and that's what our  
7 report is.

8 I don't think you have to feel like this is it,  
9 "If I don't get this right, it's over."

10 DR. COOMBS: Right.

11 DR. MILLER: This is going to go on for multiple  
12 years.

13 DR. COOMBS: Well, I was thinking about this, in  
14 light of what Sue just said, the winners and losers under a  
15 situation like that, and that may be another way to think  
16 of it. Who wins if we were to go into this recommended  
17 kind of model? And with consolidated areas, with the areas  
18 that have floating SNFs and floating IRFs, that they're  
19 virtually open and closed when they need the beds, those  
20 are the kind of places that might be -- because their  
21 overhead is much less. So I was just thinking about those  
22 kind of entities that would be at an advantage that are

1 under their institution.

2 DR. CROSSON: Okay. This is a bit of a head-  
3 buster. Some of the issues we get when we're lucky are  
4 kind of dichotomous, like should we go left or should we go  
5 right. This one, I think, requires a GPS because there's  
6 so many twists and turns here and so many adjustors that  
7 could be added and the like. This is going to take us a  
8 little bit of time, but we don't have a lot of time, right?

9 DR. MILLER: Well, what the game plan is for the  
10 year -- or for this particular cycle is to return to this  
11 issue multiple times.

12 I can't remember the exact number that Jim is  
13 starting to sketch out, but we're going to be at this three  
14 or four times, is my guess, over the course of the year.

15 We do have a June 2016 deadline by law, and we  
16 will hit that. And I think we are going to have to come  
17 forward with what we know at that point in time, and we'll  
18 be very clear what we don't know is the way we'll have to  
19 navigate it.

20 DR. CROSSON: And the limits of the prototype, as  
21 you put it, that we've created.

22 DR. MILLER: Right. And then to Mary's initial

1 comments, not to forget way back in this session, ideally  
2 there may be other directions that Congress wants to  
3 consider, "But you asked us to do this. Here's what we  
4 know. Here's what we don't know." That's what I'm --

5 DR. CROSSON: Yeah. Warner?

6 MR. THOMAS: So just to comment on this, the  
7 mental model I have is thinking about post-acute the way an  
8 acute care hospital works. So, in an acute care hospital,  
9 you have an ICU. You have stepdown. You have Medsurge.  
10 You have different kind of levels of care, and I guess  
11 right now, post-acute, we keep thinking about the mental  
12 model, that there's an LTCH that's a separate facility,  
13 there's a rehab that's a separate facility, there's a SNF.  
14 And should we be trying to get our head around the mental  
15 model, that it is a post-acute entity, that would have  
16 access to all of these different levels of payments, just  
17 like an acute care hospital does?

18 Because if we think about trying to go to a  
19 common payment, but you're going to have all these  
20 entities, and then there's going to be the selection of  
21 payments. You're going to have big winners and losers.  
22 You're going to have a lot of people fighting over it

1 versus if you say, "Look, there's going to be a post-acute  
2 entity." You're going to have LTCH patients. You're going  
3 to have SNF patients. You're going to have everything in  
4 the middle. Should there be a combination of home health  
5 in post-acute, so you have a full continuum? And that's  
6 kind of the mental model I have, so that you could actually  
7 play in all of those areas and actually should play in all  
8 of those areas because the patient's care evolves as they  
9 go through that process.

10           So I don't know if that's more confusing or more  
11 problematic, but that's the mental model, I think. And  
12 then you say to post-acute providers, "You should plan all  
13 of these areas, frankly," and then complete for all those  
14 patients. And then we'll have a payment mechanism that  
15 would essentially, hopefully track with the acuity of that  
16 patient through post-acute, the idea of a post-acute  
17 payment.

18           But I think if we keep thinking the mental model,  
19 that all of these are different entities, I think it is  
20 going to be very difficult for us to come to a solution  
21 that is going to be palatable or be able to be implemented,  
22 frankly.

1 DR. CROSSON: Jon wants to comment.

2 DR. CHRISTIANSON: Warner, would that be like the  
3 accountable provider and a bundled payment approach?

4 MR. THOMAS: That would be the mental model, I  
5 would think. Yeah. And whether it's a bundled payment or  
6 whether it is a payment that is adjusted based on severity  
7 of a patient, like a DRG system is for inpatient, you would  
8 basically have access to any of those payments, depending  
9 upon the acuity of the patient.

10 Now, there's a lot of regulatory issues because  
11 of the different requirements for LTCH versus rehab versus  
12 SNF, but I think that's one of the real problems in post-  
13 acute today because that has just created the  
14 fragmentation.

15 DR. CROSSON: So maybe I don't understand.  
16 Warner, you're talking about something in addition to a  
17 population-based paid integrated delivery system that then  
18 has those dollars that include coverage of post-acute care  
19 and is able to make choices, depending on the nature of the  
20 patient among the available post-acute care settings in  
21 that geography. That exists. You're talking about  
22 something different, I think, which would be the creation

1 of some new intermediary entity that would be charged with  
2 making those decisions, or am I missing your point?

3 MR. THOMAS: No, not necessarily a new entity,  
4 but, I mean, think about it today. You have an acute-care  
5 hospital. You don't have an ICU hospital and then a  
6 Medsurge hospital for the most part. There are, obviously,  
7 special need hospitals, but for the most part, you don't  
8 have that all fragmented into different entities. You have  
9 an acute care hospital. So why wouldn't we have a post-  
10 acute care hospital that takes care of LTCH to SNF and even  
11 potentially be in home health business, because essentially  
12 these folks evolve, their care evolves? So that's just the  
13 mental model that I think of.

14 Whether you do it as a global payment, you say,  
15 okay, it's going to be one payment, but we know most in the  
16 post-acute care space are not ready to take a global  
17 payment for all post-acute care. You could say roll it up  
18 into the bundle, but those are, once again, based on  
19 specific specialties.

20 But I just think the mental model of post-acute  
21 care is to get out of the fragmentation and get to the  
22 integration of the different post-acute models into one

1 post-acute entity.

2 DR. CROSSON: Okay. All right.

3 DR. MILLER: And there was some site visits, some  
4 of the staff went on where they were talking to providers  
5 who were moving in that kind of direction, and to the  
6 extent to pull that in, we might pull some of that thought  
7 into the report to see if we can't build out your point.

8 DR. CROSSON: Let me be clear. We're talking  
9 about a structural consolidation?

10 DR. MILLER: Well, I don't think he's necessarily  
11 saying, but I think -- I think he's saying two things. Of  
12 course, he's sitting right here, so it's awkward.

13 [Laughter.]

14 DR. MILLER: But this is what I hear.

15 MR. THOMAS: Maybe I'll even tell you what I'm  
16 thinking, even when I'm saying it.

17 DR. MILLER: Here's what I think he's saying. I  
18 think he's saying potentially two things. One is, as a  
19 mindset to think about as you consider the issues, this is  
20 the way I, Warner, think about it. So I think that's one  
21 of your points.

22 I think the other point that you could be saying

1 is, to the extent that we changed or the Congress  
2 eventually changes how it pays and assume with some  
3 breakdown of the regulatory barriers and assuming the  
4 transition that allows it, rather than to be highly  
5 disruptive a transition, it may be that the post-acute care  
6 providers begin to think about it that way and say, "I can  
7 play in more of these areas potentially." I'm making this  
8 part up. You didn't say all this. I think his analogy was  
9 "Within the hospital, I have an ICU patient. I have a  
10 different kind of patient. My payment is adjusted on that  
11 basis, and if I'm in the post-acute care space, my payment  
12 -- you know, I could play in home health. I could play  
13 somewhere else."

14           But I think he mostly was saying, out of the  
15 blocks, "Mentally, this is how I'm thinking about it." Is  
16 that relatively close?

17           MR. THOMAS: Correct, yes.

18           DR. CROSSON: Okay. All right. So slide 25, we  
19 have got some requested input, and rather than divide them  
20 up individually, because of issues of time, those of you  
21 who have been thinking about input into additional  
22 beneficiary groups, suggesters, or policy considerations

1 that have not been mentioned already, let's start down this  
2 way. Kathy?

3 MS. BUTO: Just a quick one. I don't think it's  
4 been mentioned, but I think it's possible it was mentioned.  
5 As we look at changing or even suggesting changes in  
6 payment across sites of care for the same kinds of  
7 payments, I think it will be important for us to mention  
8 the need for outcomes, measures. I don't think we're going  
9 to get into it necessarily, but how will we know if we're  
10 doing more harm than good if we recommend a set of changes  
11 and we don't know how it turns out for the beneficiary?

12 DR. CROSSON: So would that be -- I mean, I  
13 suppose you could consider that an adjustor, or you could  
14 consider it a concomitant evaluator, or what?

15 MS. BUTO: I think that goes into things like the  
16 phase-in, the assessment, the ongoing assessment of how is  
17 it going in terms of changes that we make. We don't do  
18 enough of that in Medicare, look at "We've made a big  
19 change. How is it actually going?"

20

21 DR. CROSSON: We should develop it, and then the  
22 2020 MedPAC Commission can analyze the results. How's

1 that?

2 [Laughter.]

3 DR. CROSSON: Going around. Jack.

4 DR. HOADLEY: I think this has kind of been said,  
5 but, I mean, the notion of looking geographically in  
6 particular around sort of -- and to the extent that you had  
7 this in this limited data set or extended in the extended  
8 analysis, you do the kinds of communities that have  
9 different mixes of the providers. I mean, it really does  
10 seem like if you've got -- if the modeling came out very  
11 differently in a market that had no LTCH or in a market  
12 that had a really sophisticated set of SNFs -- that is  
13 measureable, sophisticated -- that would suggest that maybe  
14 some of these -- the fact that we're using cost as driving  
15 things in particular ways -- or if the parameters really  
16 kind of hold up across those different kinds of markets,  
17 maybe the underlying patient factors that you're using are  
18 working better.

19 DR. CROSSON: Craig? Nope.

20 Alice, the last comment. Not you personally.

21 The Commission.

22 [Laughter.]

1 DR. COOMBS: As I mentioned earlier, as I was  
2 thinking here, it might be interesting to go back, just  
3 with the PAC dem, is to look at was there an aggregation of  
4 those patients that we talked about, say, for instance, go  
5 backwards, take dialysis or take Dent and see what the  
6 distribution is across those, those entities.

7 DR. CROSSON: Okay. Thank you again, Carol and  
8 Dana, and I hope you've got some work to do because I heard  
9 a lot of it. You also deserve our congratulations for  
10 taking on this task, and we will support you through the  
11 process as best we can.

12 [Pause.]

13 DR. CROSSON: Okay. Now we're going to move on  
14 this afternoon to take a very preliminary analysis of the  
15 Medicare Advantage encounter data, and I would stress that  
16 this is the first look at the information, which is a bit  
17 raw, and, nevertheless, we're beginning a process of  
18 evaluating this and potentially at some point way down the  
19 line making some recommendations. That's not what we are  
20 today, and as a matter of fact, I think we're going to  
21 stress that the information is so preliminary that we would  
22 hope that no one draws any conclusions from it. We

1 certainly are not going to and would recommend that no one  
2 else do that either.

3 Now, I hope that's not a downer in terms of an  
4 introduction, Julie, but take it away.

5 DR. LEE: In the past few years, the Commission  
6 has been thinking about the effect of Medicare's different  
7 payment models on the delivery and quality of care. In  
8 particular, the Commission has been interested in whether  
9 the MA program, which has very different payment rules and  
10 financial incentives, produces different patterns of care,  
11 use of services, and outcomes for enrollees.

12 In 2012, CMS began collecting encounter data from  
13 MA organizations. MA encounter data include diagnosis and  
14 treatment information for all services and items provided  
15 to a plan enrollee. We appreciate the effort CMS has put  
16 into this work.

17 DR. MILLER: And, Julie, could I get you just to  
18 pull the mic a little bit closer? I'm sure my hearing is  
19 going.

20 DR. LEE: For our initial analysis, we focus on a  
21 segment of encounter data that is equivalent to Part B fee  
22 schedule services in fee-for-service claims data. This

1 part of the encounter data is a good starting point because  
2 it includes services MA enrollees routinely receive, such  
3 as E&M visits.

4           Today's presentation is in three parts. First,  
5 we describe the data. Second, we validate the data,  
6 testing for their completeness. In other words, does our  
7 data set contain all encounters for all MA enrollees?  
8 Third, we present preliminary comparison of service use  
9 between MA and fee-for-service for 2012 by broad category  
10 of Part B services, for selected E&M services, and in two  
11 specific geographic markets -- Portland and Miami.

12           Data for Part B services include claims from non-  
13 institutional providers, such as physicians, physician  
14 assistants, and nurse practitioners, in all practice  
15 settings. Our encounter data for Part B services include  
16 services provided at the HCPCS level, diagnosis codes, MA  
17 contract and plan numbers, provider numbers, and  
18 beneficiary's demographic information. There were a total  
19 of almost 522 million observations in the data set, and  
20 over 13 million MA enrollees and about 3,100 MA plans were  
21 represented in the data, most of them being HMOs and PPOs.

22           The overall quality and usefulness of MA

1 encounter data depend on whether each encounter was in the  
2 data accurately and completely. Therefore, we tested for  
3 the completeness of the encounter data in the following  
4 way:

5           First, we defined the universe of MA enrollees  
6 based on Medicare enrollment data, which include monthly  
7 enrollment status -- whether fee-for-service or MA -- of  
8 every Medicare beneficiary. Using this information as the  
9 reference, we then compared the number of MA enrollees we  
10 see in encounter data to the reference enrollment data. In  
11 other words, from encounter data we calculated the total  
12 number of enrollees by MA plan. Then we compared what we  
13 see in encounter data with the reference enrollment data,  
14 in terms of the number of plans and enrollees. If  
15 encounter data were complete, we would expect to see two  
16 things. One, with respect to plans, the number of MA plans  
17 in encounter data should equal the number in the reference  
18 enrollment data. And, two, with respect to enrollees, the  
19 number of MA enrollees in encounter data should be about 90  
20 to 95 percent of the number in the reference enrollment  
21 data, or roughly the share of MA enrollees using at least  
22 one service during a plan year.

1           From this test, we should be able to infer  
2 whether we have all MA enrollees in encounter data. But we  
3 won't be able to infer whether we have all encounters for  
4 all enrollees.

5           This slide shows the results of our test. Let's  
6 start with the first set of three columns related to the  
7 number of MA plans. The first column shows the number of  
8 plans in the reference enrollment file; the second column  
9 shows the number in encounter data; and the third column  
10 shows the ratio of encounter data divided by the reference  
11 enrollment data. Overall, encounter data contained about  
12 94 percent of MA plans.

13           Now, let's look at the second set in the table,  
14 which shows the analogous information in terms of the  
15 number of MA enrollees. It shows that about 91 percent of  
16 MA enrollees are represented in encounter data. In  
17 general, these results varied by plan type. So throughout  
18 our presentation, whenever we present our analysis by plan  
19 type, we focused on HMOs and PPOs that are not SNPs or  
20 employer group plans that had the majority of MA  
21 enrollment.

22           Before we look at the numbers, we want to mention

1 several important caveats to our preliminary analysis.

2           First, 2012 is the first year of collecting  
3 encounter data. Consequently, there may be issues with  
4 data reporting and data file construction that could limit  
5 the usability of the data to some degree.

6           Second, as with any large-scale data collection  
7 efforts, we would expect there will be some missing  
8 encounters and errors in the data, at least for some plans  
9 more than others.

10           And, third, there are key differences between MA  
11 and fee-for-service -- and among MA plans -- that we  
12 haven't yet adjusted for in our analysis, such as  
13 differences in risk scores and coding practices. All these  
14 factors are very important to understanding how MA  
15 encounter data compare with Medicare fee-for-service data.  
16 So we need to keep these caveats in mind when we look at  
17 the numbers.

18           Here's a preliminary comparison of MA encounter  
19 and fee-for-service data, focusing on services billable  
20 under Medicare's fee schedule for 2012. Those services are  
21 grouped into six broad categories we see on the left side  
22 of the table. For encounter data, which correspond to the

1 first set of numbers in the table, the first column shows  
2 the count of services. And the second column shows the  
3 rate of service use per enrollee, which we calculated by  
4 dividing the count of services by the total number of MA  
5 enrollees. The second set of numbers in the table shows  
6 the analogous information for fee-for-service data.

7           So, as an example, let's look at the first row.  
8 For evaluation and management services, there were 134  
9 million units of service in MA encounter data compared to  
10 426 million units of service in Medicare fee-for-service  
11 data. In terms of use rate per capita, these service  
12 counts translated into 9.9 in encounter data versus 12.9 in  
13 fee-for-service data. Overall, the use rate was generally  
14 lower in MA compared with fee-for-service across most fee  
15 schedule services.

16           On this slide, we continue our preliminary  
17 comparison of MA and fee-for-service. But this time, we  
18 focus on selected E&M services, such as office visits and  
19 hospital visits. The first set of numbers in the table,  
20 consisting of four columns, shows the use rate per capita  
21 for the E&M services listed on the left. The first column  
22 is for all MA plans in encounter data. The second and

1 third columns are for two plan types in encounter data --  
2 HMOs and PPOs -- that are not SNPs or employer group plans.  
3 And the fourth column shows the use rate for fee-for-  
4 service data. Finally, the last column in the table shows  
5 the ratio of the use rate for all MA plans in encounter  
6 data to the use rate in fee-for-service data. In other  
7 words, the first column divided by the fourth column.

8           So, once again, let's look at the first row as an  
9 example. For office visits by established patients, the  
10 use rate is 5.9 visits per capita in encounter data,  
11 whereas it's 6.8 visits in fee-for-service data, resulting  
12 in the ratio of about 90 percent. Overall, the ratio of  
13 use rates in MA versus fee-for-service for selected E&M  
14 services varied across service types, ranging from 40  
15 percent to 90 percent.

16           We also looked at encounter data in two specific  
17 market areas. As you know, Portland is a low fee-for-  
18 service spending area, whereas Miami is a very high fee-  
19 for-service spending area. We limited this part of our  
20 analysis to HMOs and PPOs that are not SNPs or employer  
21 group plans, because these two plan types made up the vast  
22 majority of MA enrollment in each area. In Portland, there

1 were 15 HMOs and 13 PPOs in 2012, with higher enrollment in  
2 PPOs. By contrast, in Miami, there were 38 HMOs but only 2  
3 PPOs, with very low enrollment in PPOs. In both areas, the  
4 overall MA enrollment rate was higher than 50 percent.

5 In terms of reported average risk score, the two  
6 areas were quite different. In Portland, MA reported  
7 higher risk score than fee-for-service. By contrast, the  
8 Miami fee-for-service reported higher risk score than MA.  
9 However, the average risk score was higher in Miami than  
10 Portland overall.

11 This table shows the use rates per capita in  
12 Portland and Miami for fee schedule services grouped into  
13 six broad categories. This is the two-market version of  
14 the table you saw a couple of slides ago. Rather than  
15 going through the table in detail, we'll make a few general  
16 observations at this point, but we are happy to go over the  
17 details on question.

18 The first observation is that the use rate per  
19 capita is higher in Miami compared to Portland. This is  
20 true for fee-for-service -- as noted in red circles -- and  
21 also true for MA -- as noted in yellow.

22 Second, the use rate per capita appears generally

1 higher in fee-for-service compared to MA. This is true in  
2 both Portland and Miami.

3 Finally, within MA, the use rate appears  
4 generally higher for PPOs compared to HMOs. These  
5 observations are perhaps not surprising. In fact, they're  
6 consistent with our general expectations about the two  
7 areas and very stylized differences between MA and fee-for-  
8 service.

9 However, whether and how cleanly these  
10 observations hold up is going to vary by service. We point  
11 to just few examples in this table, which shows the use  
12 rate per capita for selected services.

13 First, let's look at office visits by established  
14 patients in Miami. We actually don't see much difference  
15 between MA and fee-for-service, 7.7 visits for HMOs versus  
16 7.9 visits for fee-for-service. The difference in use  
17 rates is more pronounced in Portland, but there could be  
18 many reasons for that difference. For instance, HMOs may  
19 be more likely to use substitutes for office visits, such  
20 as call centers.

21 The second example is specialist visits for  
22 psychiatry in Miami, which show 1.4 visits per capita for

1 fee-for-service compared with 0.1 visits for HMOs. Once  
2 again, there are various potential reasons for this  
3 difference. The underlying prevalence of mental illness  
4 could be higher in fee-for-service compared with MA, or  
5 fee-for-service and MA may use different types of providers  
6 to treat such illnesses. Without further analysis, it's  
7 hard to know what conclusions or inferences to draw. At a  
8 minimum, applying risk adjustment would likely change the  
9 comparison.

10           Finally, let's look at the row for flu  
11 immunization, which shows a much higher rate for MA in both  
12 Portland and Miami. Anecdotally, we heard that many fee-  
13 for-service beneficiaries get flu vaccine for free in  
14 nontraditional settings, such as health fairs, retail  
15 stores, et cetera. But those cases might not be captured  
16 in fee-for-service claims. By contrast, flu vaccine is one  
17 of the HEDIS measures, and there's a strong incentive for  
18 MA plans to capture that information. Therefore, the  
19 reason for the difference in flu vaccine rates might be  
20 more about what's missing in fee-for-service claims rather  
21 than anything else.

22           These examples point out the challenges in

1 interpreting what the numbers actually mean and the  
2 importance of keeping our caveats in mind when looking at  
3 the numbers.

4           We've just begun our analysis of encounter data,  
5 and what we presented today is a preliminary analysis of  
6 just one part of the data. For next steps, we'll refine  
7 our current analysis, for example, apply risk adjustment;  
8 analyze other parts of encounter data, such as hospital  
9 inpatient and post-acute services; and explore using  
10 encounter data for the purpose of risk adjustment in MA;  
11 and any additional issues and questions of interest for the  
12 Commission. We look forward to your discussion and  
13 guidance on our next steps.

14           That concludes our presentation, and we are happy  
15 to answer your questions.

16           DR. CROSSON: Thank you, Julie.

17           We are going to go and do a round of clarifying  
18 questions, and I am going to start with one, and it applies  
19 to a number of charts.

20           One subset of MA plans, actually one subset of  
21 HMO MA plans are plans that have an integrated delivery  
22 system, and where the delivery system, particularly the

1 physicians, are capitated.

2 I came from one earlier in my life. One of the  
3 things that I have seen increasingly in those systems is  
4 the use of alternatives to direct patient encounters, and  
5 that would include things like phone visits, e-mail  
6 communication with patients, in some cases telemedicine,  
7 things that are generally not covered in fee-for-service  
8 Medicare at least at the moment.

9 So I guess my question is, Is it possible down  
10 the line as this evaluation goes on that we could capture  
11 those types of visits on the MA side for those plans who  
12 employ that sort of care delivery?

13 DR. LEE: So, in encounter data, we do have plan  
14 numbers, so we can track the encounters by plan. Now, to  
15 the extent that we can characterize the plans on those  
16 dimensions, then we should be able to categorize the plans  
17 by those characteristics.

18 DR. CROSSON: Right. And so that information,  
19 that categorization, is not present, but it's possible, for  
20 example, that we could sample?

21 DR. LEE: Yes. I mean, for example, we can go  
22 and look at the contract employee number for Kaiser, for

1 example.

2 DR. CROSSON: Some organization you chose  
3 randomly, I assume.

4 [Laughter.]

5 DR. CROSSON: But there actually are plenty of  
6 others. But thank you. That's an answer to my question.

7 Okay. So let's start on the right this time with  
8 clarifying questions. Is that a pass or a wave or --

9 DR. NERENZ: I'm sorry. Pass.

10 DR. CROSSON: Holy mackerel. What are we going  
11 to do with the time? Kate.

12 DR. BAICKER: I'll fill it.

13 [Laughter.]

14 DR. BAICKER: No, no. I'm just really excited  
15 about these data. It's wonderful to have them, and just a  
16 couple of clarifying questions about what you have. I  
17 realize this is just a first pass at the analysis, but  
18 you're focusing here on Part B-type services. My  
19 understanding is you've got the Part A-type services. It's  
20 just harder to make apples-to-apples. So you feel as  
21 though you have the -- first question is, Do you have the  
22 universe of utilization from the plans for whom you have

1 them as much as you know the buckets? I realize if an  
2 individual encounter was missing, you'd have no way of  
3 knowing that.

4           And then the second question is, When you have 90  
5 percent of plans represented or of enrollees represented,  
6 do you have a sense of whether that is 100 percent of a  
7 bunch of insurers, but one insurer is missing, or it's all  
8 of the insurers are present, but only 90 percent of their  
9 enrollees are there, or is it some insurers are giving you  
10 all of their enrollees, and a few are only giving you 50  
11 percent? I'm trying to get a sense of whether I should be  
12 thinking about the missing 10 percent as just a random  
13 smattering or if it's not representative in some particular  
14 ways. So those are my two data questions.

15           DR. LEE: In general, in terms of missing plans,  
16 they are mostly in the category of special plans, so like a  
17 patient's cost of their plans. And the CMS told us that  
18 they are under different special rules for submitting  
19 encounter data, so it is expected that more of them should  
20 be missing.

21           Now, outside of those plans, we have about 98  
22 percent of the plans. So it is just kind of looking at the

1 data by plan. It's more likely that we have each plan, but  
2 it's more some plans be -- we are seeing a much smaller  
3 share of enrollees compared to others. So I think it is --  
4 rather than a plan, that entire plan is missing or not,  
5 it's more of some of the encounters or some enrollees are  
6 missing. I think that is more likely.

7 DR. BAICKER: And then the universe of data?

8 DR. LEE: I'm sorry. On the universe of --

9 DR. BAICKER: So you have every category of  
10 encounter you think is present.

11 DR. LEE: Mm-hmm.

12 DR. BAICKER: You haven't analyzed them all yet,  
13 but you think that the encounter data are complete in terms  
14 of the types of utilization from inpatient to outpatient to  
15 prescriptions to equipment to whatever, all the categories.

16 DR. LEE: So we should have what's equivalent to  
17 Part A and Part B, all services. Now what we do not have a  
18 good sense of is a particular type of service that is more  
19 likely to be missing encounter, so not -- that, we do not  
20 have a sense of.

21 DR. BAICKER: Thank you.

22 DR. CROSSON: Jack.

1 DR. HOADLEY: Right now, you have data for 2012.  
2 Is there a sense -- I know in the Part D world, the gap  
3 between the current day and the available data got shorter  
4 over time. Is there a sense that there will always going  
5 to be like a three-year lag, or is there a sense that they  
6 might get it sooner in time?

7 DR. MILLER: Jim, you might have a better feel  
8 for this.

9 DR. HOADLEY: Yeah.

10 DR. MATHEWS: We would expect to receive 2013 and  
11 2014 data within the next, say, six-month time horizon.

12 DR. HOADLEY: So it will catch up. That's  
13 useful.

14 And the data include utilization. Do they have  
15 any kind of price attached?

16 DR. LEE: For 2012, the extract that we have, we  
17 do not have payment data.

18 DR. HOADLEY: Okay.

19 DR. LEE: For encounter data, that plans to  
20 submit. They do have that.

21 DR. HOADLEY: Okay.

22 DR. LEE: We just do not have it.

1 DR. HOADLEY: You don't have it, okay.

2 And in terms of as you're working through things,  
3 you do have Part D drugs as part of these data sets?

4 DR. LEE: Yes.

5 DR. HOADLEY: Okay.

6 DR. MILLER: And just on the payments, Jim,  
7 Julie, we do want to set a lower bar there. We expect more  
8 potential caveats associated with that than even this.

9 Is that fair, Jim, or --

10 DR. MATHEWS: Yes. It would require some  
11 additional analytic work once we have the 2013 and 2014  
12 files to establish what it is we were looking at with  
13 respect to a payment number that appeared on a field. Is  
14 it a per-enrollee, per-diem payment for a hospital stay?  
15 Is it a pro-rated DRG stay? Is it a fraction of a  
16 capitated payment? There would be a great number of  
17 caveats that we would have to work through.

18 DR. CROSSON: If I remember this, rightly --  
19 Scott, you can probably correct me here, but I think on the  
20 MA side, there's a calculation of what the average office  
21 visit would cost as opposed to what -- on fee-for-service,  
22 what the actual office visits cost, or is that not the

1 current methodology?

2 DR. MILLER: I would say we don't know, and what  
3 I would say is I am going to try and keep you guys focused  
4 on utilization as long as I can before I can get into the  
5 payment side of things because I think it's going to be a  
6 lot more complicated, and I'm terrified of it.

7 DR. CROSSON: Where were we? Cori?

8 MS. UCCELLO: So I just want to make sure I  
9 understood your answer to Kate in terms of the plans who  
10 have submitted data that we know are in there. Those  
11 plans, there are missing encounters likely within those  
12 plans, so it's not like -- the plans that submitted did not  
13 necessarily submit 100 percent.

14 DR. LEE: So the -- yes. So, even where we seem  
15 to be seeing most of the number of enrollees in terms of  
16 just for a given plan number of enrollees, that number  
17 seems reasonable. We expected that for those enrollees,  
18 some encounters could be missing. We just do not know  
19 that.

20 One thing that one MA plan told us about the data  
21 submission process is that whatever the information they  
22 get out of their claims system, that when those data get

1 submitted to CMS through the encounter data system, some  
2 encounters can be rejected if you do not have all the  
3 fields populated or for various reasons. And they are  
4 supposed to correct those encounters and resubmit them.

5 I think there is a variation on how well they  
6 follow through on those submissions to get resubmitted. So  
7 I think they are kind of in the process where potentially  
8 the encounters could end up missing.

9 MS. UCCELLO: And I think you may have said this  
10 in the paper, but I just can't recall. So these tables  
11 that show per capita rates for MA plans, because we don't  
12 have all of the enrollees in the data, but you're using as  
13 the denominator, total -- or are you using total MA  
14 enrollees, the total enrollees that are in the data?

15 DR. LEE: So for the per capita use rate  
16 calculation, we are using the total number of enrollees  
17 from the trustees report, so it is not from encounter data.

18 So if they are missing encounters in encounter  
19 data, that is going to lower your per capita use rate.

20 DR. CROSSON: Warner?

21 MR. THOMAS: Just a clarifying question. On  
22 slide 10, the comparison of the two market areas, I was

1 surprised under Miami-Dade that the risk score for fee-for-  
2 service is actually higher than HMO because I think there's  
3 been a lot of talk that HMO scores -- or given the work  
4 done there on the risk scores are higher. Is this true  
5 kind of with all the data you look at or just really in  
6 this marketplace?

7 DR. LEE: These are just for these two  
8 marketplaces.

9 MR. THOMAS: Do you have the risk scores for  
10 traditional fee-for-service and all of the MA data  
11 submitted to compare?

12 DR. LEE: Overall, it is higher in fee-for-  
13 service. We looked at everybody.

14 MR. THOMAS: It's higher in fee-for-service or  
15 MA?

16 DR. LEE: It's -- oh. Oh, hold on. I did put it  
17 in the paper, so I think it is actually --

18 DR. REDBERG: It is 1.15 --

19 DR. LEE: Yes. It is higher in MA versus -- yes.

20 DR. REDBERG: On page 6.

21 MR. THOMAS: Okay, thanks.

22 DR. CROSSON: Going down, clarifying questions?

1 Rita.

2 DR. REDBERG: Related to that, do you just have -  
3 - first of all, thank you for doing this report. It is  
4 really helpful to start preliminary looking at this data.  
5 Do you have the age and sex for MA versus fee-for-service?

6 DR. LEE: I have that enrollee information in the  
7 data. We have not actually looked at those specific types.

8 DR. REDBERG: Okay. I was just interested in  
9 seeing, sort of in a broad cut, what the difference was,  
10 and then not really clarifying, but we talked this morning  
11 or at least it was mentioned in the mailing materials for  
12 the update on Medicare payment that more people are moving  
13 into MA. And I'm wondering if we have any insight into why  
14 more people are moving into MA, but that's a little --  
15 because it would impact sort of -- I don't know if it's  
16 related to these encounter data or not, but it's suggested  
17 that at all levels, new enrollees and that people are  
18 switching from fee-for-service to MA. But I wasn't clear  
19 if we know why.

20 DR. LEE: So that, we should -- okay. It is  
21 going to require more than one year of being able to see if  
22 we are from year one, the beneficiaries that were in

1 encounter data versus year two, how many of them are still  
2 in or not. But if they are not in, we would not be able to  
3 tell why they are not in.

4 DR. CROSSON: Rita, later we will be taking a  
5 comprehensive look at MA for the March report, so we'll get  
6 that.

7 DR. REDBERG: Thank you.

8 DR. CROSSON: Clarifying questions. Okay. So  
9 I'm looking for somebody to start the discussion who has no  
10 interest in this topic.

11 [Laughter.]

12 DR. CROSSON: Craig.

13 DR. SAMITT: So thank you for this report. I've  
14 been waiting for this day for three years, so I'm very  
15 excited to be able to respond to this.

16 There are three things that I'd love to comment  
17 on. One is we've never really had a chance to discuss,  
18 once we had the encounter data, what we wanted to do with  
19 it, and so I would be interested in feedback from the  
20 balance of the Commission as to the types of answers that  
21 we would want to have, now that we have the wealth of this  
22 information.

1           The reason I believe we've raised it multiple  
2 times over the course of the last few years is the desire  
3 to really look for innovation in MA versus fee-for-service,  
4 that there are greater degrees of flexibility that as we  
5 look to identify additional payment policy recommendations,  
6 we can truly see under the freedom of aligned incentives,  
7 what may be done differently within MA versus fee-for-  
8 service. And so my primary interest would really be to get  
9 at that, where do we see true differences that would  
10 suggest higher quality outcomes at a lower cost under the  
11 MA environment, and if the data can provide us that  
12 information, that would be incredibly useful. So I think  
13 we should brainstorm that a little bit before going deeper  
14 into the analysis.

15           The second comment that I would make is that I am  
16 concerned about averaging, and I know that we have divided  
17 HMO from PPO, but I think going to Jay's point a little  
18 bit, I think we have to realize that not all MA plans are  
19 alike. And even within products, between products they're  
20 not alike. So I think we need to identify ways to study  
21 encounter data at broader or additional subsets of the  
22 division of the MA pool.

1           So, for example, I would be interested in looking  
2 at utilization patterns of all of the five-star MA plans  
3 versus all of the other MA plans. We already presumed that  
4 they're higher quality. Let's see what the difference  
5 would be in utilization in those plans. So Kaiser, in  
6 addition to others, would fall into that category. Let's  
7 see what they look like comparatively. so that would be  
8 the second thing. I think we would want to decide, beyond  
9 just geographic differences, what are the other differences  
10 in MA plans that we would want to study.

11           And then the third thing that I would say is  
12 addressed with your caveats. I think we should be careful  
13 about how we believe we want to use this information. I'd  
14 be curious to understand how CMS wants to use this  
15 information as well because I think it's premature to think  
16 about using it at any respect, especially for things like  
17 including encounter data in risk score methodologies. It  
18 seems like it's way too premature to think about that  
19 without validating the dataset and understanding what's in,  
20 what's out, what may be missing, and the differences in  
21 what encounter data gives us versus BID data versus RAPS  
22 data, I think they're all different. And we should be

1 careful not to create bridges between the three, assuming  
2 that they're all aligned, until we really study the dataset  
3 a little bit more carefully.

4 DR. MILLER: Can I just ask? What was the last  
5 RAPS data? Am I just missing some vocabulary?

6 DR. SAMITT: So the data elements that would be  
7 used to discuss risk score, risk adjustment, which  
8 currently does not include encounter data as part of that  
9 risk adjustment methodology, as I understand it.

10 DR. MILLER: Let me just ask this: Are you guys  
11 familiar with the vocabulary he's using? Okay. I'm out of  
12 the loop. You keep going.

13 DR. CROSSON: RAPS. He's talking about RAPS.

14 Craig, what is that?

15 DR. MILLER: All my crew know, so you're good.

16 DR. CROSSON: Oh, they all know? So it's just  
17 you and me? It's just you and me. No, it's just you and  
18 me.

19 DR. MILLER: We'll ask them after --

20 DR. CROSSON: Okay.

21 DR. MILLER: You're good. Craig, you're good.

22 You're good.

1 [Laughter.]

2 DR. CROSSON: All right. Okay. Thank you,  
3 Craig, and let's have a discussion on this topic starting  
4 at this end this time. Rita?

5 DR. REDBERG: So, thank you. And, building on  
6 that, I would be interested as we get into the data in  
7 looking at comparing outcomes, because, clearly, there is  
8 difference in utilization of all kinds of services between  
9 fee-for-service and MA, and so it would be helpful to see  
10 what the outcomes difference are. Perhaps we could do it  
11 by big diagnostic groups, you know, heart failure or atrial  
12 fibrillation, joint replacement, other, and look at those,  
13 because it would help us just get a little more insight  
14 into what was going on and what was driving those  
15 differences as well as understanding the populations that  
16 are -- particularly with the movement that I just commented  
17 on from fee-for-service to MA that we've seen in the last  
18 few years.

19 DR. CROSSON: Moving on down this way, then  
20 coming, coming, coming -- Cori.

21 MS. UCCELLO: Notwithstanding Craig's hesitation  
22 about using this to look at risk adjustment, I think we

1 need to think about exploring these data to look at risk  
2 adjustment. So, I think, you know, we do need to kind of  
3 just look at this more and make sure we're comfortable with  
4 it, but I think that is a primary area that I think you're  
5 already planning to look at, but I think it's an  
6 appropriate thing to be doing.

7 DR. CROSSON: Jack.

8 DR. HOADLEY: So, I want to second what, Jay, you  
9 started and Craig added in terms of thinking about  
10 different types of plans. I mean, it's unfortunate we  
11 don't really have a variable, typically in administrative  
12 data, on sort of what defines an integrated plan. So,  
13 figuring out how to sort of capture that is obviously its  
14 own methodological challenge. But, I think it really will  
15 be useful to try to pick up on the fact that one MA plan is  
16 not another MA plan, try to understand what we're seeing,  
17 and maybe part of that can be driven by the data, to see  
18 what -- find the subset of plans that differentiate in the  
19 same way we look at things like efficient hospitals and  
20 stuff like that.

21 I think there's other variables about markets. I  
22 mean, you've already obviously shown some real interesting

1 examples with the two markets, but I'm thinking of share of  
2 the market that's in MA, or do we see something different  
3 in small penetration markets versus large penetration  
4 markets, the maturity of the market in terms of its use of  
5 MA, if it's one that's been doing Medicare Advantage for  
6 many years versus others that have been doing it only for a  
7 relatively short period of time in terms of significant  
8 amount of penetration. So, it might -- I think exploiting  
9 the differences across markets would be useful.

10           The other thing I wanted to do, and I'm looking  
11 at Slide 9 as just kind of a way to -- it sort of picks up  
12 on this caveat that we don't want to over-interpret what we  
13 see, but to use that as a kickoff point to ask questions.  
14 So, when I see 5.9 office visits versus 6.8, and then I see  
15 1.7 hospital visits versus 2.9, that makes me say, okay,  
16 that's really interesting, but what's underneath that?  
17 Obviously, when you start to look at hospital use, the  
18 natural question is, okay, if the MA plans have, on  
19 average, much lower hospital use, how do you reflect that  
20 this is just the natural consequence of differences in  
21 hospital use.

22           And, I think, throughout these, we should be

1 looking, you know, let's look at the psychiatry differences  
2 or their nursing home differences, which have even larger  
3 ratios. Is there something -- you know, does the nursing  
4 home difference reflect a different patient mix that's  
5 going in, or does it reflect different decisions on how to  
6 use nursing homes? Until you get the Part A data to put  
7 together with this, I wouldn't want to over-read that, oh,  
8 somehow the MA plans are doing a better job at controlling  
9 nursing home visits. In fact, maybe it's different uses of  
10 nursing homes, which, in turn, comes down to what the  
11 physicians are doing.

12           Anyway, I think you know probably all of this,  
13 but sort of how these pieces fit together to tell a  
14 complete story, you know, which is to me both the  
15 suggestion of why these are really exciting to start to  
16 see, but they trigger more questions, and you're exactly  
17 right on size that we don't want to draw too many  
18 conclusions until we start to disentangle all the pieces.  
19 So, this is just one where I can start to see the natural  
20 questions -- the threads that I'd like to pull on if I were  
21 the data analyst on this.

22           DR. CROSSON: Alice.

1 DR. COOMBS: I'd be interested in something that  
2 probably would be very hard, maybe very hard to get, and  
3 that would be, first of all, if you were to tease out  
4 vulnerable populations by indicating a certain indicator  
5 with one group versus fee-for-service and looking at  
6 whether or not there were kind of disruptive innovations  
7 that were happening in the MA plan to result in better  
8 outcomes or if there are better outcomes.

9 And, then, the other thing I was interested in is  
10 looking at how much of the decrease in the hospitalization  
11 is a result of more OPD activity, and I don't know that  
12 that is broken out here --

13 DR. CROSSON: Do you mean hospital OPD or --

14 DR. COOMBS: Yes, hospital OPD, maybe counter to  
15 visits. I don't know how it would fall out on this graph  
16 on page nine. But, other things that are interventions  
17 that result in -- say, for instance, the psychiatry piece,  
18 I was trying to envision why there would be less site  
19 visits. It might be that they're using psych surrogates,  
20 people who fulfill the same kind of role with the same kind  
21 of coverage, and that might be an area of opportunity for  
22 clinical -- meeting the clinical access demands as well as,

1 you know, providing patients with what they need at one  
2 level and maybe a referral process to psychiatry for  
3 certain things. So, it's true that sometimes patients will  
4 be under your umbrella and you will be able to triage them  
5 more effectively, depending on what their diagnosis is.  
6 So, that would be one thing.

7 I think what I've always wondered in the back of  
8 my little brain is what is the comparison, basically, MA  
9 plans. Do they really look like fee-for-service,  
10 especially in what the high-cost and the low-cost markets?  
11 What's the difference in those areas.

12 DR. CROSSON: So, the first part of the question,  
13 Julie, race and ethnicity. Is that in the database or is  
14 it not?

15 DR. LEE: I think race is.

16 DR. CROSSON: Okay.

17 DR. LEE: But, I do not remember how many  
18 categories. I bet there are only the traditional five  
19 categories in that.

20 DR. CROSSON: But, it is possible to look at  
21 that.

22 Jon -- oh, sorry. Kate.

1 DR. BAICKER: So, there are all sorts of  
2 interesting possibilities, and I'm sure you're going to  
3 have a wish list that is longer than could possibly be  
4 addressed with the time available, so I'm happy to throw  
5 some more things on.

6 I share Cori's fixation on risk adjustors. I do  
7 think it's really important, and so much of the payment  
8 adjustment that we do -- what? I see you doing something  
9 over there.

10 [Laughter.]

11 DR. CROSSON: I'm doing this, doing this.

12 DR. MILLER: It's directed at Cori.

13 DR. BAICKER: Okay, good.

14 DR. MILLER: Cori's obsession.

15 [Laughter.]

16 DR. BAICKER: It's a good obsession, because so  
17 much of what we do in payment modeling is -- or trying to  
18 minimize incentives for cream skimming, adjust payments  
19 across settings, hinges on risk adjustors drawn from a very  
20 particular setting that may not, in fact, be correctly  
21 applied in a different setting. So, exploring the  
22 robustness of the specific risk adjustors in these

1 different populations, I think, is of first order  
2 importance.

3           And then, also, of course, I take with even more  
4 grains of salt the preliminary results that are shown here  
5 when you have not yet been able to fully incorporate risk  
6 adjustors, because who knows what's going on about the  
7 patient mix in the different areas. We know there are two  
8 factors at work. As per Warner's point, there is both  
9 selection of different types of patients into MA versus  
10 fee-for-service and then conditional on the type of  
11 patient, differential coding of particular characteristics.  
12 So, we're not yet at apples-to-apples, so I take this as an  
13 example of what analysis might look like rather than the  
14 final numbers you'd want to hang your hat on.

15           Once we get closer to those final numbers, I'd  
16 love to see more about the disease management and mix of  
17 care along the lines Jack was saying. Does it look like  
18 there is substitution of one kind of care for another kind  
19 of care? Are people being treated in lower-cost settings  
20 with no adverse consequences? Is one kind of use staving  
21 off another kind of use? And, of course, just  
22 observationally, you're going to get some correlations

1 without causal connections necessarily, but there's a whole  
2 cottage industry of academic researchers who are trying to  
3 sort of sneak their way into these questions without these  
4 data -- and, by the way, when do we get these data?

5 [Laughter.]

6 DR. BAICKER: -- sneak their way into these  
7 answers by, you know --

8 DR. MILLER: Not until Craig has had all of it  
9 for a while.

10 [Laughter.]

11 DR. BAICKER: I have got to chat with Craig.

12 So, there are people who have done lots of  
13 examples with just one insurer because they've got that  
14 insurer's data, or you can look in just the hospital  
15 setting if you have hospital discharge records that include  
16 MA and fee-for-service. But, there's no -- and those  
17 researchers have developed strategies for isolating causal  
18 effects that could be applied much more productively to  
19 these data and that would let you get at some more causal  
20 connections between substitution of one kind of care for  
21 another care, how care management affects outcomes and  
22 total expenditures, and all of that, and I think that would

1 give us some important insights into improving value  
2 throughout the system.

3 DR. CROSSON: Jon.

4 DR. CHRISTIANSON: Julie, when we get the next  
5 data that Jim talked about, six months or whatever that  
6 time is going to be, when we get that data, will we be able  
7 to look at the fee-for-service beneficiaries and see which  
8 ones are attributed to ACOs and be able to do an  
9 MA/ACO/fee-for-service comparison in markets where the ACOs  
10 existed?

11 DR. MILLER: I'm going to say, we think so. We  
12 should be able to know --

13 DR. CHRISTIANSON: I would put that on my list of  
14 things I'd want to see, in that case. I think we've talked  
15 a lot about trying to understand whether anything different  
16 is going on in terms of care delivery in ACOs versus MA  
17 plans versus fee-for-service.

18 DR. MILLER: Yeah, and so it would be -- we would  
19 have the encounter observations, then try and break fee-  
20 for-service into a couple of categories. Yeah. We can  
21 start thinking about that, and that's enough lead time that  
22 whatever problems, we can start sorting through.

1 DR. CROSSON: Scott.

2 MR. ARMSTRONG: Just briefly, to amplify two  
3 points that my colleagues have made, maybe in slightly  
4 different words. I really thought Craig's comment about  
5 we're doing this because we're looking for outcomes that  
6 confirm that innovations are working in our MA plans, I  
7 like that, and maybe even to the question about ACOs. I  
8 wouldn't just keep it an open slate, though. I mean, I  
9 would look at, well, what do we already have teed up in the  
10 next year or two as policy agendas that we think without  
11 this data could advance our cause and actually focus in on  
12 whether this data gives more insight sooner rather than  
13 later to whether, in fact, we were right about that or not.  
14 So, but I think that's really a great way of thinking about  
15 this.

16 And then, second, to a point, Jay, you brought up  
17 earlier, but it's been alluded to a few times. I don't  
18 know enough about how this is reported and analyzed, but  
19 encounters are changing. We have many practices where 60,  
20 70 percent of the interactions our primary care providers  
21 have with their patients are through e-mail and by  
22 telephone. We've seen a number of group visits skyrocket

1 for all sorts of different populations. We have providers  
2 who will show up at fitness classes, who will do, you know,  
3 clinical visits afterward and before. And, I just don't  
4 know how that has -- and these are good, and we want to  
5 promote that, but I don't know how that has any influence,  
6 then, on the information that we're looking at.

7           So, just as we get into this a little bit more,  
8 remind ourselves to ask questions about are we really clear  
9 about what we are actually -- are they apples-to-apples  
10 that we're comparing.

11           DR. CROSSON: Kathy.

12           MS. BUTO: Just a question of whether you can get  
13 Part B pharmaceutical data in this list. I think it would  
14 be helpful to know the use rate. It doesn't break out that  
15 way?

16           DR. LEE: Actually, I don't think we have Part D  
17 data.

18           MS. BUTO: I know there are E&M services  
19 associated with drug administration.

20           DR. MILLER: Well, I want to --

21           MS. BUTO: We might be able to do something --

22           DR. MILLER: I want to clarify what's going on

1 here. So, if you're talking -- did you say utilization  
2 data, or did you qualify it, or did you just say Part D  
3 data?

4 MS. BUTO: Any Part B -- B --

5 DR. MILLER: Oh, B.

6 DR. CROSSON: Oh, B. It sounded like you were  
7 saying --

8 MS. BUTO: Part B.

9 DR. MILLER: Okay.

10 MS. BUTO: Not D. No, I assume D is separate  
11 from this.

12 DR. MILLER: It is, and that's why I  
13 misunderstood what you were asking.

14 MS. BUTO: And this is Part B data, right?

15 DR. MILLER: Okay. I misunderstood. I thought  
16 you were saying D, as in dog. So, I'm sorry, Julie. Back  
17 to you.

18 DR. LEE: Yes, so we -- I'm sorry. Can you say  
19 your question again?

20 MS. BUTO: I just wondered if you could get a  
21 breakdown, not on the E&M service per se, but there's  
22 another list, all fee schedule services, and I don't know

1 if you can break out Part B, because, obviously, you've got  
2 administration codes, but ultimately, we just want to know  
3 how fee-for-service and MA compare, I think, in the use of  
4 Part B drugs, would be my question.

5 DR. LEE: So, as long as there's a code, then I  
6 should be able to --

7 MS. BUTO: You can find it?

8 DR. LEE: Yes.

9 MS. BUTO: Okay.

10 DR. MILLER: But, I also see the way you're going  
11 at it. To the extent that somebody infuses something,  
12 there should be an administration code and we should -- and  
13 you're saying, could we tease that out. Yeah, I think if  
14 it's been submitted, we should be able to find it.

15 MS. BUTO: [Off microphone.] If we're looking at  
16 drugs, we ought to --

17 DR. MILLER: Absolutely.

18 MS. BUTO: -- and we're looking at this, why not  
19 --

20 DR. MILLER: I completely get it.

21 DR. CROSSON: Herb.

22 MR. KUHN: So, I'm like everybody else. There's

1 lots of opportunities here in the area of program  
2 improvement. I like what Craig and Scott have said about  
3 the opportunities to study and evaluate innovations. I  
4 think that's a great opportunity.

5           But, also, I think, going to this issue of risk  
6 adjustment, and I agree with Craig that you don't want to  
7 kind of venture into this area, and I wouldn't --  
8 hopefully, CMS wouldn't venture into this area until fully  
9 validated data. I think that's just dangerous to the  
10 program. But, at the same time, we suspect that they  
11 probably will want to do this, or someone will advance that  
12 notion, and would it be a proper place for the Commission  
13 to at least begin to think about what would be the right  
14 way to do that so that perhaps it could influence some of  
15 that development, or if they had a specific proposal, then  
16 we would have a basis or platform on which to comment on  
17 that to help guide that policy going forward.

18           So, I think, even absent the validation, I think  
19 it is worth doing some of the development work in the area  
20 of risk adjustment just to be prepared to help either  
21 influence or to be able to react that's out there. But, I  
22 completely agree, I think it's dangerous without pure

1 validation.

2           Having said that, there might be other areas  
3 where this data could be helpful in terms of program  
4 improvement, and one might be are there elements in the  
5 payment system that it could help refine part of that  
6 process. Is that something to look at?

7           And then, finally, in the coding adjustment area.  
8 I think CMS is pretty sophisticated at looking at coding  
9 adjustment, but is there anything here that can help  
10 influence that or refine the process more.

11           DR. CROSSON: Thank you. Moving down -- nobody.  
12 David.

13           DR. NERENZ: Well, just a quick observation, that  
14 I'm attracted to the idea of using individual plan as the  
15 level of analysis and the kind of traction you might get  
16 here. In what we've seen, plans are grouped together,  
17 either all of one type, or one type in a community, and  
18 that's fine. We see interesting things. But, a plan is a  
19 real thing. It's got real boundaries. It's got real  
20 members at a period of time. It's got a management  
21 structure. It's got characteristics. And, there are  
22 things that we can do with that that you can't typically

1 do, then, with fee-for-service data.

2           So, I'm imagining, for example, by variant plots  
3 where you have on the one hand a member level risk score or  
4 severity score, and on the other hand you have utilization  
5 or cost or something, and you can start seeing outliers.  
6 You can see those who are doing sort of remarkably, what  
7 appears to be good, efficient utilization, perhaps in a  
8 high severity population. You can see the other side.  
9 And, you can see it at the plan level and then you can  
10 start to identify, are there characteristics of the plans  
11 that live in this quadrant or that quadrant or wherever it  
12 is.

13           So, just as a very generic observation, I'd like  
14 to see us capitalize on the individual plan structure or  
15 the data set and see what we can learn from it.

16           DR. CROSSON: Yeah. I think, you know, for  
17 example, as we move towards more subcategorization, you  
18 know, as Jack suggested and Craig, if we move to more  
19 subcategorization, if we start seeing significant  
20 differences emerge, then there's a suggestion maybe that we  
21 need to go further, even down to individual plan level, in  
22 order to understand, at least on a sampling basis, the

1 reasons for those differences.

2           Yeah, Jack.

3           DR. HOADLEY: So, one other thing that occurred  
4 to me, looking again at this table here, I'm thinking about  
5 that line on the psych differences. The HMOs and PPOs  
6 you're looking at here exclude the SNFs, is that right, and  
7 so the fee-for-service, however, would include dual-  
8 eligibles, because you're using all fee-for-service here.  
9 So, that's another, I think, caveat, and we, obviously, at  
10 some point need to think about, you know, with or without -  
11 - most duals that are on the Medicare Advantage side are in  
12 SNFs. There would be some in any other plan, but the share  
13 would be a lot less. So, that's another kind of variable  
14 that probably pretty quickly needs to be teased out before  
15 anybody wants to start drawing anything like a conclusion.

16           And, one other question. This would be  
17 considerably down the line, I would assume, but there's no  
18 reason we could not link these encounter data to Part D  
19 MAPD data. We'd have the patient identifier, I assume,  
20 that would allow that linkage?

21           DR. MILLER: If Shinobu will let us, yes.

22           [Laughter.]

1 DR. MILLER: But, yeah. In theory, we should be  
2 able to start to knit this across with the --

3 DR. HOADLEY: Yeah. I mean --

4 DR. MILLER: -- with the D data, which is what I  
5 started with Kathy with --

6 DR. HOADLEY: Right. That's why I thought of the  
7 question.

8 DR. MILLER: Yeah.

9 DR. HOADLEY: I mean, that might be several years  
10 down the road yet, but --

11 DR. CROSSON: Okay. Thank you very much, Julie.  
12 Again, the beginning of a very interesting highway.

13 [Pause.]

14 DR. CROSSON: Okay. So now we're going to move  
15 to the final discussion of the day, final presentation.  
16 Carlos is going to take us through the Medicare Advantage  
17 plan star ratings, and we'll focus in on some factors  
18 influencing those, and I think in this particularly  
19 presentation, although it's preliminary, we may be wanting  
20 to provide some direction in terms of some paths with  
21 different levels of complexity involved.

22 Carlos?

1 MR. ZARABOZO: Thank you, and since Julie was so  
2 efficient in the use of her time, I guess I have a lot of  
3 time for this presentation.

4 DR. CROSSON: You do.

5 MR. ZARABOZO: It can be very leisurely, so just  
6 to be respectful of your time, do you have any evening  
7 plans that begin prior to 9 p.m.?

8 [Laughter.]

9 MR. ZARABOZO: Okay then.

10 DR. MILLER: Carlos, I told you not to do that.

11 MR. ZARABOZO: So as Jay said, I am going to be  
12 presenting the results of work we have been doing looking  
13 at the star ratings of Medicare Advantage plans and what  
14 explains some of the variation in ratings across plans for  
15 particular populations. And since you just finished  
16 talking about plans, when I use the term "plan" here, it  
17 means contract. So there are thousands of plans, as Julie  
18 pointed out, but the number of contracts that I looked at  
19 for these data were 269. So this is contract because the  
20 star ratings are assigned at the contract level.

21 In the presentation we will first review how star  
22 ratings and eligibility for bonus payments are determined,

1 discuss why we're looking at this issue, and talk about our  
2 findings and CMS' findings. Then we'll conclude with a  
3 discussion of options for addressing the issues.

4           Since 2012, Medicare Advantage plans have been  
5 eligible for quality bonus payments. Plans are evaluated  
6 on their quality using a five-star rating system, and those  
7 that receive a star rating of four or higher receive a  
8 bonus payment. The bonus takes the form of an increase in  
9 the plan's payment benchmark.

10           A plan's star rating also determines the level of  
11 rebates a plan can offer when the plan bid is below the  
12 benchmark.

13           A plan's overall star rating, which determines  
14 its bonus status, is based on the plan's performance on a  
15 collection of measures that evaluate quality and contract  
16 performance. In the data that I have, there were 44  
17 measures unique quality measures. Currently there are 45  
18 measures. For MA plans, they include -- this is for  
19 measures judging an MAPD plan that includes drug coverage.

20           The 44 measures include measures of improvement  
21 and one for health improvement and one for drug plan  
22 improvement, which CMS calculates based on the results from

1 the 42 other measures.

2           The issue that we are examining is whether there  
3 are systematic population differences in the star rating  
4 system with respect to certain populations. Plans with a  
5 high share of low-income beneficiaries maintain that they  
6 are unable to perform as well on quality measures because  
7 their enrollees have more complex care needs and their  
8 socioeconomic status makes it difficult for the plans to  
9 provide optimal care.

10           This is important to certain plans, because for  
11 some plans their enrollment can consist entirely of  
12 beneficiaries who are dually eligible for Medicare and  
13 Medicaid. The law allows special needs plans for the  
14 dually eligible, or D-SNPs, to exclusively enroll only  
15 dually eligible beneficiaries.

16           The problem that the Commission has had with the  
17 argument made by D-SNPs is that there are plans that enroll  
18 only the dually eligible and yet they are able to do well  
19 in the star rating system. So if some plans have good  
20 performance, why do others not perform as well? One  
21 possibility, as suggested to us by a plan representative,  
22 is in the nature of some of the D-SNP plans. For

1 historical reasons, some D-SNPs have been allowed to enroll  
2 only beneficiaries age 65 or older. Beneficiaries under  
3 the age of 65 -- that is, beneficiaries entitled to  
4 Medicare on the basis of disability -- are not allowed to  
5 enroll in the legacy D-SNPs that are for the aged only.

6 In the March 2015 report, we looked at plan  
7 overall star ratings in relation to shares of enrollment of  
8 the under 65 -- that is, Medicare beneficiaries entitled  
9 based on disability or end-stage renal disease. We found  
10 an association between high shares of enrollees with  
11 disabilities and low star ratings. Within the D-SNP group,  
12 star ratings were better among plans enrolling only the  
13 aged. In the most recent star ratings, the only bonus-  
14 level plans that exclusively enrolled the dually eligible  
15 were the D-SNPs that limit their enrollment to  
16 beneficiaries age 65 or older.

17 CMS looked at this issue at the level of  
18 individual measures as opposed to our look at the level of  
19 the plan stars. The agency looked at measures that are not  
20 case mix adjusted or otherwise not implicated, for example,  
21 contract performance measures. CMS found significant  
22 differences between low-income status and poorer

1 performance for 6 of the 19 measures the agency examined,  
2 and the differences they were looking at were statistically  
3 significant and meaningful differences of practical  
4 significance, that is, it made a difference, and we used a  
5 similar standard. It made a difference of 5 percent in the  
6 score for a given population.

7           In view of these findings, what CMS had  
8 originally proposed doing was to reduce the weighting  
9 assigned to the measures where the agency found systematic  
10 population differences in the results based on low-income  
11 status. This was intended as an interim measure, but the  
12 proposal was withdrawn after public comment. Consequently,  
13 there was no change proposed for the 2016 stars that would  
14 address this issue. We will return to the discussion of  
15 possible solutions after we look at the more recent  
16 findings.

17           To continue our examination of this issue, we  
18 undertook work that was similar to CMS' approach and looked  
19 at 36 measures. We limited the plan set to HMOs, with some  
20 exceptions. We combined quality results at the individual  
21 patient level with demographic and health status data to  
22 attempt to isolate the effect of low-income status and

1 disability status. Our analysis was based on 2012 data,  
2 which is also true of CMS' work. For its part, CMS  
3 continued its analyses and specifically began looking at  
4 the question of whether disability status is a factor.

5           Our findings and CMS' findings were substantially  
6 similar. We found systematic differences across  
7 populations based on low-income status -- in our case,  
8 using dual eligibility status -- and systematic population  
9 differences based on disability status, which includes the  
10 aged whose original entitlement to Medicare was on the  
11 basis of disability, as well as those currently on Medicare  
12 because of a disability. For people under the age of 65,  
13 Medicare entitlement is only on the basis of disability or  
14 end-stage renal disease.

15           In both our work and that of CMS, we found that  
16 it was not always the case that results were worse among  
17 low-income individuals or among the disabled compared to  
18 other populations. Of the 12 measures that were in the  
19 star ratings that we looked at, that CMS examined, seven  
20 showed differences based either on low-income status or  
21 disability status. Two of those measures only showed a  
22 difference for the disabled population in both our analysis

1 and CMS' analysis.

2           For one measure, the rheumatoid arthritis  
3 management measure, we show better performance among the  
4 disabled, which is true of our analysis as well as CMS'  
5 analysis, and poor performance among the low-income  
6 beneficiaries. And if you want to talk about the specific  
7 measures, I can take during the question session.

8           So the results of our analysis used a method of  
9 analysis that sought to control for a plan effect that  
10 might explain population differences. That effect can be  
11 phrased as the question shown here, which is: To what  
12 extent is it a matter of differences that reflect the  
13 characteristics of a given population versus differences  
14 that arise because certain types of beneficiaries are more  
15 likely to enroll in plans that are poorer performing plans?

16           One way to answer the question I just posed is to  
17 look at within-plan differences which would show that it is  
18 the nature of the population, more so than the nature of  
19 the plan, that explains differing results by population.

20           Here we show actual results for the blood glucose  
21 control measure in a large MA plan. In the particular  
22 plan, for each of the beneficiary categories, rates of poor

1 blood glucose control are higher -- meaning worse -- for  
2 dually eligible beneficiaries than for non-dually eligible  
3 beneficiaries in each category, but the bigger difference  
4 is the difference between beneficiaries under age 65 and  
5 aged beneficiaries. In relation to the rates for aged  
6 beneficiaries, rates for the under-65 are more than double  
7 the rates for the non-dual population -- 7.5 percent  
8 compared to 16.9 percent -- and are at almost twice the  
9 level for the dually eligible population -- 10.8 percent  
10 versus 19.2 percent.

11           Returning now to the proposal that CMS originally  
12 made to address the issue we are talking about -- which is  
13 systematic population differences in quality results that  
14 may adversely affect particular plans' star ratings and  
15 bonus status because they have a high share of certain  
16 populations. What the original CMS proposal would have  
17 accomplished would have been a partial leveling of the  
18 playing field, in that there would have been more weight  
19 assigned to measures that showed no systematic population  
20 differences or potential bias. Giving more weight to  
21 unbiased measures gives you a more accurate picture of what  
22 the differences are in performance across plans because

1 doing so diminishes the effect of measures that show  
2 population differences. Again, this is a partial leveling  
3 of the playing field, and it also assumes that there is no  
4 issue with regard to measures that are case mix adjusted  
5 and which CMS did not examine because they are case mix  
6 adjusted.

7           As for alternative ways of dealing with this  
8 issue, the Commission does have a precedent it can look to,  
9 which is the peer grouping approach used for the hospital  
10 readmission penalty. Another approach I'll explain is to  
11 have star thresholds determined by population groups.

12           For the hospital readmission policy on penalties  
13 for high readmission rates, the Commission has suggested  
14 that the penalty determination should be based on  
15 comparisons among similarly situated hospitals with regard  
16 to their share of low-income beneficiaries, given the  
17 association between a hospital's proportion of admissions  
18 of low-income beneficiaries and its higher readmission  
19 rates.

20           This approach is complicated in the MA setting  
21 because the peer grouping would have to vary from measure  
22 to measure. That is, for some measures, the majority of

1 people to whom a specific measure applies may be under 65  
2 in virtually all plans, even though overall most plans have  
3 a very low share of enrollees under the age of 65.

4           Rather than peer grouping of plans, another  
5 approach is to group like categories of beneficiaries  
6 within a plan to evaluate performance. This graph  
7 illustrates what we mean by systematic differences by  
8 population. Here we show that for this hypothetical  
9 screening measure, rates among the under 65 are  
10 systematically lower than among the aged. For each plan,  
11 we determine a screening rate for the under 65 and a  
12 screening rate for the aged, which is what is plotted here.  
13 Rates are generally higher among the aged -- as shown by  
14 the yellow, solid line -- and the only instances in which  
15 the screening rate is above 80 percent for either  
16 population is for the aged in a plan, where the screening  
17 rate reaches a maximum of 95 percent. The line of dashes  
18 shows that the highest screening rate among the under 65  
19 was 80 percent among some plans.

20           The preceding slide used an illustrative example  
21 to make a point. In this slide we use actual breast cancer  
22 screening rates among the HMOs in the subset we examined to

1 show the difference in results between the disabled and the  
2 aged. The first column lists performance thresholds, which  
3 you could think of as star ratings, but to avoid confusion  
4 we are not using stars here because the percentile cut-off  
5 points do not represent how CMS determines cut-offs for  
6 star ratings. So what this slide shows is how performance  
7 varies between the two populations and what a plan's  
8 relative performance would look like if you separated the  
9 two populations, versus looking at the combined  
10 populations.

11           The first column of numbers shows results for the  
12 combined aged and disabled population. If you arrayed the  
13 results for all the plans and you considered the highest  
14 level of performance to be at or above the 90th percentile,  
15 a plan with a breast cancer screening rate at or above 83  
16 percent would be included in the highest-ranked plans. If  
17 you looked only at plan results for the disabled, which is  
18 the next column of numbers, and you arrayed only those  
19 results, the 90th percentile, or high performance, would be  
20 a screening rate at or above 79 percent. This contrasts  
21 with the next column where high performance among the aged,  
22 when looked at as a separate group, would be a rate of 85

1 percent or higher -- a six-percentage-point difference  
2 between the aged and the under 65. In the remainder of  
3 the rows you see the different results between the aged and  
4 the disabled at various levels of performance.

5           To continue with this example, here we look at a  
6 hypothetical plan where the only members who meet the  
7 criteria for inclusion in the breast cancer screening  
8 measure are enrollees who are 65 or older. If this plan  
9 had a breast cancer screening rate of 84 percent, when the  
10 performance thresholds are based on the combination of the  
11 two age groups, as in the first column, we see that this  
12 plan is classified as a high-performing plan. Measured  
13 against the standard applicable to the aged alone as a  
14 subpopulation, in the last column, we see that the plan  
15 falls below the highest performing level to what we are  
16 calling the medium-high level.

17           In this slide we illustrate how a plan that  
18 includes only the disabled would move up one rank in a  
19 population based grouping. This plan, with a screening  
20 rate of 76 percent, would change from being rated as  
21 average to being rated as medium-high.

22           As I mentioned, there are plans that exclusively

1 enroll the dually eligible, and among the D-SNPs there are  
2 plans that only enroll the aged. The more common situation  
3 is to have a mix of types of enrollees. For mixed plans,  
4 you would determine the plan's overall star rating by  
5 weighting the plan's composition of enrollment. In our  
6 illustrative example, you would determine a star rating for  
7 the plan's aged population and then a star rating for the  
8 plan's disabled population. If for this measure 50 percent  
9 of plan's population was under 65 and 50 percent aged, the  
10 overall star rating for the plan for this measure would be  
11 the average of the two ratings, given that each population  
12 is equally weighted at 50 percent. For other enrollment  
13 mixes, you would determine the appropriate weighted average  
14 star rating. And I used the terms in the slide Group A and  
15 Group B to sort of depart from the concept we're dealing  
16 with the under-65 and we're dealing with the aged to say  
17 what we're dealing with is we're dealing with a group of  
18 people who are being evaluated on this metric and a  
19 separate group of people who are being evaluated on this  
20 metric.

21           We have described one method of dealing with  
22 systematic differences in plan performance that are the

1 result of population -- oh, sorry -- one method of dealing  
2 with differences in plan performance that are the result of  
3 population differences. There are other methods of  
4 approaching this issue, such as by scaling the results for  
5 one group to have comparability with another group.

6 CMS is continuing to considers ways to address  
7 this issue, including by applying case-mix adjustments to  
8 more measures or by increasing the weight of the  
9 improvement measure, which has helped some plans that are  
10 lower rated in the past.

11 The population-based grouping that we have  
12 described is a complicated way of dealing with the issue we  
13 are discussing. One thing to consider in deciding how to  
14 address this issue is that there may not be a major effect  
15 on plans' overall star ratings if a small subset of  
16 measures is adjusted. We tried to simulate the results of  
17 CMS' original proposal and found that only a few plans  
18 would move from non-bonus status to bonus status. Although  
19 the adjustments would be important to a plan seeing an  
20 increase in the star rating, the system by which  
21 adjustments are to be made should be as administratively  
22 simple as possible for both the plans and for CMS.

1           This concludes my presentation. I look forward  
2 to your questions and your discussion of possible options  
3 for addressing the issues that have been raised. Thank  
4 you.

5           DR. CROSSON: Thank you, Carlos.

6           Let me just ask one question. You said at the  
7 end, only a few plans. What was the denominator again,  
8 number of plans?

9           MR. ZARABOZO: The 2012 year is 446. Now, I was  
10 looking at only HMOs and the data to this extent, but the  
11 total plans, 446.

12          DR. CROSSON: No. But the --

13          MR. ZARABOZO: Yeah. Sorry. The denominator for  
14 that purpose.

15          DR. CROSSON: Is it a few over or what?

16          MR. ZARABOZO: Yeah, 446, something like that.

17          DR. CROSSON: 446.

18          MR. ZARABOZO: 440, yeah.

19          DR. CROSSON: And few is less than five?

20          MR. ZARABOZO: Few would be like four.

21          DR. CROSSON: Almost close to four.

22          MR. ZARABOZO: Assuming I did the calculation

1 correctly.

2 DR. CROSSON: Right.

3 MR. ZARABOZO: It was a matter of re-weighting  
4 all the steps.

5 DR. CROSSON: Okay, all right.

6 MR. ZARABOZO: Based on the original proposal of  
7 there are only six measures that would be -- that would be  
8 changed.

9 DR. CROSSON: Right, right. Okay. So the  
10 adjusted measure set or something. Right, okay.

11 All right. So clarifying questions start with --  
12 Herb wants to start. Go ahead.

13 MR. KUHN: A couple quick questions, Carlos. One  
14 is on the CMS proposal that they offered and withdrew. I'm  
15 trying to kind of understand, a little bit, the makeup of  
16 that. So the way I understood it is it's kind of like a  
17 tournament model, that it affected all plans throughout the  
18 entire part, and there are those that went up and those  
19 that went down, versus an option that just targeted those  
20 that needed help as designed by their research that had  
21 high numbers of disability in LIS. Is that correct, kind  
22 of more of a tournament model than just directly

1 benefitting those one kinds of --

2 MR. ZARABOZO: Yes.

3 MR. KUHN: Okay.

4 MR. ZARABOZO: Because you're down-weighting a  
5 measure where somebody might be doing really well, and so  
6 it may affect their overall score. Yeah.

7 MR. KUHN: And was that primary most of the  
8 criticism or the comments that came in? Was that --

9 MR. ZARABOZO: That was one of the comments,  
10 which is "Why are you hurting me to help somebody else?" in  
11 a sense, one way to look at it. Yeah.

12 MR. KUHN: Okay. And then the second thing, I  
13 think I heard or read somewhere that RAND is the CMS  
14 contractor doing the evaluation on this, and they released  
15 some recent findings as early as this week?

16 MR. ZARABOZO: Yes. Tuesday night. Tuesday  
17 night, they released findings.

18 MR. KUHN: Tuesday, yeah. With a slide deck or  
19 something as well.

20 MR. ZARABOZO: Yes.

21 MR. KUHN: That I guess the upshot was that they  
22 said they continued to find evidence that disability in LIS

1 do significantly impact. So the evidence continues to  
2 build here; is that correct?

3 MR. ZARABOZO: Right.

4 MR. KUHN: Okay.

5 MR. ZARABOZO: Yes. They've added -- I don't  
6 know that you would say -- I mean, there are measures for  
7 which there are differences, and the impact, you know,  
8 varies from measure to measure. And again, they added the  
9 disability component there, so right. Yeah.

10 DR. MILLER: Just to put something in your head  
11 to think about for Round 2 -- and I know that deck just  
12 came out, so you may not be familiar with it. Did they get  
13 into how much movement there is?

14 MR. ZARABOZO: They did not.

15 DR. MILLER: Okay. So, at least based on Carlos'  
16 analysis, I want you guys to keep in mind not --

17 MR. ZARABOZO: The validity of this analysis, of  
18 course, is, you know, who knows?

19 [Laughter.]

20 DR. CHRISTIANSON: Is that what you wanted him to  
21 keep in mind?

22 DR. MILLER: There's somebody at the table who

1 can prescribe medication, right? I want to talk to that  
2 person afterward.

3 [Laughter.]

4 DR. MILLER: Yes. Assuming that you've done your  
5 best here, Carlos, I do want you to keep in mind the notion  
6 that wee and CMS in many ways are saying the same thing.  
7 There is an accumulated evidence here, but how much it  
8 moves the dice around or the chess pieces around, keep your  
9 eye on that and whether you want a very complex solution to  
10 the problem or something more simple. That's one thing I  
11 want you to think about.

12 MR. ZARABOZO: Yeah. I will say on the  
13 disability, for example, if you looked at the slide deck,  
14 something that we talked about in the March chapter was  
15 that the medication adherence measures, which are heavily  
16 weighted coming from Part D, there's this big difference  
17 between the D-SNPs that are aged only versus the ones that  
18 include. So when they did the analysis based on disabled,  
19 those measures come up as, yes, there's an effect for the  
20 disabled that we don't see in the low-income population.  
21 So that's very heavily weighted at 9 overall out of about  
22 80 of the weight.

1 DR. CHRISTIANSON: Are there other clarifying  
2 questions? Kate.

3 DR. BAICKER: So I think that I could probably  
4 infer the answer to my question from the combination of  
5 information here, but it's way too late in the day for me  
6 to be able to divide. So do the plans that serve a greater  
7 share of the harder-to-succeed-with populations do better  
8 with those populations than the plans with the lower share?  
9 And why I'm asking, which may help clarify the ill-posed  
10 question is, do we want to think about concentrating people  
11 who are harder to hit quality metrics on in the plan? Will  
12 concentrating them raise the quality on average that that  
13 group gets or lower the quality on average that that group  
14 gets?

15 MR. ZARABOZO: Yes. It's a question that at  
16 least I have been thinking about, and we have periodically  
17 -- it's sort of like the question -- we have D-SNPs that  
18 are specialized plans. Is there really a reason? Do they  
19 provide what they're supposed to provide? It has been hard  
20 to show one way or the other.

21 Now, some of the data would indicate that there  
22 are high-performing plans and there are plans that don't

1 perform as well, and for example, in the data where I  
2 showed the one plan on the blood glucose monitoring, that  
3 is a very, very high-performing plan that includes  
4 vulnerable populations. So they have -- in other words,  
5 part of the component is a D-SNP, and they do well on their  
6 D-SNPs. They don't do as well for the disabled and the low  
7 income as they do for the aged, but if you compare them to  
8 other plans, they do much better for this population. But  
9 again, this is among the highest-performing plans.

10           So yes, we would like to be able to answer the  
11 question: Do these specialized plans really -- you know,  
12 is this the best way to serve this population through a  
13 specialized plan? No. Do they do better? Yeah.

14           DR. BAICKER: But we don't know what the answer.

15           DR. MILLER: NO, we don't know.

16           MR. ZARABOZO: We don't. Yeah. And I have been  
17 trying to look at what are they good at kind of thing. For  
18 example, risk fall management, they are very good at risk  
19 fall management. Some of the plans, the members are very  
20 loyal, for example. They have very low disenrollment  
21 rates. So there are some things that they are very good  
22 at, some things that they are consistently not good at.

1 DR. BAICKER: So a simpler version of the  
2 question. What's the correlation between the share of a  
3 plan's enrollees who are disabled and the quality of care  
4 that their disabled enrollees receive?

5 MR. ZARABOZO: And I can't answer that question  
6 right now. I mean, but from the star ratings, the more  
7 disabled you have, the lower your --

8 DR. BAICKER: But that's the lowest -- overall,  
9 that's telling you that that group on average has lower  
10 quality.

11 MR. ZARABOZO: Yes.

12 DR. BAICKER: But I want to know conditional on  
13 being in that group.

14 MR. ZARABOZO: Right. Yeah.

15 DR. CHRISTIANSON: Clarifying questions?

16 DR. SAMITT: Can I ask Kate: How do you answer  
17 that question? So how do you --

18 DR. BAICKER: That is an easy factual question if  
19 one had the data in front. You'd just look at the  
20 correlation between the plans, share of enrollees in a  
21 particular bucket, and the share of success in that bucket  
22 on any of these quality measures. So it's the

1 interpretation. It's open to multiple interpretations, but  
2 the basic fact is not a tricky one. You can't calculate it  
3 off the top of your head, of course.

4 DR. NERENZ: And there are some of those analyses  
5 out there and not necessarily in this context, but perhaps  
6 for commercial HMOs. I mean, some of these exist, and a  
7 couple I know about, there's essentially no relationship,  
8 meaning that the gap, say, disabled or poor or whatever, is  
9 essentially a constant across plans, regardless of the  
10 proportion. That's one possible outcome, but other  
11 outcomes are possible.

12 DR. CHRISTIANSON: Clarifying questions, Scott.

13 MR. ARMSTRONG: Yes. More of a process question,  
14 and that is my understanding is, as we're doing this work,  
15 it is parallel to CMS and what they are doing, and I don't  
16 really know how they relate to each other and what the  
17 likelihood is that we'll do a whole bunch of work here, and  
18 CMS will draw some conclusions independently, anyway?

19 DR. MILLER: Actually, what I would say, I think  
20 they have been listening to us quite a bit, and there has  
21 been a lot of back-and-forth between the staffs. So, for  
22 example, when CMS came along and did their low-income stuff

1 and we started looking at it, we were kind of looking at it  
2 anyway, because the questions were coming independent from  
3 various sources.

4 And then Carlos' work suggested it wasn't just  
5 income; it was also disability. And then CMS turned around  
6 and went back and started to pick that up and tease through  
7 it.

8 So what I would say is this is one of those  
9 situations where I think if you wanted to say something and  
10 directionally orient, I think they are listening, and I  
11 don't think there's any sense of conflict. I think they  
12 are feeling like they're trying to figure this out, and to  
13 date have appreciated the input that has come out of,  
14 largely, Carlos' work here.

15 DR. NAYLOR: So you had this somewhere in the  
16 chapter, but can you remind me? You talked about the  
17 number of plans that would have moved to a bonus situation  
18 if the adjustments were made, as you described. How many  
19 would have improved? I mean meaning gone from 3.0 to 3.5.

20 MR. ZARABOZO: What I was looking at was how many  
21 plans are not in bonus status under the --

22 DR. NAYLOR: I'm asking how many plans would have

1 gotten better. I mean been on the path to improvement  
2 because you're looking --

3 MR. ZARABOZO: Well, you mean closer to 4 than  
4 they previously had been?

5 DR. NAYLOR: Improved, yes.

6 MR. ZARABOZO: Yeah. I didn't do that  
7 calculation. Yeah, I didn't do that.

8 The other thing is that the way I would do the  
9 calculation, it's just an average of all the measures, but  
10 then CMS also has this sort of -- the additional bump-up  
11 for high-quality plans where the quality is good across all  
12 the measures, so I would have to take that into account  
13 too. So it's a little bit complicated, but --

14 DR. NAYLOR: Thank you.

15 DR. CROSSON: It raises an important point which  
16 is, is this about the stars, or is it about the money?

17 DR. MILLER: I mean, I think what at least one of  
18 the things that we're trying to say here is that if a plan  
19 has a lower star rating, we may want that information  
20 available and would like that plan to be trying to improve  
21 its performance and for these populations.

22 Next thought. However, recognizing from a money

1 point of view -- and I don't mean this to be all about  
2 money -- from a money point of view, maybe you don't want  
3 to penalize them as much, given the fact that -- or at all,  
4 whatever the case may be, given the fact that they're  
5 struggling with a more difficult population. So, in a  
6 sense, in other conversations and potentially in this one -  
7 - this is why I'm saying it -- there is this "Well, what is  
8 the performance of the plan?" then second thought, "What do  
9 you want to do about the money given that they might be  
10 working with a harder population?" And I think we're  
11 trying to address at least starting this conversation with  
12 the second one, but it's an open conversation.

13 DR. CROSSON: Right, because, you know, I mean, I  
14 think you could argue both sides of it. It is really about  
15 the money. In that case, the solution becomes potentially  
16 a little easier. But if it's really about the stars,  
17 whether that's getting to the threshold of four or being  
18 able to evaluate the performance over time if you're a  
19 manager of these plans and if you're looking outside as a  
20 beneficiary, is this plan improving, getting worse, staying  
21 stable, then that's a different kettle of fish.

22 MR. KUHN: I think it's a little of both,

1 particularly on the money side. It really optimizes the  
2 resources those plans need to reach this population. I  
3 mean, these folks are hard to reach. They're hard to build  
4 trust. Oftentimes, they take more resources. So it's  
5 really critical for these plans to succeed to make sure  
6 that they have the resources to deal with this tougher  
7 population.

8 DR. CROSSON: Right. I'm sorry. I don't doubt  
9 that. I'm just thinking in terms of solutions.

10 MR. KUHN: Oh, I see.

11 DR. CROSSON: You could imagine a scenario here,  
12 particularly for dealing with -- if we're just dealing with  
13 the threshold to get to the bonus, and in support of what  
14 you're saying, if it's really about the money, a relatively  
15 simple solution would be to identify these small numbers of  
16 plans that are disadvantaged and provide, through one  
17 mechanism or the other, the money, which could then be used  
18 to help them improve. So it's kind of like do we want to  
19 solve both problems, or which one do we want to solve?

20 DR. MILLER: Yeah. And I know you're not saying  
21 this. And in that instance, just to -- you wouldn't make a  
22 lot of -- I'm asking -- make a lot of changes to the star

1 methodology.

2 DR. CROSSON: Yeah.

3 DR. MILLER: You would just do some after-the-  
4 fact adjustment.

5 DR. CROSSON: Exactly. Right.

6 DR. MILLER: Whereas, some of these solutions  
7 we've put in front of you definitely get into the star  
8 methodology.

9 DR. CROSSON: Right.

10 Clarifying questions. Jack.

11 DR. HOADLEY: Your analysis was just HMOs?

12 MR. ZARABOZO: Just HMOs.

13 DR. HOADLEY: Why did you not include the  
14 portfolios?

15 MR. ZARABOZO: I didn't want to confound results  
16 based on plan type, and also, all of the D-SNPs, the 100  
17 percent D-SNPs are HMOs.

18 DR. HOADLEY: Are HMOs.

19 MR. ZARABOZO: Yeah.

20 DR. HOADLEY: And was the CMS analysis also --

21 MR. ZARABOZO: CMS is all plans. I think they're  
22 doing all plans. We do have a couple measures, one measure

1 where we do have a difference in result, and then they did  
2 not do the separation of administratively ported and  
3 medical record group, so we have a difference there too.

4 DR. HOADLEY: Okay. Thank you.

5 DR. CROSSON: Okay. So now we will get into the  
6 substance more, and just by happenstance, we're going to  
7 start at that end of the table with David.

8 DR. NERENZ: Thanks.

9 Thanks to Carlos. This is wonderful work, and I  
10 want to thank both you and those managing our agenda for  
11 putting this in front of us. I think this is crucially  
12 important, and I want us to keep paying attention to this.

13 And let me follow on Jay's comment. I think this  
14 is important not only in the context of stars and Medicare  
15 Advantage, but also related concepts like hospital pay-for-  
16 performance and public reporting, physician pay-for-  
17 performance and public reporting. It's a lot of the same  
18 issues, same dynamics, same consequences. So I think we're  
19 going to see this -- or should see this over and over again  
20 outside this particular context. I think it really does  
21 matter.

22 I would echo Jay's points and maybe answer the

1 question. As I look at this issue -- and I have been very  
2 actively involved in this now for much of the last year and  
3 a half -- I think it's more about the stars our the public  
4 reporting than it is about the money. We're embedding --  
5 we're doing physician compare. We're doing hospital  
6 compare. We're doing the star ratings. We're getting into  
7 this for, say, home health and nursing homes. And we're  
8 getting more and more in a position of identifying  
9 providers as being good or bad publicly, and we're  
10 presumably offering this information up for consumer  
11 choice, perhaps for choice among professionals who might be  
12 referring patients or choosing providers. So this really  
13 matters, and it matters more than simply, say, the  
14 threshold from bonus to no bonus. And I think when we do  
15 that, it's crucially important that we do that fairly and  
16 accurately.

17           And everything I've looked at recently suggests  
18 that without some form of attention to these social and  
19 demographic factors, the ratings and the rankings that we  
20 put out there, again, without adjustment, can be biased.  
21 They can be misleading. They can be unfair and just flat  
22 out wrong, and to me, the most compelling argument for some

1 form of attention to these factors are it's just good  
2 measurement, and it's good public reporting to take these  
3 into account in some way.

4 I think the evidence of the effect of factors  
5 like poverty or like we had earlier this afternoon, living  
6 alone, are accumulating. There was a nice article in  
7 Health Services Research just last month relevant to this.  
8 I understand there's an article in JAMA Psychiatry today  
9 about the effect of some of these social factors on  
10 quality-of-care measures, so we just see it over and over  
11 again. It matters.

12 Now, we can debate in a certain context. Is it 6  
13 out of 19 measures? Is it this or that? But I think  
14 enough for us to pay attention, it matters.

15 And as an example of sort of why it matters or  
16 sort of the underlying dynamic, outcome measures in general  
17 are part of these overall packages. They lead in this  
18 example to star ratings, but they're used sometimes as  
19 stand-alone; for example, hospital readmission. And as a  
20 class of measures, outcome measures are multiply  
21 determined. They reflect quality of care, to some extent,  
22 and they reflect other things. And many of those other

1 things are outside the purview and the control of the  
2 entity being measured, whether that's a plan, whether  
3 that's a doctor, whether that's a hospital.

4           And in many of the things I've looked at closely,  
5 the effect of measurable quality of care is very small. If  
6 we're thinking about it as R-squared, the R-squareds that  
7 we see are in the 5 and 6 percent range for the entire set  
8 of measurable process variables.

9           On the other hand, the effect of external  
10 factors, including one study set in the context of hospital  
11 readmission, is very large, 60 percent R-squared, .6.

12           So particularly, when we look at outcome  
13 measures, we have to be careful about the extent to which  
14 we think of them as literal measures of quality. I think  
15 we have to back off a bit and think of them as hints, as  
16 indicators, but we get trapped in our own language a little  
17 bit. So there's a significant signal and noise problem,  
18 particularly in the domain of outcome measures, and I do  
19 think it's important that, in one way or other, we think  
20 about how to get rid of the noise so that we can see or  
21 hear the signal more clearly.

22           Now, you've given us a really nice example, in

1 fact, a couple possible examples of how that might be done  
2 in this context, and that's good. I would just point out  
3 that there are other ways. There are direct and indirect  
4 standardization methods. There are regression-based models  
5 that yield coefficients that then can be used for  
6 adjustment. There are all sorts of ways, and to the best  
7 of my knowledge, there's no one way that always stands  
8 alone as being best or right. They have pros and cons.  
9 They fit certain circumstances better than others.

10           So the two things I would take away from this and  
11 offer for suggestions, one is it is great that we are  
12 working on this. Again, thank you. I think we should stay  
13 on top of this not only in the context of stars and MA, but  
14 also in other similar things that involved P for P or  
15 public reporting.

16           And I think we should remain flexible and  
17 actually actively explore alternative methods of dealing  
18 with these statistical relationships. You've shown us a  
19 couple, and they're interesting, and they have interesting  
20 features. But there are other adjustment methods as well,  
21 and I think as our discussion of this continues, we can get  
22 more into those pros and cons, so thank you.

1           MR. ZARABOZO: I would like to mention that what  
2 CMS posted on Tuesday night, they included an SES factor,  
3 the census tract funding poverty and education, which had  
4 minimal effect or no effect, I think. I forget exactly how  
5 they phrased it. Now, some -- our factors included income,  
6 you know, income in the sense that we have the duals, and  
7 on the other end we have the employer-sponsored people who  
8 tend to be higher income. So, there's, to some extent, a  
9 socio-economic content here.

10           DR. NERENZ: Yeah, and that's all to the good,  
11 and that just prompts me to say, and then I'll let this  
12 move on, the effect of these variables and how you deal  
13 with them is always context dependent -- what unit of  
14 measurement, what particular type of conclusion we're  
15 trying to draw.

16           In our system, for example, we have 36 primary  
17 care clinics and we measure HEDIS measures at the level of  
18 the clinic. Empirically, there's a correlation of about  
19 0.6 between neighborhood median household income and HEDIS  
20 measures. That's pretty powerful. And if we didn't  
21 somehow adjust for that, we would conclude that the clinics  
22 and the doctors in the rich neighborhoods are good and we

1 would conclude that the clinics and the doctors in the poor  
2 neighborhoods are bad, and we would be wrong. We would be  
3 absolutely, flat out wrong.

4           So, in that context, there's a pretty powerful  
5 effect, but in other contexts, you might not see that  
6 effect. So, it always has to be judged on what the data  
7 tell us, what sort of the theoretical relationships might  
8 be. Sometimes, it's a big deal. Sometimes, it's not a big  
9 deal.

10           DR. CROSSON: Let's move down this way. Bill  
11 Hall.

12           DR. HALL: David, I admire your passion on this  
13 issue.

14           I think we could help inform CMS in this  
15 analysis, because I think star ratings are very poorly  
16 understood by consumers and even other people who make  
17 decisions for consumers, like health care providers. The  
18 new Medicare population with the Baby Boomers are used to  
19 looking at star ratings. If they're going to buy a new  
20 toaster or a computer, they'll look at star ratings. And  
21 what they find is that sometimes the star ratings, while  
22 they may be different, are not particularly relevant to the

1 purchase that they want to make. And, also, many times  
2 when you go to the store, you find out that the item has  
3 changed. It's a different item now, and so how do you make  
4 these determinations.

5           So, if you look at the consumer part of the CMS  
6 website, it doesn't really explain the star ratings except  
7 to say that a certain star rating is always better health  
8 care than one that isn't. So, I think in terms of looking  
9 at how we can help the beneficiaries, any of the  
10 clarification work we do here could be very useful.

11           DR. CROSSON: Thoughts? Scott.

12           MR. ARMSTRONG: Yeah. I wish this was a more  
13 well developed point of view, but I, just in thinking about  
14 -- the underlying goal for the star ratings is to improve  
15 overall the effectiveness of the system, to achieve  
16 outcomes, quality, service, and so forth. And part of what  
17 a star rating does is it creates a set of standards by  
18 which we evaluate how people are doing relative to their  
19 past and relative to other alternatives. And, so,  
20 actually, we want the star ratings to demonstrate  
21 differences, and to force us then to ask, well, what's the  
22 underlying reason for these different outcomes so that you

1 have something actionable and you can do something with it.

2           And, so, I just -- I worry about methodologies  
3 for adjusting the rating system that smooth out some of the  
4 differences driven by economic status or whatever other  
5 variable we might be talking about, because the star rating  
6 system, in fact, is supposed to amplify the differences and  
7 give us insight into what you might do about that.

8           Now, that sets aside, of course, the fact that  
9 the star ratings now also are tied to payment, and so there  
10 are a lot of concerns about disadvantaging certain systems  
11 to achieve incremental payment if, in fact, they have a  
12 harder population to manage.

13           But, I just -- I don't know, it's, like I said,  
14 it's not very well formulated, but it seems like those are  
15 two different issues that are getting kind of bungled up in  
16 the same conversation.

17           And then a final question that I think I  
18 certainly have as we go forward with this evaluation is  
19 that SNPs, for one thing, but there may be other programs,  
20 are designed, in fact, with different kinds of tools and  
21 resources specifically for the purpose of creating a more  
22 effective system for advancing the health towards higher

1 quality outcomes. And, so, my question would be if -- how  
2 much do you rely on the design of the tool itself to close  
3 the gap between the outcomes versus, you know, adjusting  
4 the metrics that measure outcomes so that you're not  
5 creating disadvantages given the population that you're  
6 serving.

7           And, I assure you, before we talk about this next  
8 time, I'll think through that question again. But, it just  
9 -- that's just disclosing sort of how I'm having a  
10 difficult time really understanding what the best approach  
11 to solving this. I agree, it's a real issue and we should  
12 be taking responsibility for how we improve the health of  
13 all the beneficiaries that we serve, and some are having  
14 consistently differential outcomes. What are we going to  
15 do about that? I think that's a real issue.

16           DR. CROSSON: Jack.

17           DR. HOADLEY: So, I was -- I found Dave's  
18 comments very provocative, and Scott's, as well. Scott,  
19 you talked about stars having a purpose of creating some  
20 incentive for plans to improve, to give them a sense of  
21 where they stand. There's the payment side of it that sort  
22 of is complicated and in some ways orthogonal to the other.

1 And then there's also the consumer shopping or even the  
2 general public awareness.

3           And, I think about it, and I thought about a lot  
4 of this on the Part D plan side, which is really the same  
5 set of issues, although it doesn't have the payment bonus  
6 involved, and I'll hear the statement made that the  
7 benchmark plans on the Part D side that are the ones  
8 available to low-income beneficiaries at zero premium are  
9 not as good as the other plans. They're just sort of --  
10 they're poorer quality, and that's sort of set as an  
11 assumption I'll hear people make without necessarily having  
12 looked at any data on the point.

13           And, in a sense, this is the kind of thing that I  
14 think this whole thing goes to, because if we do look at  
15 stars to sort of go back and see if that's true, well, it's  
16 a problem if the stars, in fact, are correlated with some  
17 of these economic and other factors that we're talking  
18 about here.

19           And, so, on the one hand, there are some measures  
20 -- again, the one I can think of on the D side is, and we  
21 don't actually have this as a star measure, but if we had a  
22 measure, say, of what drugs are on formulary and sort of

1 the quality of the formulary, that's something that's just  
2 a fact. I mean, it's their list of drugs. You can analyze  
3 it. It doesn't matter who's enrolled in the plan. But,  
4 most of the measures we use are not that sort. They are  
5 these other kinds of measures.

6           And, I guess what I really struggle with is how  
7 to fix this if it needs to be fixed, or how to use this  
8 information, use these findings, because I'm taken by the  
9 comment that maybe we don't want to go inside the  
10 methodology and jigger it around and change it, and then  
11 you really have no longer, in one sense, apples-to-apples,  
12 although in another sense you've made it maybe more  
13 comparable. Do we want to do something that says, well, if  
14 the real problem is the payment bonus, and I think, Jay,  
15 maybe you were the one that was sort of saying this, that  
16 we could just fix that by having some mechanism to pay the  
17 bonus differently if we had evidence that the stars are  
18 penalizing certain kinds of plans.

19           That still leaves alone sort of what it looks  
20 like to consumers, and if we really think, you know, this  
21 plan is out there and it's got a lower star rating, but  
22 it's really for factors outside of its control, we're sort

1 of saying to the public profile, to the consumer shopping  
2 among plans, that's not as good a plan. But, in fact,  
3 maybe it is just as good given the circumstances it's  
4 operating under.

5           The only other thought I would make, and this  
6 goes to one of the down in the weeds things, but, you know,  
7 you had to start this analysis from the fact that the stars  
8 are assigned at the contract level, and I wonder if there  
9 should be some push-back to CMS about rethinking that  
10 concept. And in particular, and I know -- I think you said  
11 that a contract cannot have a mix of PPOs and HMOs, but it  
12 can have a mix of SNPs and regular plans, and it can have  
13 mixes of other kinds of plan types mixed in. And, so  
14 you're -- on the Part D side, it can have a mix of  
15 benchmark plans and non-benchmark plans or basic plans and  
16 enhanced plans under the same contract that all get the  
17 same rate, even though they are doing different things.

18           And, so, you know, maybe one small fix we could  
19 make, or could be -- CMS could make -- is to say that a  
20 contract at least has to have plans all in the same  
21 category. We could figure out which dimensions of category  
22 we want to mean by that, but at least not have, you know,

1 SNPs and non-SNPs mixed together, or basic and enhanced  
2 drug plans mixed together, and that might be -- I mean,  
3 that's not going to fix the larger set of these problems,  
4 but it might help at least to sort some things out and let  
5 us understand better what's going on.

6 DR. CROSSON: Thanks, Jack.

7 Cori.

8 MS. UCCELLO: All right. Since Carlos said we've  
9 got a lot of time, I've got a lot of comments.

10 [Laughter.]

11 MS. UCCELLO: I'm not sure any of them will be  
12 useful, but --

13 [Laughter.]

14 MS. UCCELLO: First, can someone on staff -- not  
15 this instant, but at some point -- send us a link to that  
16 slide deck that people are talking about.

17 Two, so, Mary was talking about with Carlos this  
18 idea of, well, how many plans show just an increase in  
19 their star rating if we change the way it's measured and  
20 the word "improve" was used, and I just kind of want to  
21 highlight that if we change the measure and a plan goes  
22 from a three to a 3.5, that doesn't mean that the plan

1 improved. It just means that our assessment of that plan's  
2 quality changed. So, I just want us to be careful about  
3 how we frame that.

4 Another thing is in the paper, I think, Carlos,  
5 you did a really good job of highlighting several areas of  
6 bias. We talk about biased measures, biased ratings, but  
7 there can be different reasons underlying -- sources of  
8 that bias, and those reasons could have different ways to  
9 solve them. And, so, I think you kind of did this in the  
10 paper somewhat, but, you know, one source of bias is that  
11 the outcomes that are being measured for certain subgroups  
12 are outside of the provider's control, and that would  
13 suggest some kind of adjustment.

14 Another is that certain subgroups might just  
15 answer questions differently. So when we're talking about  
16 patient experience, I think was the example you used, that  
17 certain subgroups might just be more easy on the providers  
18 than others. So, that would maybe suggest a different kind  
19 of adjustment to those responses.

20 And, the third source of bias, which is where I'm  
21 really interested in us exploring more, is whether the  
22 questions that are asked, the metrics that are included,

1 are relevant for the different groups that we're talking  
2 about. Are some metrics that are being used just not  
3 really relevant for this particular subgroup, and are there  
4 better questions that we could be asking that gets at  
5 better of whether or not that group is being appropriately  
6 cared for.

7           So, just thinking more about, well, what are --  
8 for the disability group, are there certain questions that  
9 aren't part of this -- not that I want to add to the number  
10 of measures we're having, but are there certain outcomes  
11 measures or whatever that better get at is this group being  
12 cared for well. So, just thinking more about that, I'd be  
13 very interested in.

14           Another thing is, I would just urge caution when  
15 we use the term "level playing field." I use this term in  
16 my day job a lot, so it gets thrown around. But, I just --  
17 this afternoon, it just hit me. It's, like, well, level  
18 playing field for whom? You know, we're coming at this  
19 from the context of the plan, but what about from the  
20 perspective of the beneficiary, and we want to make sure  
21 that those beneficiaries in those vulnerable subgroups are  
22 not, you know, we don't have lower expectations for them.

1 Let's level the playing field for them.

2           And, finally, several years ago when we talked  
3 about this issue of risk adjustment, we brought up the QIOs  
4 and providing additional funds for low-performing providers  
5 and enabling those funds to be used for -- I don't know  
6 what the right terminology here is, but for reaching out to  
7 the community and doing more coordination with the  
8 providers to kind of help certain vulnerable groups,  
9 bringing in all the resources of the community to help  
10 provide them better outcomes. And, I didn't know if any of  
11 those funds used for those purposes would also be  
12 benefitting these plans that serve these populations. So,  
13 that was just a question.

14           DR. CROSSON: Craig -- oh, I'm sorry. Warner.

15           MR. THOMAS: Just a couple of comments. I agree  
16 with Scott that I don't think we should modify measurements  
17 just to potentially have plans look better, or as Cori  
18 said, have a situation where we drop a measure and then a  
19 star rating goes from three to 3.5. However, I do think  
20 that comparing plans that have different mixes of members  
21 when it looks, according to the data, that it looks like it  
22 could be proven that the scores on those measures are

1 different based upon the types of members you have in your  
2 plan is something that should be considered seriously.  
3 And, I think, going to Cori's point, I also think that you  
4 don't want to have a situation where somebody thinks  
5 they're going into a four-star plan, but yet that plan is  
6 four stars because of the mix of members it has, and you  
7 may not be one of those types of members. So, it can play  
8 the other way, as well.

9           So, I just think considering the comparator and  
10 the mix of members to me is really important, not  
11 necessarily changing the measures. To me, the measures  
12 ought to all be consistent. But, the mix of -- I think,  
13 going to David's point, the mix of members or the mix of  
14 patients does drive a difference in the score and I think  
15 it ought to be considered.

16           DR. CROSSON: So, I want to -- just to the  
17 earliest point you made there about perhaps creating a  
18 separate category of plans, so you'd have to -- you've got  
19 some threshold for plans that had lower socio-economic  
20 patients, and I could see how you could -- so, you're  
21 suggesting having a different --

22           MR. THOMAS: No, I'm not saying --

1 DR. CROSSON: -- rating system?

2 MR. THOMAS: I'm not saying you have a separate  
3 categorization of plans. I think the point being, somehow,  
4 you probably ought to be able to have some sort of weighted  
5 view of the types of members that are in one plan versus  
6 another. So, if one plan has a disproportionate share of  
7 under-65 dual-eligibles, you ought to be able to be  
8 considerate of that mix of members in the plan versus one  
9 that has a disproportionate amount of over-65 members.

10 DR. CROSSON: And, so, to get right down to it,  
11 whether we're talking about lower socio-economic group or  
12 disabled tend to correlate, based on what you're saying,  
13 then you have two choices. You've identified this group of  
14 worthy plans or disadvantaged plans or whatever you want to  
15 call them. You could either -- well, you could do three  
16 things. You could go into the star rating system and  
17 rejigger the mix of measures, which has been done.

18 MR. THOMAS: Right.

19 DR. CROSSON: You rejigger them more so that you  
20 favor those sorts of plans more than they're disfavored  
21 now. You remove more measures that seem to be affected by  
22 these external factors. Or, you could not do that but just

1 simply leave the measurement process in place, but then get  
2 an uptick based on that status.

3 MR. THOMAS: Right. And I think the latter is  
4 the one I would look at, because I think the measures are  
5 what the measures are across the plans. I think to start  
6 measuring plans with different measures based upon their  
7 mix of members doesn't -- it seems like it's overly  
8 complicated, frankly.

9 DR. CROSSON: Well, let me just say that the  
10 third option is -- again, this has to do with is it the  
11 star rating or the money, you could simply say, we're going  
12 to leave the measurement process alone, because 3.5 is 3.5  
13 on these measures, right.

14 MR. THOMAS: Mm-hmm.

15 DR. CROSSON: But, we're going to recognize that  
16 these plans are disadvantaged in terms of getting to that  
17 threshold, and whether it's through the QIO process or some  
18 other mechanism, they're going to receive more money, the  
19 explicit purpose being to try to help them overcome the  
20 barriers that they've got in getting to these measures.

21 MR. THOMAS: And, you know, I think that there's  
22 a number of reasons the star ratings are important. I

1 think Scott has mentioned before that it may not  
2 necessarily be the key factor in how someone chooses a  
3 plan. I think that probably one of the biggest issues is  
4 that, I believe it's five-star rated programs have  
5 reenrollment kind of year-round, is that correct?

6 MR. ARMSTRONG: [Off microphone.] Correct.

7 MR. THOMAS: So, I think that's probably one of  
8 the bigger factors, if you will, of a plan that ends up  
9 achieving five stars, in addition to the money.

10 So, once again, I would not -- I would not  
11 recommend personally that we change the measures based upon  
12 the type of member, that the measures are what the measures  
13 are, but that the comparator be considered. You know, if  
14 we have a plan that has 40 percent people that are under  
15 age 65 and one that has ten percent, that that ought to be  
16 considered in the evaluation process.

17 DR. CROSSON: And we leave open the question of  
18 how it should be considered. So, I think -- Kate, on this  
19 topic?

20 DR. BAICKER: Just the way I feel about whether  
21 to include those SES, disability, other kinds of things as  
22 risk adjustors, I think Cori would, on the one hand, say we

1 don't want to say that it's okay for those groups to have  
2 worse outcomes, but then other people might say, well,  
3 wait, we don't want to punish plans --

4 DR. CROSSON: Right.

5 DR. BAICKER: -- that enroll those groups of  
6 people. And how I feel about which of those competing  
7 factors is most important depends on the answer to my  
8 previous question, which is are those plans that  
9 disproportionately enroll the harder to serve populations  
10 doing a better job with those populations than other  
11 people, because I want to steer people and money to the  
12 place where they're getting the better outcome. So, the  
13 answer to that question would help me weigh those two  
14 competing factors that have been raised.

15 MR. THOMAS: I think you've got to have a plan  
16 that has, that, for whatever reason, is more attracted to a  
17 disproportionate sector of the population. You could also  
18 have an area that just has a disproportionate amount of  
19 those folks that are just in that plan. So, I think you  
20 could have both that drive that situation.

21 DR. CROSSON: But, Kate, you wouldn't extend what  
22 you said to say, okay, now we're going to have two classes

1 of plans. We're going to have these plans and we're going  
2 to have plans that have passed this threshold of more  
3 vulnerable patients and we're going to have them rated  
4 against each other. You just want to know experientially  
5 what the difference is.

6 DR. BAICKER: Right, although I don't think  
7 anyone -- I haven't heard sentiment in favor of that  
8 extreme that you're talking about, but I think we have to  
9 acknowledge to ourselves that if you include those SES kind  
10 of risk adjustors, you are implicitly generating a  
11 different schedule --

12 DR. CROSSON: Yes, you are.

13 DR. BAICKER: Even though it's the same formula,  
14 you are letting -- you are comparing plans holding that  
15 enrollment mix constant, which is a subtle version of that  
16 extreme thing that I haven't heard anyone really get  
17 behind.

18 DR. CROSSON: And I just wanted to make sure  
19 that's not what you're saying, and Warner said that's not  
20 what he's saying, either.

21 DR. BAICKER: [Off microphone.] No one is saying  
22 that.

1 DR. CROSSON: Down the line, Craig?

2 [Laughter.]

3 DR. CROSSON: How did it come up, then?

4 [Laughter.]

5 DR. SAMITT: So, I would say that this is very  
6 much worthy of additional discussion. I think this -- we  
7 really owe it to this population of beneficiaries to work  
8 this, and this is from someone who has pretty much spent  
9 their career working in delivery systems or plans that care  
10 for these disproportionate percentages of vulnerable  
11 patients and members, and so I think it is less about a  
12 level playing field, but more about assuring that the  
13 adequate resources are deployed to the organizations that  
14 are caring for these vulnerable populations and they  
15 shouldn't be disadvantaged given that they've stepped up to  
16 really innovate and focus additional effort and resource in  
17 caring for this very distinct group.

18 And whether that's being disadvantaged because of  
19 star ratings in terms of the freedoms and flexibilities  
20 that five-star plans get, or whether it's additional  
21 resources, I don't presume to know what the right  
22 methodology is, but I do think that these types of plans

1 that have the SES-related implications should be recognized  
2 in some way, both in terms of freedoms and financial  
3 recognition and reward.

4 And, I think if our concern is about complexity  
5 related to the Medicare payment program, we're way too  
6 late.

7 [Laughter.]

8 DR. SAMITT: We're already there. The degree of  
9 complexity is already very high, and so I think if this  
10 gets it right for that subset of the beneficiaries, I think  
11 added complexity is warranted.

12 DR. CROSSON: Yeah. So, just -- right. If  
13 complexity is bad, then it's not necessarily true that more  
14 complexity is okay. Yeah.

15 MR. ARMSTRONG: Just a point, Craig, that you  
16 made, was stated far better than I said it earlier, but  
17 that was the point I was trying to make about I thought,  
18 and I wish I knew more about this, but I thought the D-SNPs  
19 actually were designed in order to create the kind of  
20 flexibility and resources to manage this particular  
21 population of patients. And so as we go through this, I  
22 think we want to understand, if that's inefficient or

1 insufficient and we're looking for some other way at the  
2 back end at rewarding success as an additional way of  
3 supporting the care for this population, we should really  
4 understand the net of all of that.

5 DR. HOADLEY: I wanted to make sure we --

6 DR. CROSSON: I'm sorry, Jack. Rita was next.

7 DR. HOADLEY: Okay. Go ahead.

8 DR. REDBERG: [Off microphone.] I was just --

9 DR. CROSSON: Just what?

10 DR. REDBERG: Going to make comments, but not on  
11 this.

12 DR. CROSSON: Okay.

13 DR. REDBERG: Okay. And, I think it is a really  
14 important issue and an important discussion, and I  
15 appreciate most of the comments that have been made, except  
16 that I don't think we should -- we should avoid more  
17 complex. I'd agree that our system is incredibly complex,  
18 but I wouldn't want to add to it.

19 But, aside from that, it reminds me a little bit  
20 of our earlier discussion about the social service  
21 expenditures in addition to health care expenditures,  
22 because if we're really looking at outcomes in health,

1 we're only looking at one part of it when we're looking at  
2 health care, and I think a lot of the issues that separate  
3 the low SES and the high SES are outside of the health care  
4 system and that's why we see these differences.

5           And it makes me think that when we do look at  
6 the, you know, comparators, how much we spend on health  
7 care and measures of how well we're doing in the U.S., we  
8 need to look not at the overall, actually, health and  
9 social services, but at the ratio we spend on health care  
10 to social services, because I suspect that countries like  
11 Sweden and the other countries that have higher -- lower  
12 health care but better life measures are spending a lot  
13 more than we are on social services and that we're spending  
14 a lot less, and I think that's where a lot of these  
15 disparities are coming from, things that we really can't  
16 address in the health care system. When people are going  
17 home to very untenable situations, it's not good for  
18 health, and they don't take their medicines and they don't  
19 come back and things don't -- so, I think that's an  
20 important sort of bigger picture problem.

21           But, specifically with regard to measures,  
22 because we are very committed to measures, I just want to

1 point out that it really is disturbing to me that all of  
2 these measures are process measures, and I understand that  
3 the process measures are weighted lower than the outcomes  
4 measures, but 44 measures is a lot of measures, and I feel  
5 like we've gotten so many measures that it's no wonder that  
6 doctors can't really take care of their patients because  
7 they're too busy checking off all these lists, and that  
8 perhaps we could have better care if we had fewer measures.  
9 You know, I'm just not -- there's very poor correlation, if  
10 any, between a lot of these process measures and actual  
11 outcomes, and so you can, you know, check off all these  
12 kidney disease monitoring, but I don't know that anyone's  
13 better off for it.

14           And, for example, on the example you gave us on  
15 Slide 13, the blood sugar control, which I think is  
16 considered, according to the mailing materials, to be an  
17 intermediate outcome measure, but it's not really an  
18 outcome measure. It's a measurement of blood glucose. You  
19 know, there's so much debate over what is the right HbA1c,  
20 you know, it changes all the time and we're over-treating a  
21 large percentage of the population, you know, and certainly  
22 in my Journal, JAMA Internal Medicine, we published

1 multiple studies that show that there are more Medicare  
2 beneficiaries who are suffering from hypoglycemia than from  
3 hyperglycemia. And, so, it makes me think we have to  
4 really go back and question our measures, because I don't  
5 know that they're measuring quality, and they're certainly  
6 not sort of related to health and outcomes, which I think  
7 is what we really want to achieve.

8           So, you know, we don't directly do that, but if  
9 we got feedback back to CMS on sort of less measures and  
10 more meaningful measures in terms of outcomes and less  
11 process, I think we'd overall see better quality care.

12           DR. CROSSON: Jack.

13           DR. HOADLEY: I was going to make a comment  
14 that's somewhat similar to Rita's in the sense of thinking  
15 about the -- then I was struck by something I took out of  
16 Cori's comment that I think might have passed by a little  
17 bit, which is that, to some extent, some of the measures  
18 that we're using may be biased in ways that aren't -- it's  
19 not a matter of correcting them, but maybe going back and  
20 revisiting the methodology to do the measurement. So, if  
21 we're using a survey-based thing for one of these things  
22 and there's some thought that maybe there's a response

1 bias, or maybe that's not the right question to ask for  
2 particular populations, let's make sure to go back and look  
3 at the list of measures for things like let's -- you know,  
4 we've gone through over the years reduce the number of  
5 process measures, weighted them less. Maybe there are  
6 still, per Rita's point, too many of those.

7           But, also, it's a chance to go back and look, not  
8 necessarily to add measures, but to change the way some of  
9 the data are collected to be less vulnerable, if we can  
10 figure out how to do it, to the kinds of biases that we're  
11 talking about here. So, I mean, I think that's another way  
12 to address this that might escape some of these other  
13 issues that we're grappling with.

14           DR. CROSSON: Okay. To wrap this up into a tight  
15 little bundle --

16           [Laughter.]

17           DR. CROSSON: I think, at the risk of over-  
18 simplifying or over-complicating, I think we do have some  
19 commonality. I think there's a general sense here that  
20 this is a real problem that needs to be addressed, and to  
21 not address it would be wrong.

22           I think we have some difference of opinion at the

1 table about the relative appropriateness of some  
2 approaches. One would be to, for example, to go into the  
3 measure set. Jack suggested examining the measures and  
4 either changing or throwing out some of the measures that  
5 are in addition to the adjustments that have already been  
6 made. Or, you know, reweighting the measures, weighting  
7 them even more and differently. You know, there is  
8 complexity in that, not only for CMS, but to try to make  
9 sure that we've done it right and haven't made the  
10 situation worse in some direction.

11           The other aspect of complexity, at least in my  
12 mind, is to the extent that we want the star rating system  
13 to be viewed as fair and appropriate and well thought out  
14 and scientifically credible, the more machinations that go  
15 in inside of it, you know, the more we risk people, you  
16 know, in the plan world in general saying, you know, this  
17 is rigged one way or the other and we don't like it. And,  
18 I don't know that they would necessarily pursue a different  
19 course, but I think we want to be careful we don't suggest  
20 something that fundamentally undermines the star rating  
21 system, assuming that we all believe that it's something we  
22 should keep.

1           You know, beyond that, there are other  
2 differences here. I mean, is it really about the money?  
3 If so, that drives us in some directions which may be more  
4 simple than others. And I've heard a couple of people  
5 think that that's the case. I've heard others, probably a  
6 larger number, say, no, preservation of this star rating  
7 system has values beyond the money, you know, to be able to  
8 compare performance over time, to be able to compare one  
9 organization against the other, whether or not it achieves  
10 the bonus that it should be, that's possible. And, so, I  
11 don't think we have unanimity of mind there.

12           Then there's the other question of, you know, if  
13 we -- if the fix here is to change the rating of plans who  
14 are deserving, so maybe we could agree on what that  
15 threshold would be, and we come up with a four instead of a  
16 3.5, have we, in fact, corrupted the process itself? I  
17 don't mean made it more complex, but just simply created a  
18 situation in which a four is not really a four, it's a 3.5  
19 with an asterisk, because I think there's an argument to be  
20 made that the quality that is produced by the plan is the  
21 quality that's produced by the plan, and it ought to be  
22 what it should be and then adjusted in some way to make up

1 for the deficiencies in the measure. At least, that's one  
2 position, and I've heard that position and I've heard other  
3 positions.

4           You know, so, I think we obviously have to come  
5 back at this again. I don't think we're ready to say to  
6 Carlos, here's what you should do. What I would hope that  
7 we could do, you know, the next time around, now that we  
8 understand this and we've begun to understand it more  
9 deeply individually, Carlos, is to come back with some  
10 options that are varied in terms of complexity -- more  
11 complex, medium complexity, less complexity -- that  
12 preserve the star rating system, or not, or alter it, and  
13 then have a discussion about the relative values of these  
14 approaches in a kind of more granular level. Is that --  
15 how does that work for you?

16           DR. MILLER: If I understand where you're  
17 landing, because I also saw differences of opinion, the way  
18 we might end up here, although it's -- having one idea and  
19 everybody behind it is the clearest signal, obviously, but  
20 if it turns out that that's not where we are, then the  
21 landing place, and I think that's what you're saying, it  
22 may be that we go through these different options, still

1 don't come to consensus, but what we produce is there are a  
2 couple different issues --

3 DR. CROSSON: The pros and cons.

4 DR. MILLER: Exactly.

5 DR. CROSSON: The pros and cons, yes.

6 DR. MILLER: And you just say -- and that may be  
7 where we have to be, if that's the -- or the lack of  
8 consensus here.

9 DR. CROSSON: It might also -- I mean, is this --  
10 when would we know, or would we know the direction that CMS  
11 may be going just to inform our discussion or not?

12 DR. MILLER: I'm not sure I can answer that.

13 MR. ZARABOZO: Well, I mean, they did post this  
14 information recently, and I think there's probably going to  
15 be more to come after that, so -- including how to address  
16 the issue, so there's more to come, I think --

17 DR. CROSSON: Yeah.

18 MR. KUHN: And presumably, they wouldn't do it  
19 until next year's letter, right, call letter?

20 MR. ZARABOZO: That's probably right, yeah.

21 DR. CROSSON: And just to be clear, I'm talking  
22 about publicly available information here, not --

1 MR. ZARABOZO: Yeah. Well, the call letter  
2 certainly would contain -- which is the February letter  
3 that would say, here's what we propose to do.

4 DR. CROSSON: Yeah. I wonder if we want to wait  
5 that long to do this reconsideration. Did you say  
6 February?

7 MR. ZARABOZO: February, yes. But I think  
8 between now and then, there will be more information coming  
9 out of CMS.

10 DR. CROSSON: Oh, okay. All right. That was  
11 sort of the question I was asking.

12 I think that's where we are, unless there are any  
13 other or different opinions. David.

14 DR. NERENZ: Just very quickly, in response to  
15 Kate's comment, you very eloquently talked about the policy  
16 dilemma. I mean, on the one hand, we don't want to  
17 unfairly either reward or penalize based on factors outside  
18 plans' control, but on the other hand, we do not want to  
19 excuse or allow truly poor quality, and the question is,  
20 how do you sort that out?

21 I just want to let people know that Ashish Jha  
22 and Alan Zaslavsky have written very eloquently about this,

1 and there's actually an analytic approach that gives  
2 traction on this point, and there's a lot of statistical  
3 deep water and we'd end up taking up Carlos's invitation to  
4 be here all night, so we're not going to do that. But,  
5 there was an article published last year. Ashish's blog  
6 post entitled, "Changing My Mind" lays it out. It  
7 fundamentally has to do with if you're looking at a gap, or  
8 a disparity, let's call it, let's say between low and high  
9 income, the question is, is that typically seen within  
10 plans or across plans?

11           If you see the same gap across all the plans you  
12 look at, depending it doesn't matter the mix of patients,  
13 it doesn't matter geographic location, if you see it  
14 consistently within, the same gap all the time, it suggests  
15 it's not a quality of care issue and, therefore, probably  
16 should be adjusted.

17           On the other hand, if you see it only in certain  
18 plans, meaning that those plans are bad for everybody, then  
19 that does suggest it's a quality care issue and probably  
20 should not be adjusted. Now, I've way oversimplified, but  
21 again, nobody wants to be here all night.

22           But, if either for staff or those who are

1 interested, Ashish has been wonderful in laying this out in  
2 pretty accessible terms to non-statisticians.

3 DR. CROSSON: I think that might be very helpful  
4 to look at. It still leaves us with the question of what  
5 does "adjusted" mean and --

6 DR. NERENZ: There are multiple forms, all kinds  
7 of approaches. It's a generic term, doesn't mean one  
8 particular mathematical model, and so it's complicated.

9 DR. CROSSON: All right. So, how are you feeling  
10 about this, Carlos?

11 MR. ZARABOZO: You know I'm retired. You know  
12 that, right?

13 [Laughter.]

14 DR. MILLER: And if you want to get out of here,  
15 you've got to stop asking Carlos questions, because he'll  
16 go on --

17 [Laughter.]

18 DR. CROSSON: Do you have enough to work with, or  
19 more than you would like?

20 MR. ZARABOZO: I think we have enough to work  
21 with, and we'll talk about it internally.

22 DR. CROSSON: Okay. All right. Well, thank you

1 so much for taking on this tough issue.

2 MR. ZARABOZO: Thank you.

3 DR. CROSSON: Well, okay. So, now we're ready  
4 for the public comment session. Could I ask anyone who'd  
5 like to make a public comment to come to the microphone and  
6 line up so we can see who wants to speak.

7 [No response.]

8 DR. CROSSON: Seeing no one, we are adjourned  
9 until 8:30 a.m. tomorrow morning. Thank you so much.

10 [Whereupon, at 4:43 p.m., the proceedings were  
11 adjourned, to resume at 8:30 a.m. on Friday, September 11,  
12 2015.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 11, 2015  
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
SCOTT ARMSTRONG, MBA, FACHE  
KATHERINE BAICKER, PhD  
KATHY BUTO, MPA  
ALICE COOMBS, MD  
WILLIS D. GRADISON, JR., MBA, DCS  
WILLIAM J. HALL, MD, MACP  
JACK HOADLEY, PhD  
HERB B. KUHN  
MARY NAYLOR, PhD, FAAN, RN  
DAVID NERENZ, PhD  
RITA REDBERG, MD, MSc  
CRAIG SAMITT, MD, MBA  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
CORI UCCELLO, FSA, MAAA, MPP

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[8:31 a.m.]

DR. CROSSON: Okay. I think it's time to get going this morning. Welcome back. I hope everybody had a nice evening. Welcome to our guests in the back.

This morning we're going to open up with a discussion, a relatively broad discussion and somewhat initial discussion, for the work of the Commission in the next year or so on Medicare drug spending. We're going to hear from Rachel Schmidt and Shinobu Suzuki. That rolls right off the tongue, both of them. And I must say I need to congratulate you for the clarity of this paper that we read in preparation for this. It read so easily, I put down my novel on the plane just to read it again.

[Laughter.]

DR. CROSSON: It was an okay novel. But, I mean, the clarity and the logic was terrific, so thank you so much for that.

Who's going to start out? Rachel?

DR. SCHMIDT: Yes, I am. And Kim Neuman is also a co-author on this.

Good morning. Before we get started, we would

1 like to thank many of our colleagues for their help on this  
2 presentation. This obviously touches across all aspects of  
3 Medicare. But we especially want to thank Craig Lisk for  
4 his help.

5 Over the years, many of the Commission's  
6 discussions about Medicare policies have involved  
7 prescription drug spending. In recent meetings, several of  
8 you have asked questions that seemed to be looking for  
9 broader context around Medicare's payment policies for  
10 drugs. In response, we thought it might be helpful to  
11 start out the meeting cycle with some of that context.

12 This is the first of two presentations that we'll  
13 give. This morning we'll talk about the magnitude of  
14 Medicare drug spending across all payment systems. We'll  
15 also describe conceptually how Medicare pays for drugs.  
16 Next month, we'll provide background material about the  
17 development and approval processes for drugs and biologics,  
18 as well as information about drug-related industries such  
19 as pharmacies and pharmacy benefit managers.

20 Just to remind you, here is a list of topics from  
21 some of your most recent conversations related to Medicare  
22 prescription drug spending. I am not going to go over

1 these in detail now, but more detail about each of these  
2 topics is available in the Commission's June 2015 Report to  
3 the Congress.

4           So let's look at the magnitude of Medicare's drug  
5 spending. This chart shows estimates from the National  
6 Health Expenditure Accounts put together by CMS' Office of  
7 the Actuary. These estimates are consistent with  
8 statistics on the nation's gross domestic product, and they  
9 provide greater detail about health care producing sectors  
10 of the economy. They reflect all payers for health care  
11 including Medicare.

12           A key thing to note is that the national health  
13 accounts use a final purchase retail concept. This means,  
14 for example, that when a hospital buys prescription drugs  
15 that it uses for surgery, drugs are an input to hospital  
16 services -- the final product. The expenditure accounts  
17 measure the value of hospital services, but they don't  
18 separately measure the drugs used for surgery. We'll show  
19 you a broader spending concept in a moment.

20           The national health accounts include retail  
21 prescription drug spending, such as when Part D enrollees  
22 fill a prescription at a drug store or grocery store or

1 when a physician's office buys drugs to administer to  
2 patients.

3           In 2013, across all payers, retail drug spending  
4 made up 9 percent of all national health expenditures.  
5 However, retail drugs made up a higher share of Medicare  
6 spending -- 13 percent. Medicare's retail spending in 2013  
7 reflects Part D program spending of \$64 billion and another  
8 \$10 billion in prescription drugs billed separately under  
9 Part B.

10           Since 2006, when the Part D program began,  
11 Medicare's importance as a payer for prescription drugs has  
12 grown. This chart shows all the different payers in the  
13 economy for retail prescription drugs from the national  
14 health accounts. If you summed up all of these lines for  
15 any given year, it would total 100 percent. Before 2006,  
16 retail drug purchases paid by Medicare only made up 2  
17 percent of total drug spending, which is shown in the blue  
18 line. Medicare's share jumped immediately to 18 percent in  
19 2006 because of Part D, and its share grew to 28 percent by  
20 2013. The Office of the Actuary projects that Medicare's  
21 share of retail drug spending will reach 34 percent by  
22 2024.

1           You may notice that Medicaid's share -- the  
2 yellow line -- fell dramatically in 2006 as Medicare took  
3 over most of the responsibility for the drug spending of  
4 the dually eligible beneficiaries. Notice also that  
5 there's be a long-term downward trend in the share of  
6 retail drug spending paid out of pocket by patients, which  
7 is shown in the red line. Private health insurance -- the  
8 green line -- mostly provided through employers, has  
9 historically been a very important payer for drugs. It is  
10 still very important, but its share has been declining  
11 somewhat.

12           Oops. This slide is not great there. I  
13 apologize for how that turned out.

14           To get another sense of the magnitude of Medicare  
15 drug spending, we developed estimates that include not only  
16 retail drug spending but also spending for drugs and  
17 pharmacy services used as inputs at health care facilities.  
18 We based these estimates on Medicare cost reports, Medicare  
19 claims, and estimates of program spending from the  
20 Trustees' report. I'm happy to go into more detail about  
21 methodology on question.

22           Ultimately, the estimates are all in terms of

1 Medicare program spending -- what the program paid for.  
2 There's also another block of spending associated with what  
3 beneficiaries paid in cost sharing for drugs that is not a  
4 part of this estimate.

5           First, look at the left. Medicare program  
6 spending totaled \$574 billion in 2013, and we estimate that  
7 drugs and pharmacy services made up 19 percent of that.  
8 Typically people think of 9 or 10 percent, but we think  
9 it's about 19 percent in this broader concept. You can see  
10 how we get there by looking at the right -- at least if you  
11 look at your handouts.

12           [Laughter.]

13           DR. SCHMIDT: Part D is the largest piece and  
14 makes up 57 percent of the total. This includes drug  
15 benefits in both stand-alone plans and in Medicare  
16 Advantage drug plans. If you add in separately billed  
17 physician and supplier drugs administered in physician  
18 offices and hospital outpatient departments, that brings in  
19 the other two green pieces of the pie, or another 15  
20 percent of the total. Now, if we add in drugs used as  
21 intermediate inputs for hospitals, skilled nursing  
22 facilities, hospice agencies and so forth, along with the

1 same sort of spending delivered in Medicare Advantage  
2 plans, we get to the total.

3           To summarize so far, you might have heard before  
4 this morning that drugs make up about 9 or 10 percent of  
5 health care spending. That figure comes from the national  
6 health accounts and reflects retail spending on  
7 prescription drugs compared to all health care spending in  
8 the economy. For Medicare, that final consumption, retail  
9 concept percentage is higher; 13 percent of Medicare  
10 spending is made up of retail prescription drug spending.  
11 If we use a broader measure that takes retail spending for  
12 Part D and some Part B drugs, and also add to it spending  
13 for drugs and pharmacy services that are inputs for other  
14 providers like hospitals and SNFs, we think altogether that  
15 comes to about 19 percent of Medicare program spending.

16           Now Shinobu will describe the approaches Medicare  
17 uses to pay for prescription drugs.

18           MS. SUZUKI: Thanks, Rachel.

19           So I won't go into the details of each payment  
20 system. Generally, though, Medicare pays in different ways  
21 across the health care sectors. Here we've grouped them  
22 into four categories. In the first type, the cost of drugs

1 are included within prospective payment bundles. Payments  
2 for most institutional providers fall under this category.  
3 The second type, used for certain Part B-covered drugs, is  
4 paid separately on the basis of their ASP plus an add-on.  
5 The third is Medicare Advantage plans that receive  
6 capitated payments based on fee-for-service benchmarks and  
7 bids for their broad bundles of Parts A and B services, as  
8 well as prescription drugs. Finally, under Part D,  
9 Medicare uses a combination of capitated payments based on  
10 plan bids and reinsurance subsidies to pay for the drug  
11 benefit.

12           We'll go over these in more detail in the next  
13 few slides, but generally in each case Medicare's influence  
14 over drug pricing is fairly limited. In other words,  
15 typically it is the provider of the health care service or  
16 the plan that negotiates prices for drugs, not Medicare.

17           This chart gives you a sense of how much of  
18 Medicare's drug spending falls into each of those four  
19 categories, using the broader estimates we developed.

20           On the left is the distribution of Medicare drug  
21 spending for 2007, which we estimated was about \$82  
22 billion. Medicare program spending for Part D made up 56

1 percent, followed by 21 percent for drugs paid within  
2 prospective payment systems, 14 percent with ASP-based  
3 payments, and 9 percent for Parts A and B services  
4 delivered by MA plans.

5           On the right you can see that the distribution  
6 for 2013 did not change all that much. We estimate that  
7 total Medicare drug spending was about \$112 billion, and  
8 Part D program spending made up 57 percent of that total.  
9 The proportion associated with prospective payments fell to  
10 16 percent, but that mostly reflects the growth in  
11 enrollment in MA plans, which are shown as the gray piece  
12 of the pie.

13           Prospective payment bundles are used to pay for  
14 Part A and some Part B services. They group together  
15 services that are expected to use similar levels of  
16 resources. Examples include inpatient and outpatient  
17 prospective payment systems that group services based on  
18 diagnosis-related groups and the outpatient dialysis  
19 payment system.

20           For skilled nursing facility and hospice  
21 services, Medicare bases payments on per diem rates. These  
22 prospective payments are intended to give providers

1 incentive to manage their costs of care. For services paid  
2 under these payment bundles, drugs are used as an  
3 intermediate input to health care services. The cost of  
4 drugs in these payment bundles reflects prices that  
5 providers, their group purchasers, wholesalers, and  
6 pharmacies negotiated with manufactures -- meaning that  
7 Medicare does not have a direct influence over the prices  
8 paid for drugs included in the payment bundles.

9 Medicare generally pays for most Part B-covered  
10 infusible and injectable drugs administered in physicians'  
11 offices and in hospital outpatient departments separately  
12 rather than bundling them into payments for other services.  
13 By law, the payments for these drugs are set at ASP plus 6  
14 percent. The ASP reflects the average price realized by  
15 the manufactures based on sales to nearly all purchasers.  
16 That is, although the payment rates for Part B drugs are  
17 set administratively by CMS, the use of market-based ASP  
18 data to set these rates means that Medicare's influence on  
19 what prices are paid is indirect.

20 Part D makes up the largest spending on drugs,  
21 accounting for over half of all payments for drugs by  
22 Medicare. As with other payment areas, Medicare has little

1 direct effect over prices for outpatient drugs covered  
2 under the Part D program because payments are made to plans  
3 based on bids that they submit, which reflect prices  
4 negotiated between plans, pharmacies, and drug  
5 manufacturers. The bids are essentially premiums that  
6 plans need to collect in order to provide the benefit.  
7 Medicare subsidizes the premiums through two forms of  
8 payments: the capitated direct subsidy payment and an  
9 open-ended individual reinsurance payment. While plans are  
10 at risk for the benefit spending covered by the direct  
11 subsidy, Medicare pays for individual reinsurance that  
12 covers 80 percent of the catastrophic spending. These two  
13 payments average to 74.5 percent of the total premium, and  
14 the remaining 25.5 percent is paid by the enrollees.

15           In addition, Medicare pays plans that enroll low-  
16 income beneficiaries most of their cost sharing and  
17 premiums. The law that created the Part D program included  
18 a provision that prohibits the Secretary from interfering  
19 with the negotiations between drug manufacturers and  
20 pharmacies and plan sponsors. It also prohibits the  
21 Secretary from requiring a particular formulary or  
22 instituting a price structure for reimbursement.

1           Here we list some examples of how other federal  
2 programs pay for drugs. Medicaid purchases drugs through  
3 retail pharmacy distribution channel as in Part D.  
4 Manufacturers are required by law to provide statutory  
5 rebates in exchange for coverage of their drugs under  
6 Medicaid. Most states obtain additional rebates by using  
7 placement on their preferred drug lists as negotiating  
8 leverage. The Veterans Affairs and the Department of  
9 Defense generally purchase drugs directly. Both programs  
10 have access to discounted prices that are set in law, and  
11 they both obtain further price reductions using placements  
12 on their drug formularies as leverage.

13           While statutory discounts allow some federal  
14 programs to pay lower prices for drugs, such discounts are  
15 not available to private insurers. Now I'm going to walk  
16 you through how private payers may obtain rebates or  
17 discounts from drug manufacturers.

18           One way a payer may have leverage in negotiating  
19 lower prices is by being able to move market share -- that  
20 is, successfully encouraging its members to use certain  
21 drugs over competing therapies.

22           Another common strategy is to use a formulary.

1 Nearly all Part D plans use formularies with tiered cost  
2 sharing. The tier placement or applicability of  
3 utilization management tools, such as prior authorization,  
4 can provide plans with leverage when negotiating rebates  
5 and discounts. Some payers may also use comparative  
6 effectiveness studies to not only make coverage decisions  
7 but also to obtain rebates and discounts from  
8 manufacturers. However, these strategies may not be  
9 effective when there are no competing therapies.

10 Our goal today was to provide background  
11 information on how Medicare pays for drugs. Next month, we  
12 will be coming back to you with another presentation that  
13 will provide background information on drug-related  
14 industries. We would be happy to answer any questions  
15 about today's presentation and would also be interested in  
16 finding out if you have any information you would like us  
17 to look at for next month that would be helpful in your  
18 discussions about Medicare drug policy issues.

19 That concludes our presentation.

20 DR. CROSSON: Thank you. Thank you very much,  
21 Rachel, Shinobu.

22 So, I think what we're going to do now, as we

1 usually do, is take clarifying questions, and we'll start  
2 with the right end of the table.

3 DR. NERENZ: I wonder if you could just talk a  
4 bit more about outpatient drugs, Part B drugs. The  
5 prototype in my mind is a chemotherapy infusion, but I'm  
6 curious, are all Part B drugs paid as part of a larger  
7 bundle, or are there some that are purely drug payments?

8 DR. SCHMIDT: Yeah, most of them are separately  
9 billable, actually, under Part B --

10 DR. NERENZ: So the --

11 DR. SCHMIDT: -- under the ASP plus 6. There's a  
12 small amount of spending that is packaged within the  
13 outpatient prospective payment system. It's packaged  
14 within the payment rates for that.

15 DR. NERENZ: So, the packaging is relatively  
16 small. The direct payment is relatively large. Okay.  
17 Thank you.

18 DR. MILLER: And by direct payment, David, in  
19 asking that question, there's two things that happen when  
20 this happens. Medicare pays for the drug, and then  
21 Medicare pays an administrative --

22 DR. NERENZ: Yeah.

1 DR. MILLER: Right.

2 DR. NERENZ: Okay. It was relative size.

3 MS. THOMPSON: Foundational. Do we understand,  
4 or can you help us understand, how is ASP -- how is the  
5 average sales price set and how is the average AWP set?

6 MS. SUZUKI: AWP is a list price that  
7 manufacturers set. It's not a market-based price.  
8 Usually, most payers do not pay the AWP. They negotiate  
9 prices that are different from that. ASP is a market-based  
10 price, but it reflects the rebates and discounts that are  
11 negotiated, and it could be retroactive rebates, but all of  
12 that is reflected in the final price. So, it's what  
13 manufacturers receive for the sale of a particular drug.

14 MS. THOMPSON: I understand it's what they  
15 receive, but how is it set? Is there a formula to the  
16 establishment of those numbers?

17 MS. SUZUKI: So, it's an average, volume-weighted  
18 amount.

19 MS. THOMPSON: So, the manufacturers are  
20 reporting that information to CMS, correct, and then CMS  
21 calculates the average? Okay.

22 DR. HALL: Thank you. This was a very, very

1 informative chapter.

2           It's been said in our own materials here and  
3 elsewhere that a substantial part of the increase in prices  
4 and expenditures for Part D is related to a couple of  
5 products, some of the new biologics that have come out.  
6 Hep C treatment is one that's been focused. Is there any  
7 way to break that down a little bit more, and if we remove  
8 these additional expenditures for drugs that have no  
9 competition, essentially, what are the other factors that  
10 are causing the rise in drug expenditures overall? Do you  
11 have any more detail on that?

12           DR. SCHMIDT: Well, so generally, I think, in  
13 some of our past presentations about Part D, we've tried to  
14 emphasize that there's almost a bimodal distribution of  
15 spending. So, the bulk of beneficiaries are taking  
16 medicines that have gone generic, by and large, and then a  
17 relatively small amount are hitting the catastrophic region  
18 and it's their use of some of the higher-cost drugs is  
19 higher, although it's still relatively small. They're  
20 using lots of other drugs, as well.

21           General factors behind increase in prices? I'd  
22 say the biggest thing is that there's kind of a transition

1 going on right now. A lot of the blockbuster drugs have  
2 already gone generic at this point and we're now into a new  
3 stage where it's more biologics entering, you know, off the  
4 pipeline and getting approval from FDA for marketing, and  
5 it's just the flow of a portfolio of drugs into kind of  
6 this new world that's more biologics that's driving  
7 spending increases, I'd say.

8 DR. CROSSON: Herb. Kathy.

9 MS. BUTO: I wonder if you could -- because the  
10 paper actually goes into detail about the different growth  
11 rates in the different sites of care, and I think you  
12 pointed out that MA, the growth rate in drug spending in MA  
13 is driven by the growth in enrollment. I also noticed that  
14 OPDs, outpatient departments, are growing faster than, say,  
15 Part D, for example, and I guess the lowest is inpatient  
16 hospital spending on drugs, as you've extrapolated or been  
17 able to figure it out.

18 But, could you say a little bit more about what  
19 the reasons are behind the differential growth rate, if  
20 you've taken a look at that, and sort of related to that,  
21 say something about why Medicare's retail spend is higher  
22 than private, or all other drug spending, sort of in the

1 National Health Accounts. So, say a little bit more about  
2 the 13 percent versus the --

3 DR. SCHMIDT: Right. Let me --

4 MS. BUTO: -- nine or ten percent --

5 DR. SCHMIDT: Let me start with that one so I  
6 don't forget it. It's higher than -- the 13 percent is  
7 higher than the nine percent largely because of the -- I  
8 think that -- actually, I had a different answer in mind.  
9 I mean, it's encompassing both the Part D retail spending  
10 as well as the Part B drugs, and I think the use of those  
11 biologics probably tends to be higher within the Medicare  
12 population than the population as a whole, is my  
13 hypothesis. So, that's that one.

14 MS. BUTO: Just a quick follow-up. So, in the  
15 nine or ten percent for the population as a whole, that  
16 also includes whatever use of biologics is going on in the  
17 --

18 DR. SCHMIDT: If it's going through retail  
19 channels, yes.

20 MS. BUTO: Okay. Because, I think, based on your  
21 definitions, it looked to me as if the all of Part B drug  
22 spending would be counted in that number, but you might not

1 pick up that, since private insurers pay for drugs  
2 differently. It may not be a total apples-to-apples, is  
3 what I was thinking.

4 DR. SCHMIDT: Yes, that's quite possible. You're  
5 right. I think not all of the -- not all Part B drugs were  
6 in there because of the small amount of packaging in  
7 reference to my first answer. But, it's most of Part B  
8 drugs are the separately billable ones, and you may be  
9 right. It may not exactly be apples-to-apples.

10 On your first question, the table that's in your  
11 mailing materials, yes, it's correct that I think the  
12 fastest growth rate we noted was for outpatient hospital  
13 prescription drug spending, and that's going to reflect the  
14 transition that we've seen in changing care settings,  
15 office settings into more hospital outpatient departments,  
16 by and large, I would say, as well as the use of more  
17 biologics and the higher launch prices that we've observed  
18 in recent years.

19 MS. BUTO: You don't -- or maybe you do think  
20 that the reimbursement differentials between OPD and  
21 physician office might help drive that change?

22 DR. SCHMIDT: Well, I think the transition --

1 MS. BUTO: You think there's a shift --

2 DR. SCHMIDT: It's a shift --

3 MS. BUTO: -- from inpatient to out.

4 DR. SCHMIDT: Yeah.

5 MS. BUTO: Okay.

6 DR. SCHMIDT: It's the same payment rates, right?

7 It's all based on ASP plus 6. It's just the transition of  
8 where the care is being administered.

9 And, in terms of -- I should caution you on the  
10 Part A and Part B spending providing by Medicare Advantage  
11 plans. You know, we weren't able to use detailed data to  
12 estimate that, right. So, we're assuming that it's the  
13 same proportion of spending as in fee-for-service. But,  
14 yes, we saw rapid growth in that in our estimates and  
15 that's largely reflecting growth in the enrollments of  
16 Medicare Advantage.

17 DR. MILLER: And if you think about it -- you're  
18 at a good resting place. I hope this doesn't mess things  
19 up. You know, you get in a lot of enrollment into MA, so  
20 that's some of it. We're seeing declines in inpatient  
21 admissions. We're seeing increases in outpatient  
22 utilization, which is probably secular and the shift from

1 the physician setting as hospitals purchase physician  
2 practices. So, in some ways, these trends match broader  
3 trends in -- broader spending trends.

4 MS. BUTO: Where I was trying to go was I was  
5 trying to figure out whether the 340(b) hospital issue,  
6 where there have been a lot of shift of oncology to  
7 hospital outpatient, had anything to do with that, but  
8 maybe we can't really tell.

9 DR. SCHMIDT: I'd say we can't really say for  
10 sure, unless any of my colleagues sitting over here has an  
11 answer.

12 DR. MILLER: We have looked at this a little bit.

13 MR. WINTER: You might recall from the June  
14 chapter on 340(b), we did have a section in there which  
15 compared the growth in spending for oncology services,  
16 chemotherapy in 340(b) versus non-340(b) hospitals. It is  
17 growing much faster in the 340(b) hospital setting. But in  
18 terms of attributing what share of the growth they're  
19 talking about here to that phenomenon, it would be -- it  
20 would take more work. I'm not sure it's feasible.

21 DR. NAYLOR: So, I echo this is a terrific  
22 report. I'm wondering, Slide 10, and you -- I'm trying to

1 get a sense of how -- and I thank you for the reference to  
2 the work in the June report on the oncology bundling, but  
3 I'm trying to get a sense of how -- what we know about the  
4 effects of bundling as a tool, and given the indirect  
5 influence of Medicare on drug pricing, the effect of  
6 bundling on reducing prices relative to other tools  
7 available to the Medicare program.

8 DR. SCHMIDT: I'm not very knowledgeable,  
9 frankly, about how the bundle is built in terms of the  
10 payments for the drug versus the other services. Nancy, do  
11 you --

12 MS. RAY: So, to be clear, the oncology care  
13 model, that has not started yet.

14 DR. NAYLOR: [Off microphone.] I understand.

15 MS. RAY: Okay.

16 DR. NAYLOR: [Off microphone.] Have we -- or  
17 maybe I should start with, do we have experience with  
18 bundling with other programs, ESRD, and to the extent that  
19 we do, do we know about its relative impact on costs?

20 DR. MILLER: Right, and depending on how broad  
21 your question is, I think the answer is going to be we  
22 don't know. But if I follow you, and I want to see if I'm

1 actually getting what you're asking, so some of what goes  
2 on in Medicare is the payments end up inside payment  
3 bundles, whether they're OPD bundles or inpatient DRGs,  
4 that type of thing. And your question could be, so is that  
5 a more effective way of restraining the cost of the drug  
6 versus some other methodology, and I'm not -- I don't feel  
7 like I could directly answer that question or point to any  
8 analysis that does.

9           Now, we could take this offline and run it  
10 through our heads and try and come back to you and see if  
11 there is something out there that we could bring back to  
12 it. But, I wouldn't feel real confident --

13           MS. BUTO: Will we get any more information from  
14 MA once we analyze the encounter data, do you think?

15           DR. SAMITT: I guess when we talked to ESRD,  
16 didn't we take a look at the use of Epogen before inclusive  
17 of a bundle and after?

18           DR. MILLER: Yeah. Actually, that's a really  
19 good point. So, when Epogen was put into the bundle, the  
20 utilization started to decline. There were also some other  
21 clinical -- and Nancy's going to come to the microphone --  
22 and what I think, if we could get her to sit down and stand

1 up about three or four times, I think that would be a good  
2 thing.

3 [Laughter.]

4 DR. MILLER: But, there were some clinical  
5 indication stuff that was happening, as well.

6 MS. RAY: I think the decline -- the substantial  
7 decline in Epo use was a function of both change in the FDA  
8 label as well as including the ESAs in the bundle.

9 The other thing that we did see, and this is just  
10 N of 1, but after the ESRD PPS was implemented in 2011, the  
11 drugs used for bone and mineral management, there's two  
12 primary drugs. There was a sort of little mini price  
13 competition between them, and you did see the ASP plus 6  
14 decline after the start of the PPS. But, that is just an  
15 example of one.

16 DR. MILLER: So, why don't you sit tight, unless  
17 you really want to walk back and forth.

18 [Laughter.]

19 DR. MILLER: So, the other thing -- and at least  
20 one reason I cold started on that is the Epo impact was a  
21 utilization impact, and that's another thing just to keep  
22 sorted out in your minds, is that you can put something in

1 a bundle, and it may have a utilization effect and the use  
2 of it may go down, but the price may go up or down, or you  
3 may result in some price impact, as well. But those are  
4 probably two separate effects to carry in your mind at all  
5 times about what ultimately affects your spend, how much of  
6 it you're providing and what price it is. And the Epogen  
7 effect was largely a utilization effect, if I recall  
8 correctly.

9 DR. CROSSON: And I remember there was a modest  
10 reduction in hemoglobin that went along with it, as well.

11 DR. NAYLOR: Thank you.

12 DR. CROSSON: Scott.

13 MR. ARMSTRONG: So, a couple of questions.  
14 Actually, the last couple of questions were beginning to  
15 move into the territory I was interested in asking a little  
16 bit about. Slide 6 might help us.

17 First, the unnamed --

18 [Laughter.]

19 MR. ARMSTRONG: -- piece of the pie on the left-  
20 hand side is a drug spend at 19 percent of the overall  
21 Medicare spend. Are there -- what's the next -- what are  
22 the other big categories? I could probably go back to some

1 of our old chapters, but just trying to get a feel for how  
2 this should be weighted as a priority for our review. And  
3 in particular, do you have a sense off the top of your head  
4 for, like, what our inpatient hospital spend is as a  
5 percent of the total spend these days, and how does the 19  
6 percent compare?

7 DR. MILLER: So, inpatient is probably, what,  
8 110?

9 STAFF: [Off microphone.] About the same.

10 MR. ARMSTRONG: About the same.

11 DR. MILLER: Then, you know, MA is 150, 160,  
12 somewhere in there. Physician is 65, 70. Are we good?

13 STAFF: [Off microphone.] Yes.

14 DR. MILLER: Okay.

15 MR. ARMSTRONG: That's great. Actually, that's  
16 great. So, that just affirms -- and I have to admit, I  
17 should know this better, but that this is one of the big  
18 ones and I just think that part of the analysis you've done  
19 is really to help make that clearer in terms of overall  
20 spend.

21 Second, I really appreciated Kathy's questions  
22 and then Mary's. On the right-hand side, this gives us

1 some sense for, when you break it down into these different  
2 sort of payment categories, if you will, what the division  
3 is, and we can talk about how there have been bigger or  
4 lesser changes in some of those categories over time. And,  
5 for example, hospital outpatient has been increasing at a  
6 higher rate.

7           And that's interesting, but I wonder if there's a  
8 way for us to take that total spend, \$112 billion, and  
9 break down the increase in spend by a different set of  
10 categories, and we were just talking about that. How much  
11 is driven by price per unit of service? How much is driven  
12 by utilization? How much is driven by the biologics versus  
13 generic pricing changes? You know what I'm saying? That  
14 is independent of these payment categories, but much more  
15 focused on the underlying impacts to the overall trend.

16

17           DR. SCHMIDT: I think that would take quite a bit  
18 more detailed data than we might readily have on hand,  
19 especially across all settings. You know, in our cost  
20 report --

21           MR. ARMSTRONG: Yeah.

22           DR. SCHMIDT: -- information, for example, for

1 the facilities, I'm not sure that there's that level of  
2 detail to capture the effects of price increases versus  
3 utilization of certain drugs. We might have to turn to  
4 secondary sources and that sort of thing.

5 MR. ARMSTRONG: Okay. And, I don't -- I'm not  
6 convinced it would really help us, but part of what I'm  
7 trying to get at is, ultimately, later in the year, our  
8 responsibility is to figure out, well, what do we do with  
9 this information? What's the best way for us to have an  
10 impact through our payment policy choices? And, if a lot  
11 of the spend in future years is driven by price versus  
12 utilization, that could really inform some of those. So,  
13 anyway, to the degree there's some way for us to get some  
14 insight into this, maybe the ESRD work and oncology work  
15 offers some of that, but that was --

16 And just one other point, and this is really not  
17 meant to be a loaded question. I honestly don't really  
18 know. On Slide 12 and in the paper, you do fairly  
19 explicitly point out that the law prohibits the Secretary  
20 from taking certain actions. And I'm just -- is there a  
21 real policy argument for why that is in the law? And, I  
22 just don't know.

1 DR. MILLER: Ray?

2 [Laughter.]

3 DR. MILLER: So, I don't know what you thought I  
4 was going to say --

5 [Laughter.]

6 DR. MILLER: -- Rachel. All I was going to say  
7 is, to his first question, could we do -- and I am going to  
8 come back to your second. But, in all seriousness, on your  
9 first question, the unit versus price question, we do -- we  
10 can, and I don't want to put you on the spot -- we can  
11 induce some of that in D, which is a big chunk of the  
12 action, and we can break that down and lay that out more  
13 clearly for you, and I want to be really careful because I  
14 don't want to give Kim a heart attack. Can we do that in  
15 B, price versus use? I think we could.

16 So, of the 19 percent, 13 percent of it, we  
17 could, I think, do what you said. But it's all the stuff  
18 that's tucked away in inpatient, outpatient where we would  
19 have really a hard time.

20 To your second question, you know, the main  
21 answer is I think there is really a philosophical argument  
22 that occurs, and it occurs time and time again, and it

1 occurred at the time of the legislation, whether the  
2 government directly negotiating has greater power than  
3 moving the negotiation down to a private intermediary. And  
4 so the decision at the time that the legislation was  
5 created was to say there is a negotiation power, but that  
6 negotiation power will be housed in the individual plans  
7 and that plans will negotiate the price for the government.

8 MR. ARMSTRONG: [Off microphone.] A market  
9 price?

10 DR. CHRISTIANSON: There's a little other nuance  
11 of that, which is the fact that they're going to be  
12 competitive bidding among the organizations, was going to  
13 place pressure on them to do that in negotiation part, so  
14 part of it was the establishment of the competitive market  
15 for the Part D plans, which was the justification.

16 DR. BAICKER: And just to add on, one, the  
17 analogy to we always wish we knew in Medicare Advantage,  
18 how the plans were negotiating different prices and bundles  
19 to manage care better, if only we knew what the private  
20 market prices would be, then we wouldn't have to go through  
21 these horrible formulas and revisions of schedules that are  
22 always off, I think the idea being if you have these

1 private entities competing rather than the government  
2 negotiating one monolithic price that is not necessarily  
3 going to be right, then you get both market competition and  
4 market signal. Now, whether that works well in practice is  
5 a separate question, but that seemed like the motivation.

6 MR. ARMSTRONG: And I don't necessarily have a  
7 point of view on what's better or worse, but it's -- again,  
8 it is what it is, and as we begin to formulate what we  
9 might be able to do to have some impact, maybe the question  
10 I would have is, Are there other parts of Medicare payment  
11 where there's a similar dynamic that we could learn from?

12 Again, I don't want to dwell on it too much, but  
13 if there is something about what we are expecting when the  
14 law was built, that we either have affirmed we got or we  
15 haven't gotten that would help inform what we might do  
16 going forward, I just think that might be worth at least a  
17 little bit of time.

18 DR. CROSSON: I actually had a similar question,  
19 and it has to do with Part D. And this is not to  
20 understate the nature of this problem whatsoever.

21 At the time that the law was passed, there was an  
22 estimate of what Part D would cost, and it has not proven

1 to cost that much. So the question is, To what extent do  
2 we understand, going back to the original assumptions?  
3 What's different? What has transpired that's different,  
4 and is there anything that we could learn about that that  
5 could be augmented or push us in a policy direction or not?

6 DR. SCHMIDT: Mark is laughing because many  
7 people in this room were involved with putting those  
8 estimates together.

9 [Laughter.]

10 DR. MILLER: Just for the record, speak for  
11 yourself.

12 [Laughter.]

13 DR. CROSSON: Whoops!

14 DR. SCHMIDT: In any event, I think that we do  
15 know quite a bit about why the original CBO estimates was  
16 wrong, and I think OAC's estimates was also wrong. But on  
17 the CBO side --

18 [Laughter.]

19 DR. SCHMIDT: On the CBO side, I think a key  
20 thing is that we had enrollments estimates that were too  
21 high. There was, I think, a relatively high assumption of  
22 participation in the low-income subsidy, higher than came

1 to actually happen, higher participation generally, and we  
2 had a high estimate of per capita spending. And those were  
3 the key issues. Actually, spending came in much lower when  
4 we actually saw the bids. After a year's experience, bids  
5 came in lower still, and I think then at that point, plans  
6 had a basis of claims for understanding what utilization  
7 was going to look like, what their enrollment was going to  
8 look like and that sort of thing.

9           And it's actually been a fairly competitive  
10 market, I would say, and that has been one factor that's  
11 been holding down the premium side. But as Shinobu and I  
12 have come to you and talked about before, there is also  
13 another part of the Part D program spending in reinsurance  
14 that's been going up significantly over time.

15           DR. CROSSON: So enrollment notwithstanding, in  
16 terms of the original estimate, to get back to the same  
17 point, is it primarily utilization or price or a  
18 combination of both that appears to be different than what  
19 was originally assumed?

20           DR. MILLER: Well, it's --

21           DR. SCHMIDT: Yeah. I think it's more enrollment  
22 level, so fewer bodies -- right? -- fewer numbers of people

1 participating in the program than was original estimate.

2 DR. CROSSON: Okay. So --

3 DR. SCHMIDT: And the per capita spend, which is  
4 a combination of utilization and price. I don't know that  
5 we can tease out which of those was the --

6 MS. BUTO: Rachel, do you remember what the  
7 percentage of generic use was that was assumed than the --  
8 because was that higher in actuality or about what CBO  
9 projected, generic use?

10 DR. SCHMIDT: I think we had a pretty good  
11 estimate of what the GDR was at the time. I think it was  
12 the increase in per capitas that was pretty much off.

13 DR. CROSSON: Jack, do you have a point on here?

14 DR. HOADLEY: Yeah. I mean, I've written on  
15 this, and I talk a lot in what I wrote about the generic  
16 shift being more rapid and fewer new products coming on the  
17 market in the period from not just '06, but really from the  
18 time the estimates were made, which would have been '02  
19 till almost the present. Obviously, what we've talked  
20 before about last couple of years have started to change  
21 that story a bit, but I really argue that the biggest  
22 driver of the difference between the estimates is the

1 generic shift and the fact that plans got to ride the wave  
2 of that. In a sense, that's price and not utilization,  
3 although it's price by product substitution as opposed to  
4 the price per product.

5 DR. CROSSON: Thank you. Thank you for that.

6 DR. SCHMIDT: Yeah. That's absolutely right. We  
7 knew what the GDR was at the time, but we didn't anticipate  
8 how quickly it would fall.

9 MR. GRADISON: I think that the CBO have actually  
10 gone back and taken a look at this and put out some paper  
11 on the subject, which might be helpful to summarize at some  
12 point because their estimate was significantly off. And  
13 they have also gone back and done some re-estimating, which  
14 is another subject, but of the ACA. So my sense is that  
15 they are becoming, over time, more open to publicly  
16 reviewing their own work and having people take a look at  
17 the assumptions, maybe not as much real time as analysts  
18 would like, but after the fact.

19 DR. CROSSON: Okay. Over here? Alice.

20 DR. COOMBS: I just have one clarifying question.  
21 In the handout, the paper, page 9, figure 3, there's a  
22 sliver of end-stage renal disease. I was thinking about

1 what Mary was pointing to regarding the bundle and the  
2 example that we were discussing regarding the ESRD bundle.  
3 Is some of that overlap and some of the other circles --  
4 and I'm wondering, you know, how does that get parlayed out  
5 as a 1 percent?

6 DR. SCHMIDT: In this particular case, we asked  
7 Nancy to go dive into the claims information and look at  
8 the percentage of ESRD spending from their cost reports and  
9 claims information.

10 DR. COOMBS: So this came out of the bundles?

11 DR. SCHMIDT: Yes. Right. She pulled it out of  
12 the bundles.

13 DR. COOMBS: Okay. So then there's an itemized  
14 count of drugs interfaced within the bundle. So, in terms  
15 of the calculation, I think that helps out a little bit  
16 about the predictable impact of drugs on some of the  
17 bundles. This would indicate that.

18 DR. HOADLEY: So I have a couple of clarifying  
19 questions. One, when you were talking about the national  
20 health accounts in response -- I think it was Kathy's  
21 question -- for the infusion clinics or other physicians  
22 that are doing infused drugs, if they're getting drugs

1 directly from the wholesaler, is that going to show up as  
2 in the national health accounts' retail purchase, or is  
3 that actually not going to show up there?

4 DR. SCHMIDT: We have been trying to understand  
5 it more fully, and it's a little murky, we have to admit.

6 Here's my guess, but I don't know this for sure.

7 DR. HOADLEY: Fair enough.

8 DR. SCHMIDT: I think some of these sales are  
9 taking place through what are now specialty pharmacies --

10 DR. HOADLEY: Right.

11 DR. SCHMIDT: -- right? -- which I think would  
12 count as retail spending, so that's my best guess of --

13 DR. HOADLEY: So maybe actually a mix.

14 DR. SCHMIDT: Right.

15 DR. HOADLEY: Okay. Because, I mean, just things  
16 that when we get into the weeds here to think about which  
17 things are being accounted for in that, in that trend line  
18 -- and I was glad to hear the clarification on the Part C  
19 on the Medicare Advantage drugs. So you really are just  
20 totally generating. To the extent that we are able to find  
21 those in the claims data down the road and the encounter  
22 data down the road, we may find that the drugs used on the

1 A and B side could be either higher or lower than what  
2 you're projecting from fee-for-service side.

3 DR. SCHMIDT: That's correct. Right now, we're  
4 simply assuming it's the same percentage of program  
5 spending as in fee-for-service.

6 DR. HOADLEY: Right.

7 And then just last is just an observation. I  
8 mean, I really find the breakdown of all the drugs that  
9 Medicare is doing and the way you've done in the pie charts  
10 to be terrifically helpful, but I also was noticing in our  
11 context chapter, we still have the sort of 11 percent  
12 that's the other kind of calculation, and it may be  
13 something worth in the context chapter directly referencing  
14 this. I mean, obviously, that pie chart may belong the way  
15 it is in that chapter because of sort of definitions, but  
16 at least to cross-reference this, I think this is really  
17 helpful in getting people to understand the full story.  
18 And we should make sure it's reflected in other places  
19 where we're making that point.

20 DR. MILLER: So you're wanting us to be  
21 internally consistent?

22 [Laughter.]

1 DR. HOADLEY: Yeah. I wasn't going to say that.

2 MR. THOMAS: Just a couple of questions. On page  
3 6, the 91 percent, do we have the trend of that number,  
4 kind of historical trend of what that percentage has been,  
5 or can we have that in future reports?

6 DR. SCHMIDT: We would have to go back and do the  
7 same calculation for each year. It's possible.

8 MR. THOMAS: I mean, I think what I'm getting at  
9 is a little bit going to Scott's point of how significant.  
10 I mean, it's 19 percent of the program. Today, how has  
11 that changed over the past decade or five years or whatever  
12 period of time you choose to look at that?

13 DR. SCHMIDT: So that was the point of Table 1 on  
14 page 10 in the mailing materials, was to give you a sense  
15 of the overall growth.

16 The share, let's see if I have that. Let me get  
17 back to you --

18 MR. THOMAS: Okay.

19 DR. SCHMIDT: -- on whether the share for 2007  
20 has changed significantly.

21 MR. THOMAS: Okay.

22 DR. SCHMIDT: And we can look into whether we can

1 do other years as well.

2 MR. THOMAS: And then the discussion we've had  
3 previously on the lower cost alternative, is that just  
4 something that would be considered in a future report when  
5 we look at solutions, or how does that factor into this  
6 discussion?

7 DR. SCHMIDT: Least costly alternative, that  
8 discussion?

9 MR. THOMAS: Mm-hmm.

10 DR. SCHMIDT: Yeah. That was one of, I think,  
11 the broad topics of how we might pay, considered  
12 alternative payment methods for Part B drugs. So I don't  
13 know in the future where your conversation is going to go  
14 with respect to that.

15 DR. MILLER: My recollection of how that laid out  
16 is we brought a series of ideas in front of you on how to  
17 think about this. I can't remember which cycle it was or  
18 how far back it was, although we could get Nancy up here  
19 and get her to remind us, which I think would be hilarious.

20 [Laughter.]

21 DR. MILLER: And as it ticked through those  
22 things, where that conversation spun to is there was not a

1 lot of take-up on the part of the Commissioners of looking  
2 at that, and it kind of led to the discussion of what about  
3 looking at different models like bundling, which then led  
4 to "Well, maybe we'll take a look at it in the oncology  
5 space," because there seemed to be some activity there, and  
6 then Nancy moved off in that direction.

7 Now, I've kind of forgotten when we had that  
8 conversation, but it was --

9 MS. RAY: Last year.

10 DR. MILLER: Was it last --

11 MR. THOMAS: It was in the past year. I guess my  
12 question, going back to the materiality of this issue from  
13 a cost perspective, perhaps that would be something that we  
14 may rethink, given the magnitude of this challenge to  
15 address this cost issue, so it's something that we may want  
16 to put on our list of items to discuss as we think about  
17 how we address some of the challenges here.

18 DR. CROSSON: Rita?

19 DR. REDBERG: I also want to compliment you on  
20 the chapter. It was really helpful.

21 My question, my clarifying question is kind of, I  
22 think, what Scott was getting at, price versus utilization,

1 but I am interested if you are able to tell us the spend  
2 per beneficiary, because clearly we have had increased  
3 enrollment, and also the number of drugs per beneficiary,  
4 because my sense is both of those have gone up, you know,  
5 our bennies, our many more drugs, and the drugs are more  
6 expensive, but it would be helpful if we could understand  
7 what the contribution is of each of those.

8 MS. SUZUKI: We can get back to you with the  
9 detail. We published that information for Part D in the  
10 data book in June.

11 For other sectors, I don't think we routinely  
12 calculate that information.

13 DR. MILLER: It kind of goes back to the question  
14 that got driven off over here, I think. I think we could  
15 probably do that for D and B -- I'm looking at Kim -- and  
16 then the other -- and so the 13 percent, we could probably  
17 give you a good feel for that, but then the remainder that  
18 comes out of all the other little sectors probably not so  
19 much, just given the way the data is reported and where we  
20 have to get it from.

21 DR. REDBERG: That's a good start.

22 DR. MILLER: But we can certainly tease out D and

1 B on this, and that's a lot of the action.

2 DR. REDBERG: Okay. And I just wanted to second  
3 Warner's suggestion to relook at least costly alternative  
4 this year.

5 DR. CROSSON: Okay. So keeping in mind that this  
6 is a preliminary look at the cost thing and that, in the  
7 first round, we've had a number of suggestions about adding  
8 to the information, I want to have a round. But we don't  
9 have a lot of time left. We have identified Jack and  
10 Scott. We want to make some initial points, and then we  
11 will see how many people want to add more than we've  
12 already talked about.

13 Jack?

14 DR. HOADLEY: I really want to pick up on  
15 actually some of the things that have already come up in  
16 the discussion, and I go back to the statement you have on  
17 one of the earlier slides, which is that Medicare's  
18 influence is limited, and in turn, the influence over much  
19 of the pricing and utilization is in either the  
20 intermediary institution in the case of outpatient  
21 departments, hospitals, et cetera, or the Part D plan for  
22 that side.

1           But I also think what we've already been hinting  
2 at is that the influence of some of those intermediary  
3 units are also limited, less so if it's a -- less limited  
4 if there's competing products where they can put them  
5 against each other, use the tools that Rachel and Shinobu  
6 talked about in terms of formularies and things. And we  
7 saw some of that action in the hepatitis C drugs where the  
8 first year prices were high, and then although we can't  
9 always see inside the prices, but enough press reports  
10 would suggest pretty substantial discounting in the second  
11 year once there were a couple of additional products to put  
12 in the competition.

13           Obviously, the influence of the intermediary  
14 institutions is more limited in cases where there's only a  
15 single product to treat a particular condition, as was the  
16 case in hepatitis C in the first period of time, and I  
17 think even in the cases where there is the leverage, where  
18 there's the competitive leverage, the launch price of the  
19 drug seems to be still a significant thing. So if a  
20 manufacturer -- you know, we've talked about this  
21 occasionally. If the manufacturer knows there is going to  
22 be eventually competitive pressure to bring the price down,

1 they set it higher so they can get the eventual price to  
2 land where they want it do, and so they presumably have a  
3 lot of leverage. We can't look inside under that hood to  
4 really see what's going on very clearly, but that's the  
5 suspicion a lot of us have.

6           And so I think the challenge that we're trying to  
7 think about is how do we increase leverage for either at  
8 the level of the Medicare program or at the level of the  
9 secondary institutions that Medicare has empowered,  
10 particularly for the single-source, true single-source  
11 drugs, the ones where it's really only a single treatment,  
12 but to some extent even for other products where the whole  
13 issue of the launch prices comes in.

14           The problem is, at least on the Medicare side,  
15 what tools are there, and I've already said that for the  
16 plan or the institution, if there's only a single product,  
17 they don't have the same ability as formularies. The  
18 question is: Does the Medicare program or does the  
19 government more broadly have leverage? And the problem is  
20 a lot of what you are tempted to get into are areas that  
21 are outside of our boundaries, so patent law, FDA approval  
22 processes, comparative effectiveness kinds of things, you

1 know, things that are not as clearly inside the Medicare  
2 box.

3           The Secretary's authority is another possibility,  
4 and there have been proposals out there to change the law  
5 so that there would be some secretarial authority in  
6 instances particularly where there is no competition for  
7 particular drugs, and is that the kind of place where we  
8 want to give the Secretary some role? And if so, how would  
9 that role work? Because the simple view of what  
10 secretarial authority means in the context of a world like  
11 Part D where there are a lot of competing plans is kind of  
12 hard to think through.

13           So I would like to see us try to think about are  
14 there any tools available to us, especially within the  
15 Medicare box that we tend to talk about, or even other  
16 things that we might be willing at least to describe  
17 outside of our normal box where we might make  
18 recommendations, where we could, you know, put out some  
19 ideas on how to increase the leverage.

20           The only other thing I would add is I do think  
21 it's important to continue talking along the side about  
22 beneficiary out-of-pocket costs, and I made this point last

1 year a couple of times. But Part D, people think of as a  
2 catastrophic benefit, you know, the beneficiary's liability  
3 is capped. It's not capped. It's lessened in that  
4 catastrophic phase, but it remains 5 percent, which, when  
5 somebody's really got very high drug costs, 5 percent on  
6 top of -- what is it? -- about a \$5,000 out-of-pocket cap  
7 puts a lot of money on their side. And I do think that's  
8 something we should try to think about a way to address.

9           Obviously, on the Part B side, it's part of a  
10 larger issue of no out-of-pocket limit for Medicare as a  
11 whole, and so, you know, that's a bigger bundle to talk  
12 about. But I did want to put that aspect on the table as  
13 well.

14           DR. CROSSON: So, Jack, I think what you outline  
15 is exactly what we should do, because as we've said, you  
16 know, within the Medicare program's authority, within our  
17 mandate, there are some things we can do and recommend, and  
18 there are other things that are out of our purview.

19           However, to fully consider those things that we  
20 can do and we can make recommendations on, it's probably  
21 appropriate for us to look at the whole panoply of tools,  
22 whether or not those are things that we can act on or make

1 recommendations on. And I think the intention, as you  
2 suggest, is to do that.

3 DR. SAMITT: Jay, can I also add that beyond the  
4 panoply of tools, I think there's one other set of players  
5 that we haven't talked about that have leverage, which is  
6 the prescribing clinician. And so if we feel that neither  
7 CMS nor the intermediaries have sufficient leverage, well,  
8 then, who has significant leverage? The prescribing  
9 clinician. And how well have we aligned interests around  
10 utilization in particular, not so much price, with the  
11 clinicians? And we've talked about this before, you know,  
12 especially with ACOs. If Part D trends or expense were  
13 included as part of the measurement or part of the  
14 incentives associated with ACOs, you may see additional  
15 focus on more effective prescribing patterns if that were  
16 included in the mix.

17 So I don't think we should forget that beyond the  
18 plans. We should think even further directly to the  
19 clinician.

20 DR. CROSSON: Jack, on that point?

21 DR. HOADLEY: Yeah, it is follow-up. I mean, I  
22 think that's really helpful. I was mostly focusing on the

1 price side, and there obviously is the utilization side.  
2 And so thinking about -- and one of the challenges we have  
3 is that Part D plans have no relationship with the  
4 prescribers, and they can only do things indirectly through  
5 prior authorizations that go to the patient's purchase,  
6 which means the patient in turn has to interact with the  
7 provider. And trying to think about that, whether it's --  
8 we've had some of these conversation before, whether it's  
9 integrating more of the drug side into the ACO world,  
10 whether it's coming up with more on the medication therapy  
11 management, which hasn't been very effective inside Part D.  
12 But I think you're right, thinking about it on the  
13 utilization side is really a critical part of the story.

14 DR. SAMITT: And the reason I say that is I think  
15 we think that negotiations around price drive price. But I  
16 think what we probably see more on the commercial side is  
17 focus on utilization drives price more effectively than  
18 negotiation drives price in many respects. And so that's  
19 why this is an important thing to remember.

20 DR. CROSSON: And having come from, you know, a  
21 clinical life which was characterized by the integration of  
22 in this case Part D and the rest of Medicare and Medicare

1 Advantage and having the physician community as well as  
2 individual physicians in the practice actively engaged in  
3 those utilization decisions and policies, I can only  
4 underscore what you're saying.

5           Now, there's a significant amount of complexity,  
6 as you know, in terms of taking that sort of thought and  
7 model and applying it to the Medicare program in its  
8 various separate parts. But I think that's absolutely  
9 something we need to talk about.

10           On that point, Bill? And then we're going to go  
11 back to Scott.

12           DR. HALL: I'd like to expand a little bit on  
13 what Craig just said and to some extent, Jack, what you  
14 talked about and definitely what you were mentioning, Jay,  
15 about using leverage at the provider level to figure out  
16 what we want to do with these data. And I think what we  
17 were talking about here is what's the value proposition.

18           If I develop hepatitis C, I don't care what the  
19 price of that drug is. It's invaluable to me. And ten  
20 years ago, there wouldn't have been any chance of living.  
21 So there, no matter what the price is, the value is really  
22 quite high. And it's not just the value to me as a human

1 being, avoiding cancer and all the rest. It's all the  
2 expenses I'm going to incur to the Medicare system by  
3 having to care for the sequelae of that disease. So  
4 there's an example of a really high-value proposition. And  
5 so it's not that the drug is bad or the people are  
6 prescribing it indiscriminately.

7           On the other hand, if we take all the bread-and-  
8 butter conditions that we're prone to as we get older --  
9 cardiovascular disease, respiratory disease, diabetes,  
10 obesity -- there, there's a lot of question about the value  
11 of what we're doing. One of the big differences from 2004  
12 is that we know a great deal more about the efficacy of  
13 drugs, and anytime you deal with older people, the more  
14 drugs people have, the more likely they are to die. And  
15 it's not just intuitive that they're sicker, but it's that  
16 there are a lot of complications to therapy.

17           So somewhere if we could categorize various  
18 disease entities and classification and therapeutic  
19 approaches, I think we might be able to inform  
20 practitioners and people who are regulating practitioners  
21 on the proper use of medications. Now, that's kind of pie-  
22 in-the-sky, but it's entirely possible now, and it wouldn't

1 have been possible even ten years ago. So I think this is  
2 a really important lead into what we may want to use these  
3 data for.

4 DR. CROSSON: Thank you, Bill.

5 We're going to be running short on time, so Scott  
6 was one of the initial presenters, and then I have Herb and  
7 Kathy, and Sue as well? I'm sorry. Rita. Herb, Kathy,  
8 and Rita, and then we're going to stop. Sorry?

9 DR. REDBERG: I want to respond to something Bill  
10 said [off microphone].

11 DR. CROSSON: Rita, I can't hear you. Go ahead.

12 DR. REDBERG: Not to disagree with my esteemed  
13 colleague, but I don't share your high-value view of the  
14 hepatitis C treatment because the new drug was approved on  
15 an accelerated approval on the basis of a surrogate marker,  
16 a sustained virologic response, which is we hope, you know,  
17 going to translate into these wonderful things but wasn't  
18 actually shown, and the actual facts are only a few percent  
19 of people who are infected with hepatitis C actually go on  
20 to these terrible complications. Many people live -- 25  
21 percent of people revert to a hepatitis C negative status  
22 on their own without any treatment at all. And the other,

1 of course, complicating factor is that -- I mean, I  
2 certainly see patients who have been cleared of hepatitis C  
3 and then get reinfected because they continue to use IV  
4 drugs and other problems, and it's -- or I've seen patients  
5 that have been cleared of hepatitis C, and they go on to  
6 get hepatocellular cancer.

7           So, you know, I'm not convinced it's the cure  
8 that we hope it to be, and certainly, you know, there's a  
9 lot of discussion that I won't go into now on whether it  
10 truly was priced at its value, because as I said, it was a  
11 12-week study based on a serologic market that we hope is  
12 valuable, but we don't have the data to say that it does  
13 save lives or even prevent hepatocellular cancer and liver  
14 transplants.

15           DR. CROSSON: Okay. Thank you for that. So  
16 Scott, and then Kathy and Herb, and then we'll stop.

17           MR. ARMSTRONG: So just very briefly, and I won't  
18 repeat points my colleagues have made, but just affirm that  
19 the way we are thinking about applying policy that we do  
20 apply in a lot of other parts of the program to this  
21 topical area I think is a really worthwhile endeavor.

22           I want to just step a half-step back and thank

1 the staff for an incredible piece of work. The role that  
2 MedPAC can play as a nonpartisan, objective, highly  
3 respected organization for objectively evaluating a topic  
4 that we need to face in our industry in this country is  
5 very exciting for me to see us launch into this, and this  
6 first step is an affirmation of, I think, how important our  
7 contributions will be to this topic. So thank you for  
8 that.

9 I also just want to acknowledge that -- and I  
10 think we've alluded to this, but it's just worth saying  
11 that part of what's difficult about this is that increased  
12 drug spending is not necessarily bad, and that as we go  
13 through this in the context of our total spend, we'll want  
14 to at least see how, as we have on other topics, increases  
15 in spending here is -- where it's good and where it's bad,  
16 and that obviously gets even more complicated. But I want  
17 to just acknowledge how thrilled I am that MedPAC is moving  
18 this forward, and that a real challenge will be to get  
19 beyond this objective evaluation of what is and how does it  
20 work to what are some of the levers that we can pull to  
21 have an impact in future years.

22 DR. CROSSON: Thank you.

1 MS. BUTO: I want to just add my thanks to you.  
2 I think the work has consistently been really good in this  
3 area.

4 As I step back to think about sort of what is  
5 MedPAC's objective here, I think one would be -- and we  
6 tend to get all caught up in a lot of the details, but  
7 really one would be that Medicare is paying a fair price,  
8 that the pricing that Medicare -- the reimbursement rates  
9 Medicare sets is not creating unintended consequences that  
10 are bad; and then, secondly, that payment policy itself is  
11 not driving either unnecessary utilization or utilization  
12 of drugs that are high-priced when a lower-priced  
13 alternative would be just as good.

14 So I think we have both kind of the issue of is  
15 there a fair price that Medicare is paying, and is the  
16 formula and the reimbursement methodology a fair one. But  
17 there's also the issue of are payment policies from site to  
18 site driving the right mix of care.

19 And so in that spirit, and I think picking up on  
20 what Jack said, I hope we'll look at a variety of tools.  
21 And you've started down that road in this paper, but I know  
22 that in the past -- and I am very rusty on this, but, for

1 instance, competitive bidding was tried for Part B drugs.  
2 It failed, as far as I can tell. Just a sense maybe of why  
3 we think it failed, and is it time to revisit that  
4 approach?

5 I think the issue of -- you know, in a way,  
6 people haven't really talked about this, but I have often  
7 wondered at some point do Part B drugs fall under Part D  
8 contractors? Is that a good idea? Is that a bad idea? Is  
9 that going to create unintended results? So there are a  
10 number of approaches that I hope we'll open ourselves up  
11 to.

12 Lastly, I think since there's a lot of concern  
13 around new drugs and pricing, CMS tried something called  
14 coverage with evidence development for those drugs for  
15 which there was no predecessor or nothing that was really  
16 comparable. And I wonder if we can at least touch on that  
17 possibility as one of the approaches that could be  
18 considered if there is concern about sort of widespread use  
19 without the proper, I think as Rita mentioned, kind of  
20 clinical background to assure that it's right for Medicare  
21 patients.

22 So there are a number of alternatives. Those are

1 just a few I thought of. But I hope we'll open ourselves  
2 up to trying to think about them.

3 DR. CROSSON: Thank you, Kathy.

4 MR. KUHN: Thanks, Jay. I just wanted to kind of  
5 add my thoughts on some additional maybe design options we  
6 could look at in the future. We had an interesting  
7 conversation earlier today about the private sector  
8 negotiations, and that's a system we have. So are there  
9 more tools within that private sector negotiation,  
10 opportunities that we could look at?

11 One, from things I've heard and read in the past,  
12 is the formulary design additional flexibility. The fact  
13 that CMS requires at least one drug in each subclass really  
14 does limit negotiations, from what I understand. Could  
15 that open things up?

16 Comparative effectiveness, what more is PCORI  
17 doing in this area and are there ways to interject more  
18 comparative effectiveness into the policies that we have  
19 here?

20 A little bit outside of our scope, but limited  
21 antitrust waivers. Part D plans only can negotiate among  
22 themselves. They can't come together at multiple plans, as

1 I understand, to negotiate to get more market leverage out  
2 there. Is that something worth looking at in the future?

3 And then, finally, coming back to the issue of  
4 Medicaid, and I don't know whether this is more  
5 administrative pricing or whether this is more market  
6 forces, and I'd like to hear the pros and cons on that.  
7 But the fact that dual eligibles do not have access to  
8 Medicaid pricing when Medicaid pricing is lower than the  
9 Part D opportunity out there seems like that's an  
10 opportunity of anywhere, from what I've seen, from \$3 to \$5  
11 billion, opportunity that would be not difficult to  
12 capture. But is it administrative pricing? Is it market  
13 negotiations? Kind of how would that fit into the overall  
14 structure we have under Part D? That's something else to  
15 be looking at.

16 DR. CROSSON: Well, thank you, everybody. We  
17 have a lot of good ideas here, I would say. So I think  
18 I'll have to talk to Mark, but we'll probably spend the  
19 entire October and November meetings on this topic.

20 [Laughter.]

21 DR. CROSSON: Just kidding. Just kidding.

22 Rachel and Shinobu and Kim, thank you very much,

1 and everyone else who worked on this. We're going to --  
2 we've used up a little of our time, but we'll try to catch  
3 up, and we're going to move to the next topic. Thank you.

4 [Pause.]

5 DR. CROSSON: We will move on to the next topic,  
6 which is a new topic for the Commission, and it has to do  
7 with freestanding emergency departments, which have begun  
8 to appear in the United States in larger numbers and at a  
9 faster rate. Zach Gaumer and Jeff Stensland are going to  
10 present. Zach, are you going first?

11 MR. GAUMER: Yes. Okay . Good morning,  
12 everybody. Today we will be talking about emergency  
13 department services and specifically ED services provided  
14 at stand-alone facilities, but before we start, I want to  
15 thank Dan Zabinski, Anna Harty, and Amy Phillips for their  
16 contributions on this project.

17 Today, I will be summarizing the context for this  
18 research. I will provide some background information on ED  
19 visits and stand-alone facilities, and arrive at a few  
20 policy questions for you to consider in your discussion.

21 The reason we are talking about this subject  
22 today is that some of you expressed interest in the past.

1 Specifically, Cori, you noted interest in ED visit trends,  
2 and, Craig, you expressed interest in the stand-alone ED  
3 facilities at one point in the recent past.

4 [Laughter.]

5 MR. GAUMER: This research is relevant for the  
6 Commission in two primary ways. First, the trends we  
7 observe here may cause concern about whether our payment  
8 systems encourage providers to serve patients in the ED  
9 setting rather than in the lower-cost urgent care center  
10 settings. Therefore, this is a new version of the site-  
11 neutral issue. Second, these trends may cause concern  
12 about whether stand-alone EDs materially improve access in  
13 the communities where they locate.

14 So, first, the emergency department facts. In  
15 recent years Medicare ED visits have grown moderately. In  
16 2013, there were approximately 21 million hospital ED  
17 visits under Medicare. From 2008 to 2013, the number of  
18 these visits grew 1.6 percent per capita per year. The  
19 growth in ED visits does not appear to be due to an aging  
20 of the Medicare population, as the age of beneficiaries has  
21 remained fairly stable.

22 Also, on a per capita basis. the growth in ED

1 visits was variable by metro area, as Dallas, Houston, and  
2 Atlanta and a few other metropolitan areas had more rapid  
3 growth than average.

4           In contrast to volume growth, Medicare spending  
5 for ED visits grew more rapidly. These visits accounted  
6 for approximately \$6.1 billion in spending for the  
7 outpatient ED claims and the physician ED claims, and from  
8 2008 to 2013, spending for ED visits grew 7 percent per  
9 capita per year. Now, these figures do not include  
10 spending ancillary services provided during these visits or  
11 for the spending associated with ED visits that eventually  
12 become IP admissions. And so you can look at that 6.1  
13 billion with kind of a positive sign next to it. If you  
14 add all that stuff in, it would be significantly larger.

15           The growth in ED visit spending may be associated  
16 with the growth in the reported severity of ED cases. From  
17 2008 to 2013, the severity of ED visits increased for both  
18 outpatient and physician claims. With physician claims, we  
19 observed nearly a 30 percent increase in the volume of  
20 level 5 ED visits. Those were the highest-severity visits.  
21 Within the outpatient claims, we observed an 82 percent  
22 increase in the volume of level 5 visits and nearly a 40

1 percent increase in the volume of level 4 visits.

2           These changes may signal an increase in the  
3 aggressiveness of coding by both physicians and hospitals.  
4 In addition, the inconsistency between the physician and  
5 hospital ED visit coding at each level suggests that the  
6 coding practices of these providers are very different,  
7 despite the fact that they use the same five ED codes

8           Now, moving on to the facilities, the number of  
9 hospitals reporting that they had an off-campus emergency  
10 department, or an OCED, increased 76 percent between 2008  
11 and 2015. We have identified 387 OCEDs that are currently  
12 operating. They are affiliated with 323 different  
13 hospitals, meaning that approximately 6 percent of all  
14 hospitals have an OCED, and 30 of these hospitals have more  
15 than one OCED.

16 Hospitals that operate these facilities tend to be urban,  
17 they tend to be large hospitals, and they tend to be part  
18 of larger health systems.

19           OCEDs exist in many metropolitan U.S. areas, but  
20 Dallas, Houston, and Seattle have several.

21           Information we have gathered from hospital  
22 representatives and the media suggest that there continues

1 to be significant interest in developing OCEDs,  
2 particularly for hospitals associated with large hospital  
3 systems. We anticipate more growth will occur in late 2015  
4 and 2016.

5 In the course of our interviews, hospital  
6 officials told us that OCEDs tend to locate near to their  
7 affiliated hospitals and they vary in size.

8 They also stated that they tend to develop these  
9 facilities in urban or suburban areas and areas that tend  
10 to be fast-growing, relatively affluent, well insured, and  
11 create convenience for patients. They stated that their  
12 decision to develop an OCED is often driven by competition  
13 for market share and because it can be cheaper to expand ED  
14 capacity off campus rather than inside the hospital.

15 This business model is very consistent from  
16 facility to facility. OCEDs offer 24/7 ED services, lab  
17 services, and imaging services such as CT scanners,  
18 ultrasound, and x-rays. Most importantly, they do not  
19 offer trauma services. The most common medical conditions  
20 they treat include respiratory distress, head injury,  
21 sprains and fractures, UTIs, and abdominal pain.

22 Information we've gathered from OCEDs and their

1 representatives as well as ambulances suppliers suggests  
2 that compared to hospital EDs, these facilities capture  
3 more patients via walk-in and fewer by ambulance transport.  
4 In fact, ambulance suppliers told us that they will only  
5 transport a patient to an OCED if they are certain the  
6 patient is not a candidate for inpatient admission. This  
7 suggests that patient severity at OCEDs might be lower than  
8 at hospital EDs.

9           These facilities are permitted to bill Medicare  
10 if they are deemed provider based by CMS. Among the  
11 various requirements, they must have state licensure and  
12 adhere to Medicare's conditions of participation. They  
13 also must be fully integrated with the hospital they are  
14 affiliated with and located within 35 miles of that  
15 hospital.

16           Medicare views these facilities as an extension  
17 of the hospital emergency department, and therefore, like  
18 hospital EDs, they bill Medicare under the outpatient PPS  
19 for facility services and also under the physician fee  
20 schedule for physician services. Unfortunately, because  
21 they are viewed as an extension of the hospital, their  
22 claims are not separately identifiable in Medicare data.

1           Private insurers also view OCEDs as extensions of  
2 the hospital ED and pay them as in-network providers.

3           The growth of OCEDs raises three particular  
4 questions.

5       First, do existing reimbursement systems encourage  
6 providers to expand ED capacity and steer patients to the  
7 higher-cost ED setting? Interviewees from OCEDs stated  
8 that ED visits are currently profitable, especially for  
9 privately insured patients. In addition, interviewees  
10 stated that small OCEDs can sustain themselves financially  
11 on as few as 20 ED visits per day.

12       The second question is, Do beneficiaries know  
13 when ED visits are appropriate and understand the  
14 associated financial consequences? A RAND Study from 2010  
15 concluded that between 13 and 27 percent of patients served  
16 at hospital EDs could be served at urgent care centers or  
17 retail clinics. As a result of choosing the emergency  
18 department over these urgent care settings, these patients  
19 may be unnecessarily exposing themselves to higher  
20 liabilities.

21       Third, does the development of OCEDs materially  
22 improve access to ED services in the communities they

1 inhabit? Interviewees from hospitals stated that in  
2 developing OCEDs, they focus on areas with population  
3 growth, sound payer mix, and gathering market share, rather  
4 than on areas that just lack access. However, the few  
5 OCEDs that do exist in areas with poor access may  
6 demonstrate that this facility model can be a viable model  
7 in isolated rural and urban areas that possess relatively  
8 sound payer mix as well. On the other side of the coin,  
9 OCEDs located in areas with existing capacity may be  
10 duplicative.

11           The other type of stand-alone ED facility are  
12 independent freestanding emergency centers. These  
13 facilities currently are not able to bill Medicare, and  
14 their story is relevant to MedPAC's work. There is a lot  
15 of information on the slide in front of you, but it all  
16 essentially boils down to three takeaway points.

17           First, IFECs have grown rapidly in recent years  
18 in a few metropolitan areas, mainly in Texas. These  
19 facilities have largely the same business model as OCEDs,  
20 except for the fact that they can't bill Medicare and  
21 narrowly rely on privately insured patients for revenues.

22           And then the most important of these points is

1 that in 2015, some of these facilities, specifically in  
2 Dallas, Phoenix, and Denver, began affiliating with  
3 hospitals or building their own hospitals in order to bill  
4 Medicare, Medicaid, and private insurers as provider-based  
5 EDs. Therefore, we think it is likely that at least a  
6 portion of IFECs that are currently out there will become  
7 provider based and will begin billing Medicare in the near  
8 future.

9           Okay. Before we move on, I wanted to demonstrate  
10 for you the relationship that exists between the location  
11 of IFECs and more affluent ZIP codes in the Houston  
12 metropolitan area. Among the 60 IFECs in the Houston metro  
13 area, 66 percent of these are located in ZIP codes with an  
14 average income above \$53,000 per year. These are the ZIP  
15 codes with the two darkest shades, and they are the two  
16 highest quintiles of the five categories. This map does  
17 not include OCEDs, but if it did, they would largely exist  
18 in the same ZIP codes.

19           Now I want to put these two types of stand-alone  
20 ED facilities into the broader context for you and  
21 summarize their relationship to other providers they  
22 compete with.

1           Row 1 on the table above indicates that there are  
2 three types of facilities currently providing ED services:  
3 hospital emergency departments, hospital-based OCEs, and  
4 the independent freestanding emergency centers. Urgent  
5 care centers, physician offices, and retail clinics do not  
6 provide ED visits.

7           Row 2 identifies that IFECs are the only entity  
8 of the six that do not bill Medicare.

9           Row 3 is informed by our interviews with various  
10 stakeholders, including CMS, ambulance suppliers, and many  
11 other facilities. This row illustrates in general terms  
12 the relative severity of all cases served at each type of  
13 facility. The three ED facilities handle a significant  
14 number of higher-severity cases, but of course, hospital  
15 EDs handle cases that are the most severe, such as trauma  
16 and cases that are destined for inpatient care.

17           In addition, all six types of facilities treat a  
18 significant number of low-severity cases, and this is the  
19 key point, that there is overlap between these entities in  
20 terms of serving low-severity cases.

21           We would like to gather your views on directions  
22 this research could take. To guide your discussion, we

1 have generated a list of possible directions. The  
2 Commission could consider ways to track OCEDs in claims  
3 data. The Commission could explore incentives in Medicare  
4 payment systems that encourage the growth of ED capacity,  
5 and as a part of this could consider whether CMS should  
6 explore making differential payments to off-campus ED  
7 facilities. The Commission could explore the growth in ED  
8 visit severity and coding practices, and finally, the  
9 Commission could explore the effect that the growth of  
10 OCEDs has had or may have on beneficiaries in terms of  
11 whether they understand when ED services should be used and  
12 changes that could occur in their out-of-pocket liability.

13 Thank you for your time, and I welcome your  
14 questions.

15 DR. CROSSON: Thank you very much, Zach.

16 I just want to start with one question. In terms  
17 of the interviews that you had, did you get any sense that  
18 in these marketplaces that these independent emergency  
19 rooms, even though they don't accept trauma, are  
20 essentially leading more profitable patients away from  
21 trauma centers, which have an important role in the  
22 community, or is that not the case?

1           MR. GAUMER: Well, we interviewed folks that  
2 represent the OCEDS, the off-campus hospital-based  
3 facilities, as well as individuals that represent the  
4 independents, and although they have very similar business  
5 models, I would say that that applies -- what you have said  
6 applies more to the IFECs in that their main line of  
7 revenue or source of revenue are the privately insured, and  
8 they target going into markets where they can get the  
9 privately insured. But I would say yes to your question.

10           DR. CROSSON: Okay. Thank you.

11           Yeah, Jon.

12           DR. CHRISTIANSON: This is, I think, just a real  
13 quick question. On slide 12, on the note, you have the  
14 OPPS, which doesn't appear anywhere on the slide, but the  
15 slide, you have HOPD. Are those the same things? Are you  
16 using the same nomenclature?

17           MR. GAUMER: Yes.

18           DR. CHRISTIANSON: Okay.

19           MR. GAUMER: Thank you.

20           DR. CROSSON: Okay. Clarifying questions? We  
21 went over there first the last time. We're going to start  
22 over here, so we'll start this way.

1 DR. HOADLEY: I do have one. On the policy --  
2 the last slide, you talked about the impact on out-of-  
3 pocket liability. Did I miss it, or did you talk at all  
4 about sort of what the current situation is for out-of-  
5 pocket liability? This is all just 20 percent Part D cost  
6 sharing?

7 MR. GAUMER: Yeah, that's right. And I should  
8 clarify that. So, for Medicare beneficiaries, the issue  
9 here is that if they go into one of the freestandings or  
10 they go into the OCED and their service -- say it's a lower  
11 severity type of a case -- and their service is billed as  
12 an ED visit, that will cost more for the program, and that  
13 will cost more for them because 20 percent of an ED visit  
14 is higher than 20 percent of like an E&M visit or an  
15 outpatient visit at an urgent care center that can't bill  
16 as an ED.

17 The difference here -- and this is what you read  
18 in a lot of the press articles that are coming out about  
19 these facilities. For the privately insured patients, if  
20 they go to one of the independent facilities that are out  
21 of network, then they get often hit with a significantly  
22 higher out-of-pocket cost than they would otherwise expect

1 or plan on, and that can be hundreds of dollars.

2 DR. HOADLEY: And so for the ED visit for the  
3 Medicare patient now, that is going to be billed -- whether  
4 it's the off-campus version or the on-site version, that's  
5 going to be billed under the ED E&M codes. If it's an  
6 urgent care center, that's treated as an office?

7 MR. GAUMER: So there's a very similar  
8 distinction for the urgent care under Medicare. Urgent  
9 care centers can be provider based and be deemed provider  
10 based --

11 DR. HOADLEY: Okay.

12 MR. GAUMER: -- and therefore get the hospital  
13 outpatient payment and the physician payment, but if they  
14 are not deemed provider based, then it's really just for  
15 Medicare a physician payment ball game.

16 DR. HOADLEY: Okay. Thank you.

17 DR. CROSSON: Clarifying questions. Craig?

18 DR. SAMITT: So, on slide 12 -- and this may be a  
19 bit of a tag-on to that -- the row where you talk about  
20 general severity of cases --

21 MR. GAUMER: Yeah.

22 DR. SAMITT: -- this simply came from

1 observations or interviews. So claims do not allow us at  
2 this point to distinguish between these, thus to your  
3 question about should we be evaluating these separately?  
4 My understanding from your presentation is that at this  
5 point, we can't look at claims and determine what types of  
6 cases specifically and what severity exists between  
7 hospital EDs and the OCEDs.

8 MR. GAUMER: That's absolutely right. So, to the  
9 first part of that, what you see on the third row here are  
10 examples or illustrations of the world as we understand it  
11 based upon the interviews. We're not able to drill down in  
12 the claims data and figure out what the case mix is for  
13 each one of these types of providers. Specifically, the  
14 OCEDs, which are not separately identifiable in Medicare  
15 data, that would allow us to do that. Yeah.

16 MR. THOMAS: A real quick question on a similar  
17 area. What sort of insight do we have into severity of  
18 visits in urgent care centers that are seeing Medicare  
19 patients? Do we have data on that?

20 MR. GAUMER: We didn't look at that for this. I  
21 think that -- I'm going to jump out here and say, I think  
22 that we could look at the claims for urgent care centers

1 that are provider-based urgent care centers because there  
2 is -- and I'm going to get into the weeds for a second --  
3 there is a place of service code on the claim that allows  
4 us to look to see which patients are being treated at those  
5 facilities. And, I'll look at Dan here. Is that accurate,  
6 Dan?

7 MR. ZABINSKI: [Off microphone.] I think that's  
8 correct, yes.

9 MR. GAUMER: Okay.

10 MR. THOMAS: It might just be interesting, as we  
11 look at this continuum of what types of services do we see  
12 and billing do we see in urgent care centers, versus these  
13 off-campus EDs, versus, you know, primary -- primary care  
14 is a little different, but I guess after hours or what not  
15 primary care services, because it's really a continuum  
16 that's being provided, so --

17 DR. MILLER: I want to put a marker down. We'll  
18 have to look at the data and make sure that we can do this,  
19 because I'm not sure I've thought about it this way. And,  
20 also, if we want to present the full urgent care picture,  
21 we'll want to be able to show them what is in the OPD and  
22 also in the fee schedule, and I'm not as readily clear that

1 there's a marker in the fee schedule that we can pull --

2 UNIDENTIFIED VOICE: [Off microphone.] There is.

3 DR. MILLER: There is, okay. Well, then maybe we  
4 can do it. But also keep in mind that in this continuum,  
5 we'll be missing the very animals we're talking about  
6 today. So, in some ways, we can give you the two ends of  
7 that distribution, but not the middle of it.

8 DR. CROSSON: Clarifying questions. Rita.

9 DR. REDBERG: A very interesting chapter. I  
10 wonder if you could just explain to me what it means to be  
11 provider-based.

12 MR. GAUMER: Sure. CMS has an approval process -  
13 - let's see, where is this here -- an approval process for  
14 becoming provider-based, and that's done by the CMS  
15 regional offices. There are a slew of requirements that  
16 these facilities have to meet. I won't try and name them  
17 all. But, for the sake of this presentation, I think the  
18 most important ones to remember are that the state that the  
19 facility is in has to have essentially licensed the  
20 facility and they have to be integrated with the hospital  
21 that they are affiliated with in terms of their financial  
22 calculations, in terms of quality of care efforts that they

1 have, and in terms of their clinical staff.

2           So, a good example of that is if the hospital  
3 contracts with emergency care physicians for their on-  
4 campus emergency department, the contractors have to be the  
5 same for their off-campus. The contracted physicians have  
6 to be the same. So, they have to be quite integrated  
7 clinically.

8           The other key piece here is the 35-mile radius.  
9 CMS wants the OCEDs to be within 35 miles of the mothership  
10 hospital. But, there are a bunch of other requirements  
11 that I'm kind of skating over here that CMS would probably  
12 want me to say.

13           DR. REDBERG: Okay. And one more?

14           DR. CROSSON: [Off microphone.] David.

15           DR. NERENZ: Just, first, a quick response. The  
16 essence of this all, I think, is it's part of the hospital,  
17 part of a named hospital, as opposed to freestanding. And  
18 all the stipulations are basically marker conditions for  
19 that.

20           MS. THOMPSON: [Off microphone.] And it's billed  
21 under Part A.

22           DR. NERENZ: Yeah. Okay, my clarifying question

1 actually ties to Warner's. If we can go to Slide 5,  
2 please, I want to clarify what the take-home is here. In  
3 your talking about it, you talked about aggressive coding,  
4 perhaps upcoding could be a phrase, and so what we're  
5 seeing here in terms of time trend we might judge to be a  
6 bad thing. But, also, you could see the same pattern of  
7 numbers if initiatives designed to keep low-intensity cases  
8 out of the ER were working. Medical homes initiatives,  
9 expanded primary care hours, urgent, retail clinics would  
10 produce this exact same phenomenon. So, do your data allow  
11 us to tell which of these, or is it a mix of both? I want  
12 to know, is this a good set of numbers or a bad set of  
13 numbers?

14 DR. STENSLAND: I think when we looked at this,  
15 you could say, is it good or bad, and if we saw, oh, the  
16 share of the visits that are level four and five grew, but  
17 the overall number of visits shrunk, then we could say, oh,  
18 we're getting rid of these ones and twos. But we don't see  
19 that. We see the shares of fours and fives growing, and  
20 the overall number of visits per capita are growing despite  
21 no aging of the population, and so that indicates it's  
22 probably more of a coding thing than that the ones and twos

1 are going away because the volume overall is increasing.

2 DR. NERENZ: Perfect. Thank you.

3 DR. CROSSON: Bill.

4 DR. HALL: In terms of the independent  
5 freestanding centers, you mentioned there are 17 for-profit  
6 entities that claim ownership. Are some of these physician  
7 groups?

8 MR. GAUMER: No.

9 DR. HALL: Are the majority physician groups?

10 MR. GAUMER: I don't think that they are  
11 physician groups. It appears to be -- you know, these are  
12 really all in Texas --

13 DR. HALL: Right.

14 MR. GAUMER: -- and, you know, the largest is  
15 Adeptus and they have over 50 different facilities. That  
16 is -- you know, I think I would interpret that as just a  
17 for-profit corporation. But it doesn't appear that the  
18 others are physician-driven organizations.

19 DR. MILLER: Can I just bring one thing, just  
20 before it gets too far down the line. I want to go back to  
21 Rita's question on provider-based. There are lists of  
22 requirements that are to be in place, and I realize this is

1 not directly your turf, and so I just did a little  
2 consultation. But providers can attest to that, and then  
3 the second thing is they can start billing with the  
4 assumption that they've met them, and they could be at risk  
5 for somebody then looking behind it.

6           So, I don't want to leave you with the notion  
7 that there's this long process and everything is checked  
8 and gone through. It can sort of -- there's lists of  
9 things that are to be true, but you can attest to it or  
10 even just start billing and be provider-based, and  
11 presumably, you have met all of those requirements.

12           So, I just wanted -- it's a little freer than  
13 there's a big stack and somebody's looking really  
14 carefully.

15           DR. STENSLAND: And maybe to clarify on Bill's  
16 question, there are some, like Zach had talked, like big  
17 companies, like even a publicly traded company that's owned  
18 by the stockholders, that do these. But, there's also some  
19 that we talked to where the emergency physician owned the  
20 entity that would be -- that had the ED and was billing the  
21 facility fee for the ED.

22           DR. CROSSON: Bill Gradison.

1           MR. GRADISON: Could you help me understand,  
2 please, why independent ambulatory surgical centers are  
3 eligible for Medicare reimbursement and independent EDs are  
4 not? And if that's something you want to work on, what I'd  
5 really like to see, if we do more work on this, would be a  
6 side-by-side of those two, just to try to figure out what's  
7 going on there. Would the Secretary have authority to  
8 cover these, or would it require legislation? This sort of  
9 combines my immediate question and my suggestion for the  
10 future.

11           MR. GAUMER: We'll look into that.

12           MR. GRADISON: [Off microphone.] Great.

13           DR. CROSSON: Herb.

14           MR. KUHN: Three quick clarifying questions. So  
15 here on Slide 5, the observation that you made in the  
16 report as well as orally here today was the variation we're  
17 seeing between the intensity on the physician side and  
18 maybe something different on the hospital side. And when I  
19 was at CMS, we didn't see that as a bad thing, and the  
20 reason is, is that if you have a patient that has complex  
21 medical decision making by the physician but less hospital  
22 resources, of course the physician would code maybe at a

1 four or five and the hospital would code at a two. That  
2 makes perfect sense. Versus a patient that might need a  
3 lot of nursing services, but the physician's role is far  
4 less, so the hospital resources are far higher and the  
5 physician resources are far less.

6 So, I don't necessarily see this as a bad thing,  
7 and I don't know if that's how you were presenting or not,  
8 but I think there's a lot of explanation why you see that  
9 variation out there. I don't know if you have any thoughts  
10 on that or --

11 MR. GAUMER: No, I think that makes a lot of  
12 sense, and we were looking at this as you have these five  
13 code levels and they both have the exact same set of  
14 descriptors that the hospital coders and the physician  
15 coders are using, and, you know, kind of presenting the  
16 information as --

17 MR. KUHN: Here's what we're seeing.

18 MR. GAUMER: -- here's what we're seeing, why  
19 does this exist, and kind of offer it up to you guys --

20 MR. KUHN: Okay.

21 MR. GAUMER: -- to come up with explanations.

22 MR. KUHN: And, I guess, the second thing, you

1 know, ever since the beginning of the physician payment  
2 system, coding between threes and fours and fours and  
3 fives, we always know is a perennial issue, you know, just  
4 an issue out there. And so if we're seeing a movement in  
5 the ED, or the emergency department area of moving from  
6 threes to fives or moving up the scale, are we seeing that  
7 elsewhere in other settings where physicians practice, or  
8 is this really an outlier, or is that just a general trend,  
9 we're seeing more intensity of coding across the board?

10 MR. GAUMER: Okay. I think I can offer one  
11 little example here. A couple of years ago when we were  
12 looking at observation care -- sorry to bring that back up  
13 again --

14 [Laughter.]

15 MR. GAUMER: -- we did see differences in terms  
16 of cases being coded by physicians and hospitals, you know,  
17 as whether or not they were coded as inpatient stay or an  
18 observation. There might be some natural reason for that,  
19 as well. But, we do see differences occasionally in those  
20 --

21 MR. KUHN: So, in those settings versus the  
22 physician office, we're seeing --

1 MR. GAUMER: Yeah.

2 MR. KUHN: Okay. Thanks. And then the final one  
3 I had was this issue you raised of emergency transport and  
4 the emergency transport ambulance services not wanting to  
5 transport to these freestanding facilities if they think  
6 it's going to result in an admission. And, I'm making the  
7 assumption that's because they don't want to do a second  
8 transport, and I guess from that facility then over to the  
9 hospital. Is that second transport reimbursable? Is that  
10 why they don't want to do this, or kind of -- I'm just  
11 trying to understand a little bit more behind their  
12 thinking there.

13 DR. STENSLAND: I think a lot of times, they just  
14 think that that's what's best for the patient. Like, if  
15 this patient needs to be admitted, or obviously they say,  
16 if this patient is having a heart attack, we're going to  
17 take him to someplace with a cath lab rather than take him  
18 to the freestanding ED.

19 There is a Medicare payment issue when it comes  
20 to the re-transportation. If you went to -- let's say I  
21 had a hospital, we'll just call it the Mercy Hospital, and  
22 you went to Mercy Hospital's freestanding ED, which was

1 billing under the same provider number as the main hospital  
2 campus --

3 MR. KUHN: Right.

4 DR. STENSLAND: -- and then if you get  
5 transferred from that freestanding ED to the main hospital  
6 campus, well, what happens then is the freestanding ED has  
7 to pay for that transport. That same provider number can't  
8 bill --

9 MR. KUHN: A second time.

10 DR. STENSLAND: -- a second time. But if you go  
11 to a freestanding ED and then you get transported to  
12 somebody else's hospital, the other -- then you'll get  
13 billed for that transportation by the --

14 MR. KUHN: By the second --

15 DR. STENSLAND: -- by the ambulance service.

16 MR. KUHN: Got it. Thank you.

17 DR. STENSLAND: They can both -- they can bill  
18 for the freestanding ED visit and the admission, where if  
19 it's the same campus, then the beneficiary is going to make  
20 one payment for the deductible. If it's two different  
21 entities, the patient will make two payments, one for the  
22 coinsurance on the ED visit and one for the deductible.

1 DR. CROSSON: Kathy.

2 MS. BUTO: Can you -- maybe you touched on this,  
3 but do the EMTALA requirements, you know, the requirements  
4 that hospital emergency departments have to take unstable  
5 patients regardless of ability to pay, do those  
6 requirements apply to all these freestanding facilities, as  
7 well?

8 MR. GAUMER: Yes, they do, and it's a state  
9 licensing issue more than anything, you know. The state  
10 requires that they adhere to EMTALA --

11 MS. BUTO: Okay.

12 MR. GAUMER: -- and we hear from all the IFECs  
13 that we talk to that they have to stabilize before they do  
14 anything, just like a hospital ED would.

15 MS. BUTO: Okay. And then the second question is  
16 whether the independent freestanding are totally, are they  
17 all for-profit? Are there some that are not-for-profit, or  
18 is it really being driven by for-profit entities?

19 MR. GAUMER: I don't know. I think that there  
20 could be some nonprofits in there, but I'm not certain. Do  
21 you remember?

22 DR. STENSLAND: I think everybody we've -- all of

1 them that we've talked to are for-profit entities, but in  
2 some cases they'll partner with a nonprofit hospital. So,  
3 this will -- and then it might become an OECD, you know,  
4 because then they can bill under the for-profit hospital --  
5 or the nonprofit hospital's billing number.

6 MR. ARMSTRONG: I forget when it was. In the  
7 last couple of years, we did a study on avoidable emergency  
8 room visits and avoidable hospital days. Am I remembering  
9 that correctly? I just wonder if we shouldn't dust that  
10 off and see if markets where we have more of these  
11 freestanding EDs change the broader avoidable ED visit  
12 rates, because it's -- anyway, it just might be another  
13 perspective in on how big of a problem is this and what do  
14 we want to do with it.

15 DR. CROSSON: Warner, clarifying?

16 MR. THOMAS: Yeah. I just have another quick  
17 clarifying question. On Slide 12 on the IFECs, we say that  
18 you can't bill Medicare. Is that for a tech fee? I mean,  
19 will the physician -- can the physician still bill Medicare  
20 for seeing a Medicare patient?

21 MR. GAUMER: Okay. So, there should probably be  
22 an asterisk here on this "no" on the second row. So, they

1 cannot bill Medicare for the facility fee, hospital  
2 outpatient department. CMS says that the physicians cannot  
3 bill Medicare for the physician services. But I think that  
4 what we heard from some of the IFECs was that there's some  
5 ambiguity there. They said they are not in control of the  
6 physicians that they contract with that are doing their own  
7 billing and they suspect that sometimes physicians do bill  
8 Medicare by putting in a place of service code as something  
9 like a hospital ED or an urgent care center, that kind of a  
10 thing. It doesn't make a lot of sense, and there's some  
11 ambiguity to this. But, CMS tells us that the physicians  
12 should not be billing out of the IFEC.

13 MR. THOMAS: Okay. Thank you.

14 DR. CROSSON: Okay. So, I think we have a number  
15 of suggestions from Zach and Jeff. It seems to me that  
16 they kind of fall into two categories, two elements of the  
17 issue here. One has to do whether or not the existence of  
18 these facilities of both types actually end up increasing  
19 the cost to the Medicare program of services that could be  
20 delivered less expensively. And the second one is whether  
21 or not their existence or the way they're marketing or  
22 whatever increases the beneficiaries' cost. And I think,

1 you know, my sense is both of these are problems.

2           So, I'd like to just have -- and, again, we're a  
3 little short of time, but have a round on those two issues,  
4 the relative importance of those, and some suggestions for  
5 the staff as to what's the first or second thing to go  
6 after, and we'll start with Alice, who is the person who  
7 had volunteered.

8           DR. COOMBS: Thank you very much. This is  
9 excellent. I did a little survey in my own regional area  
10 regarding some of the questions that were posed, especially  
11 in the chapter, and in terms of the IFEC, I think the piece  
12 of it that really is important is the determination of need  
13 regulatory state infrastructure, such that the reason why  
14 Texas and some of the other states have free ability to  
15 kind of navigate that for the IFECs is because the  
16 regulatory determination of need infrastructure is not  
17 there.

18           So in Massachusetts, there are a couple of sites  
19 which have these free-standings, and what they've done is,  
20 even though they're a large group, they've linked one of  
21 them to a hospital so that that one is considered to be an  
22 off-campus ED, and so that's the way they get around it.

1 All the other sites are non-Medicaid and Medicare treatment  
2 centers. So if there's a Medicaid/Medicare who wobbles  
3 into that office, they've got to be referred over to the  
4 one that will refer to an ED. So that's some of the  
5 manipulation, navigation, if you will.

6 In terms of talking to the ED physicians, I was  
7 very curious about the level visits and how they match up.  
8 So Level 5 visits would be something that was requiring a  
9 lot of intensity, someone with acute stroke, acute MI,  
10 rushing off to the cath lab. And, honestly, they said, at  
11 most they might see three to four a day at most. That's a  
12 busy, busy day.

13 So I was looking at the demographics. It seems  
14 like the Level 5, to go up that much and to be that  
15 percentage in a clinical setting, if you were to divide by  
16 days, it seems like it's an increased amount, and we have  
17 the third busiest ED in the Massachusetts area. Just  
18 looking at the numbers alone, it would seem like upcoding  
19 was probably more likely than to say that the demographics  
20 and severity of illness changed for that reason.

21 So the why part of this is, Is it because of  
22 access, entrepreneurial coordination, market forces,

1 referring institution? And the last piece that I don't  
2 think we've dealt with, in the referring institution, if an  
3 institution wants to align themselves with an IFEC because  
4 their surgical volume is low and that's a goal, guess what?  
5 That's a strategy. And so what we have found is that  
6 referrals for surgical patients to the hospitals is very  
7 easy because that's where hospitals will value services,  
8 because if surgical volume is low, obviously it's an  
9 important piece of the operational infrastructure for  
10 hospitals, which, you know, as anesthesiologists we see  
11 that.

12           The question I had with all of these is, of  
13 course, looking at the unanticipated increase in cost with  
14 ED visits at missions and things of that way and the  
15 practice of defensive medicine at some of these facilities,  
16 where doctors might not have the threshold to send a  
17 patient home but refer them because fear of lack of follow-  
18 up thereafter, because these places are not calling people  
19 the next day and saying, "I want you to go to this clinic."  
20 So I think that there might be more defensive medicine.  
21 It's just one of my biases in a setting like this, such  
22 that cure may be driven upstream with admissions and more

1 ED visits, despite them not necessarily being affiliated  
2 with a hospital. That's a piece of it that you have to  
3 understand can affect the cost and quality of a patient in  
4 terms of going to the wrong place.

5           So of all these things, I think looking at the  
6 outcomes in terms of admissions and ED visits, but also I  
7 was thinking along the lines of this is analogous to LTCHs  
8 in many ways, sort of, in terms of proprietary involvement  
9 and expansion in areas where you have higher average  
10 incomes, not necessarily access. I talked to Sue about  
11 this, and I'll be interested to hear what she says. It's  
12 only 8 percent in the rural areas. It's not like we're  
13 going to the places where, you know -- it's the Starbucks  
14 pattern, if you will. I mean, I shouldn't say that, but  
15 it's a pattern where you're going to have the people that  
16 you want in your clinic.

17           And so I would say that some of the actions that  
18 we use for LTCHs might be a similar kind of road map for  
19 this entity.

20           DR. CROSSON: Thank you, Alice. You point out a  
21 good point, that, you know, in terms of this affiliation  
22 dynamic that's going on, which I think we presented as in

1 the interest of the free-standing emergency department in  
2 order to be -- emergency facility in order to be able to  
3 bill for Medicare and Medicaid services, I think one of the  
4 points you're making is that in many cases it's also in the  
5 interest of the hospital because it serves as a mechanism  
6 to have more admissions and more procedures and the like.

7 And if we follow the Starbucks model, then pretty  
8 soon we're going to have one on every block, as best I can  
9 tell.

10 [Laughter.]

11 DR. CROSSON: So maybe this is a worse problem  
12 than we thought. Forget about that drug cost thing. Let's  
13 work on this.

14 Okay. So let's start down this way and go  
15 around, and I would say again, to help the staff here,  
16 where on the question of what do we need to do about the  
17 long-term impact on the cost of the program, and then also  
18 are there ideas about how to protect beneficiaries in this  
19 regard.

20 DR. HOADLEY: So I think these are all  
21 interesting perspectives to study, and what I'm trying to  
22 do to sort out is sort of like the question Scott often

1 asks, sort of where are the bucks here and sort of -- and  
2 whether these OCEDs are a big enough phenomenon to be worth  
3 as much attention as drugs or, you know, even some of the  
4 other -- or more specifically within this list, the broader  
5 pattern of sort of coding and severity, which strikes me  
6 could be sort of in a dollar sense a bigger impact thing if  
7 there's something screwy with how coding is going on.

8           So, I mean, the analyst in me wants to know, you  
9 know, the first one here, you know, let's figure out how to  
10 track data, let's get this on the claims form somewhere so  
11 we can track them. And I do wonder if that could be a  
12 simple thing and how burdensome it is to sort of answer the  
13 first question here. It might be worth doing regardless,  
14 but in terms of sorting out, you know, thinking about where  
15 the dollar impact would be would be helpful.

16           On the beneficiary side, you know, to me it's a  
17 little like some of the site of service things where what  
18 you really come down to and all the complexities that Zach  
19 sort of laid out, I mean, the beneficiary unwittingly pays  
20 very different amounts, depending on where they end up.  
21 Obviously in some cases, they can make a conscious choice,  
22 but these are emergencies where in many cases they're

1 landing somewhere because the ambulance took them or  
2 because it's the closest or other kinds of sort of factors  
3 that aren't economically driven, and it does seem like one  
4 of those things where it's unfortunate that they may pay a  
5 potentially quite substantial difference in out-of-pocket  
6 liability just depending on these circumstances of how they  
7 land in one particular place or another.

8           You know, again, this sort of analogy that our  
9 site-of-service differentials, maybe this is something  
10 where we ought to think about either just in terms of the  
11 beneficiary or more broadly in terms of payment there ought  
12 to be some leveling if you're getting the same service, why  
13 should you -- why should more dollars be flowing in one  
14 situation than another?

15           MR. THOMAS: Just a couple of points.

16           I think, first of all, there's -- I think we've  
17 gone through one model here of, you know, looking at  
18 Houston and kind of the -- you know, putting sites kind of  
19 all over, and I think that certainly is probably more  
20 prevalent. You know, we've also seen in situations  
21 actually have gone through converting a rural facility to a  
22 free-standing ED because it ran a census of eight or ten

1 patients and essentially shut the inpatient down and  
2 converted to a free-standing ED because it was 20 miles  
3 away from another hospital. So I think we'll probably see  
4 those opportunities as well, so I want to make sure  
5 whatever we do, we don't shut down those opportunities,  
6 because I do think that is a model that we ought to be  
7 looking at going forward that would have a more  
8 comprehensive outpatient center as a hospital and not  
9 necessarily run an inpatient census.

10 I think the other component is I think what we're  
11 seeing here is one of the reasons these are so successful  
12 is because of access to emergency services. I think you  
13 see a lot of big ERs with just such a long wait, no fault  
14 of anyone because, you know, we see it in some of our own,  
15 but there's just such a demand for it, and I think that's  
16 why you're seeing more folks that are opting for these  
17 smaller centers that essentially have easier access. I'm  
18 not saying it's right. I'm not saying it's the best thing  
19 economically. But I just think it's a fact of the  
20 situation for patients.

21 I would encourage us to look at this as a  
22 continuum, and to look at this as a continuum starting with

1 telemedicine that we brought up, you know, yesterday; you  
2 know, how can we basically facilitate telemedicine being a  
3 better option for our beneficiaries so we can help diagnose  
4 and then steer them to what we think the most appropriate  
5 facility is, whether that be a primary care practice, an  
6 urgent care, an ED, whichever that is.

7           So I would start looking at telemedicine, looking  
8 at our urgent care services, and then looking at ED, not  
9 just looking at one or the other and looking at it as a  
10 silo, because it really is a continuum of access.

11           As a point, you know, we have extended access in  
12 every single primary care clinic we have into the evenings,  
13 and on every weekend, including Sundays, and we have had no  
14 impact on our utilization of emergency services. Even  
15 though we see a lot of people using these after-hours  
16 services, it just seems that, you know, people use EDs.  
17 And I'm not saying it's right. I'm not saying it's not  
18 costly, because I understand it is. But, you know, we  
19 really thought when we expanded every location to 7, 8  
20 o'clock at night, every weekend, and we'd have an impact on  
21 utilization of ED -- haven't seen it.

22           So I would just ask us to look at it as a

1 continuum, and I would really put telemedicine on the front  
2 of this, because I think it's a way to steer people to the  
3 appropriate level of care.

4 DR. MILLER: Can I do a quick commercial on your  
5 first point, the whole notion of rural, ED, hospitals close  
6 to each other? That's a real important point, and that is  
7 something that we're going to try and come to this cycle.  
8 And when we're talking about this, I mean, I think the  
9 notion of an ED model in that instance is a whole different  
10 ball game.

11 MR. THOMAS: And I actually think if we could  
12 create incentives for smaller facilities that have a census  
13 of eight or ten to convert to this type of model and try to  
14 create some financial incentive, I think we'd see more  
15 folks do it. But right now, they keep hanging on with a  
16 census of eight or ten, and we all know that's just not  
17 sustainable long term.

18 DR. SAMITT: One of the things that was striking  
19 to me was, you know, your comment about how the primary  
20 driver of the development of these is population growth and  
21 payer mix, and it may be less about improving access. So I  
22 believe this warrants additional analysis. I'm concerned.

1 I don't know how material the issue is, but this is very  
2 much a site-neutral issue to me. If free-standing EDs are  
3 developed to provide improved access where access is poor,  
4 that is certainly understandable and warranted. But if  
5 we're seeing cases in free-standing EDs that alternatively  
6 could be seen in urgent care settings, then this is  
7 wasteful. You know, we should be enhancing our focus on  
8 urgent care if those cases can be seen there.

9           Likewise, beyond just the visit, I'm concerned  
10 about excessive imaging and anything else that would go  
11 into these free-standing ED visits that may make them more  
12 profitable, but also equally unwarranted.

13           So I think we should find a way to distinguish  
14 the claims between these facilities and EDs and begin to  
15 study appropriate utilization of these facilities as the  
16 immediate next step, which no preconceived notions as to  
17 what we'll find. We may just find that they truly are ED  
18 services. But if they're urgent care services, I'm  
19 concerned.

20           The one other thing that I would say is I don't  
21 think we should avoid a focus on urgent care facilities as  
22 well. The latest craze is the development of free-standing

1 urgent care. And I was surprised by the notion that the  
2 payment is OPD rates for urgent care facilities when these  
3 could be done in primary care physician offices for the  
4 most part. So I don't know if it should just be free-  
5 standing EDs that we focus on. I also believe we should  
6 focus on the movement of free-standing urgent care and our  
7 next analysis, maybe next year, should be on that, because  
8 I think that's the next impending wave.

9 DR. REDBERG: I'll just briefly comment because  
10 Craig said a lot of what I was thinking very well. But I  
11 do think we should consider site-neutral payments because  
12 it does seem, particularly for the reasons these are  
13 growing, these are not going to address the overflow from  
14 primary care or the lack of primary care. And I was  
15 surprised to hear what Warner said because certainly when I  
16 am attending, a lot of the patients I see that are coming  
17 in through the emergency room for non-emergent issues are  
18 coming because they were unable to reach their primary care  
19 or unable to be seen by their primary care doctor. And I  
20 don't know whether the increasing access now or increasing  
21 insurances, what kind of changes I think we're still  
22 watching, but certainly I don't think we should be paying

1 more for someone to be seen for a non-emergent issue in an  
2 emergency room setting, both for the ambulance transport --  
3 and I'm not sure, if an ambulance transports a Medicare  
4 patient to an emergency room for a non-emergency, does  
5 Medicare still pay the ambulance transport? Which is a  
6 whole different issue because people don't always know,  
7 although I was struck by the fact that the ambulance said  
8 clearly -- some of them they didn't at least consider it an  
9 emergency enough to ever to consider inpatient admission.  
10 And I do think we should -- it would be good to have the  
11 OCED claims separately so that we can analyze them.

12 DR. CROSSON: Thank you, Rita. So just to  
13 confuse things, since I've gone this way twice, I'm going  
14 to start this way.

15 MR. ARMSTRONG: Very briefly, I would just affirm  
16 I think the same pay for comparable services kind of  
17 principle is really relevant here. I won't repeat other  
18 points people have made, but would just say that part of  
19 what we're wrestling with is payment in fee-for-service,  
20 and just for a moment, I just would reflect on the fact  
21 that in an integrated system like the one I work in, we  
22 don't contract with these. It messes up the coordination

1 of care and the way in which our patients are really part  
2 of an integrated, well-managed system. And we just ought  
3 to kind of, I think, think about that.

4 And then, second, we are looking at payment --  
5 and it might be interesting to find out what ACOs are doing  
6 and how they're thinking about this, you know, through that  
7 lens.

8 And then, second, it's really interesting,  
9 Warner, to hear your points and to be reminded that it  
10 really is, when you can look at the benefit design and you  
11 can look at telemedicine and 24-hour consulting nurse  
12 services and in-ER consultants reviewing for admission  
13 criteria, that whole sort of spectrum of different ways of  
14 helping create an integrated, well-coordinated managed  
15 system, all have to kind of be aligned around the same  
16 common goals. And we can only do so much, but it might  
17 just be worth reminding ourselves of some of those things  
18 as we look at these specific payment policies.

19 DR. CROSSON: I just want to make one quick  
20 comment here. You know, this is my eighth year on the  
21 Commission now, and I can't tell you how many times on so  
22 many different topics at some point someone -- sometimes it

1 was me -- makes the comment that Scott just made, which is  
2 fundamentally to me -- you know, we wouldn't have the  
3 complexity of this issue and these perverse incentives  
4 going on if only we had integrated systems that were paid  
5 on a population basis.

6           Now, I realize that we don't have that, and we  
7 have a lot of work to do to improve the system we do have.  
8 But I do think somewhere down the line it is in the purview  
9 of the Commission to ask ourselves, you know, in a longer-  
10 term basis what it really would take to fundamentally start  
11 moving the country in that direction to the extent that's  
12 possible. And I don't know whether we can do this, you  
13 know, as a broad brush stroke or make sure that as we work  
14 through some of the more specific issues, we are always  
15 thinking about that potential direction and not coming up  
16 with policies that move in the opposite direction. That's  
17 just my editorial.

18           DR. NAYLOR: Hear, hear.

19           MS. BUTO: Hear, hear. I agree.

20           I realize this is more of a clarifying question,  
21 but are these entities for the most part physician-owned or  
22 are they hospital-owned for the most part?

1           MR. GAUMER: I think they are mostly hospital-  
2 owned facilities. The OCEDs are wholly owned by the  
3 hospital. The IFECs are mostly for-profit.

4           MS. BUTO: Owned by physicians.

5           MR. GAUMER: No.

6           MS. BUTO: Or for-profit entities.

7           MR. GAUMER: For-profit entities, and as Jeff  
8 indicated, there are some that might have some physician  
9 ownership in there.

10           MR. KUHN: Two points. On the first question up  
11 there, on tracking OCEDs, I think we ought to be doing  
12 that. As I think about it, from operations from CMS, I  
13 think an off-campus modifier would be easy for CMS to put  
14 in place. I think what would be difficult if we tried to  
15 know the exact location of the facility that was billing  
16 because then you have to have a separate billing number,  
17 and per Jeff's earlier response on emergency transport, if  
18 you have a separate billing number, does that create  
19 opportunities for gaming? You know, all that kind of  
20 stuff. So I think there's a way we can track it -- it's  
21 just what level of specificity -- and avoid unintended  
22 consequences as part of that.

1           And the other issue I'd like to kind of speak to  
2 is this issue of a little bit of what Warner teed up, and  
3 that is, you know, the incentives are driving us to convert  
4 and shed inpatient capacity that are out there. Warner  
5 gave a good example of what we're seeing in some rural  
6 areas, and we're seeing that as well. That makes sense.

7           If you look at Maryland, that has gone to a  
8 global budget. My gosh, they're shedding inpatient  
9 capacity as fast as they can, and one of the tools that  
10 they're using is these free-standing emergency departments.  
11 And so it's a tool in terms of what they want to use in  
12 order to kind of move in that direction that's out there.  
13 Some of those are part of integrated systems. So I think  
14 as we go through this, we need to understand, you know,  
15 there's different types of flavors that are going out here  
16 in terms of these facilities that are out there.

17           And, you know, at risk of kind of teeing this one  
18 up, I just would mention something Warner didn't mention,  
19 but we're at the ten-year anniversary of Katrina, and  
20 Warner has been on a lot of news stories about what they've  
21 done in New Orleans, and he and his team have just done a  
22 terrific job on that. But one of the tools they did in

1 rebuilding New Orleans was freestanding EDs. So, there is  
2 a real legitimate reason for some of these out there and I  
3 think we've just got to be careful how we parse it out.

4 DR. MILLER: That also gets to the comment that -  
5 - you know, this just occurred over here -- it may make  
6 complete -- it may be entirely different if they flourish  
7 in a population-based payment system. That may make  
8 complete sense. And the program's orientation to it may be  
9 much more -- much more indifferent in that environment.

10 DR. CROSSON: Bill.

11 MR. GRADISON: Picking up on what Craig said and  
12 my earlier question about ambulatory surgical centers, what  
13 I'm trying to think through is what forces, if any, are  
14 there that are moving or seeming to move activities out of  
15 the integrated hospital into freestanding units. What  
16 common denominators are there? What other services are  
17 there that don't come to me but might come to others of you  
18 that might move in that direction in the future? Is there  
19 any relationship of what we're talking about to the  
20 movement of some low-intensity services from high-priced  
21 tertiary care institutions, often teaching institutions,  
22 into community hospitals, which could do just as good a job

1 at a lower cost? It's the economics of this, I'm just  
2 trying better to understand.

3           One minor sidebar and a suggestion is to take a  
4 look at Georgia. There are a number of rural hospitals  
5 there that are having a really hard time of it financially,  
6 and I believe I'm correct that the state, with the  
7 encouragement of the Governor and others, has created  
8 legislation to make it possible for some of these entities  
9 to shrink down to a stabilize and transfer type of  
10 facility. Again, I don't want to trust my memory or full  
11 understanding of the facts, but my best understanding is no  
12 county has taken up on it yet, which may suggest that the  
13 problem is economic, not health care alone, that if these  
14 hospitals fail, it's because of the economics and the high  
15 concentration of low-income patients and that the ED would  
16 suffer the same problems as the hospital, even though it  
17 was operating on a much more limited basis and focused  
18 basis.

19           DR. CROSSON: David.

20           DR. NERENZ: Hopefully, just a side issue, but it  
21 speaks, I think, to point two about the incentives. In the  
22 chapter that we had, in Table 1, you illustrate the

1 different payment rates for the different settings and it's  
2 basically a factor of three-to-one for the ED versus  
3 physician office. Part of that three-to-one ratio, if I  
4 understand it, is not just more intense clinical care, it's  
5 just other things -- stand-by capacity, Katrina response  
6 capacity, whatever it is.

7           And as we think about this going forward, I  
8 wonder if we want to even step into the territory of some  
9 different payment stream for that capacity that is sitting  
10 there all the time as opposed to the individual visits, and  
11 that would allow the payment for the visits to be more  
12 comparable, but still not cut away the support for the  
13 stand-by capacity of the other mission elements. There's a  
14 reason why what we have is what we have, and I may not know  
15 that well, but I suggest that as something we could  
16 consider.

17           DR. CROSSON: Sue.

18           MS. THOMPSON: I, too -- I'm really excited about  
19 the opportunity to take this information into the context  
20 of the rural discussion that we look forward to, because I  
21 think while we do not see these independent freestanding  
22 facilities in the rural areas today, the work that's before

1 us, and I think the struggles these Critical Access  
2 Hospitals may be having -- are having -- we are going to  
3 see a lot. So, there's a lot to be learned, I believe,  
4 from the work you're doing, so I appreciate this as  
5 background.

6 I'm curious to know, as we continue to have  
7 discussion, are you seeing CT scanners, MRIs, PET-CT, all  
8 those kinds of expensive modalities going up, and not  
9 necessarily for today's discussion, but I'm interested to  
10 know if there's learnings from what we're seeing in these  
11 freestanding facilities today that we can maybe think about  
12 as we talk about the rural issue going forward.

13 And then, secondly, back to the coding and  
14 questions about is there upcoding going on, in that period  
15 of 2008 to 2013, we also saw a lot of electronic health  
16 records either come into place or we got a lot better at  
17 using them, and with that, there was a lot more capture of  
18 the detail of the clinical presentation of the patient,  
19 which may have presented a much more clear picture of what  
20 we had been seeing all along but had not been capturing.  
21 Not sure, wondering about is that a factor that may have  
22 contributed to those numbers.

1           MR. GAUMER: That was something that came up in  
2 some of the discussions that we had with folks around -- in  
3 the interview process, that one or two of the different  
4 criteria of the coding could have been fairly easily  
5 handled with the new electronic medical record in doing  
6 patient history and that kind of thing. I think you're  
7 right.

8           DR. CROSSON: Okay. Thanks very much. I think I  
9 would simply sum up by saying, Houston, we have a problem.

10           [Laughter.]

11           DR. CROSSON: And thank the Commission for the  
12 useful comments. Zach and Jeff, I hope you've gotten  
13 enough information to move along here. Thank you very  
14 much.

15           [Pause.]

16           DR. CROSSON: Okay. Our final presentation is  
17 going to be on payments from drug and device manufacturers  
18 to physicians and teaching hospitals. This is an issue  
19 that the Commission was active on a number of years ago, I  
20 think leading to the process that we have in place to track  
21 that and make that information publicly available. I think  
22 as a consequence of that and our continuing interest in

1 pharmaceutical costs, we're going to review the current  
2 status of that information. Ariel Winter and Anna Harty  
3 will be presenting, and, Ariel, it looks like you're going  
4 to start.

5 MR. WINTER: Thank you. Good morning. Before we  
6 begin, we want to thank Kevin Hayes and Shinobu Suzuki for  
7 their help with this work.

8 So here are the main points we'll be covering  
9 today. We will be going over some background on this  
10 issue, describing the public reporting program, which is  
11 known as Open Payments, presenting results of our  
12 preliminary analysis of data from 2014, and then talking  
13 about some next steps.

14 So, as Jay mentioned, back in 2009, the  
15 Commission recommended that the Congress mandate public  
16 reporting of physicians' financial relationships with drug  
17 and device manufacturers. The goal, one of the main goals,  
18 was to help Medicare and other payers and the general  
19 public better understand the scope of these financial ties  
20 and how they might affect practice patterns and health care  
21 spending.

22 In 2010, in PPACA, Congress created a public

1 reporting system. CMS implemented this program in 2013 and  
2 called it Open Payments.

3           As we expected, the media have been using this  
4 database to shed light on physician-industry ties, and I  
5 will list a couple of examples. ProPublica found that the  
6 drugs associated with the highest amounts of promotional  
7 payments to physicians tended to be newer drugs that treat  
8 similar conditions. New breakthrough drugs that cure  
9 disease or significantly extend life were associated with  
10 smaller promotional payments. The New York Times found  
11 that half of the physicians who received the most money  
12 from the manufacturer of Lucentis billed for a higher  
13 amount of Lucentis than their peers. And the Wall Street  
14 Journal has used this data to highlight hospitals and  
15 physicians who received very large payments from the  
16 industry.

17           And later on, Anna and I will be presenting the  
18 preliminary results from our own analysis of this  
19 information.

20           Under the Open Payments program, manufacturers  
21 and group purchasing organizations must report certain  
22 payments and transfers of value to physicians and teaching

1 hospitals. The law applies to manufacturers of drugs,  
2 devices, biologics, and medical supplies. The category of  
3 physicians includes medical doctors, osteopaths, dentists,  
4 optometrists, podiatrists, and chiropractors. But the law  
5 excludes other health professionals, such as advance  
6 practice nurses and physician assistances, and it also  
7 excludes institutional organizations other than teaching  
8 hospitals.

9           Manufacturers are required to report most  
10 financial interactions; for example, speaking fees,  
11 royalties, meals, research grants, and investment  
12 interests. Some types of payments and transfers are  
13 excluded from reporting, such as drug samples, educational  
14 materials for patient use, and discounts on products, such  
15 as rebates.

16           In addition, manufacturers can request that CMS  
17 delay publication of payments related to research or  
18 development of a new product for four years or until FDA  
19 approval of the product, whichever date comes first. So  
20 far, CMS has released payment data that cover the last five  
21 months of 2013 and all of 2014, and the data can be  
22 searched or downloaded from a public website.

1           Anna will now describe the results from our  
2 preliminary analysis of the data.

3           MS. HARTY: The Open Payments database contains  
4 three main files. The research file contains payments for  
5 basic research, applied research, and product development.  
6 These payments go to teaching hospitals, directly to  
7 physicians, or to research institutions that list  
8 physicians as principal investigators on a project.

9           Research payments may cover costs associated with  
10 patient care, time spent managing the study, or the drugs  
11 and devices that are studied.

12           The ownership file contains information about  
13 physicians with ownership or investment interests in a  
14 manufacturer or GPO. This could include information about  
15 a physician's stake in his or her own company.

16           The general payments file includes payments that  
17 are not listed in the other categories, such as payments  
18 for promotional speaking, royalties, and consulting.

19           This chart shows the proportion of payments in  
20 2014 that fall into each category. The total payments sum  
21 to about \$6.5 billion. If you look to the orange sections  
22 on the right, you will see that research payments make up

1 about half of the total value of payments. Within the  
2 research payments category, \$2.5 billion went to physicians  
3 and \$705 million went to teaching hospitals.

4           The green sections on the left show the general  
5 payments category, which makes up 40 percent of the total  
6 value of payments. Among general payments, just over \$2  
7 billion went to physicians and \$543 million went to  
8 teaching hospitals.

9           The blue section shows physician ownership or  
10 investment interests which, at \$703 million, make up the  
11 remaining 10 percent of the total value.

12           Around 80 percent of the total payments went to  
13 physicians, while the other 20 percent went to teaching  
14 hospitals. About 607,000 physicians and 1,100 teaching  
15 hospitals received payments. Of those physicians who  
16 received a general payment, the average payment per  
17 physician was \$3,325. Of those physicians with ownership  
18 or investment interest in a drug or device Company, the  
19 average value of interest per physician was about \$164,000.  
20 We didn't calculate the average research payment per  
21 physician because research institutions may list multiple  
22 physicians as principal investigators, so we are not able

1 to attribute these payments to specific physicians.

2           Eighty percent of physicians receiving payments  
3 were MDs osteopaths, and 20 percent were dentists,  
4 optometrists, podiatrists, or chiropractors. Seventy  
5 percent of the MDs and DOs who billed Medicare during 2011,  
6 '12, or '13 received payments from drug or device  
7 manufacturers in 2014.

8           For the next three slides, we are going to be  
9 focusing on general payments file.

10           The distribution of general payments among  
11 physicians is highly concentrated at the top. The top 5  
12 percent of physicians who received payments account for 86  
13 percent of the total payments. The top 10 percent of  
14 physicians account for 91 percent of total dollars.

15           MR. WINTER: We also examined general payments by  
16 the type of payment, and this table shows the information  
17 for physicians. There's a similar table in your paper that  
18 looks at the teaching hospitals.

19           Promotional speaking fees and honoraria accounted  
20 for about one-third of general payments to physicians, but  
21 only 6 percent of physicians who received any general  
22 payment received this type of payment. This category does

1 not include fees related to speeches that are for  
2 continuing education.

3           The average amount per physician in this category  
4 was about \$19,000. Royalty or license payments accounted  
5 for about one-fifth of general payments and had the highest  
6 average amount per physician, about \$227,000, but only  
7 about 2,000 physicians received one of these payments.

8           Food and beverage accounted for 11 percent of  
9 total payments but were received by about 568,000  
10 physicians, or 94 percent of all physicians who received at  
11 least one general payment, and this indicates that the  
12 practice of providing meals to physicians is widespread.

13           We also examined the distribution of general  
14 payments by specialty for MDs and DOs. We linked the  
15 specialty code that appears on Medicare claims to records  
16 for MDs and DOs in the general payments file, and we were  
17 able to identify specialty for 92 percent of the records  
18 that accounted for 84 percent of the dollars on this file.  
19 And this table shows the top 10 specialties.

20           Orthopedic surgery accounted for 23 percent of  
21 payments for which we identified a physician specialty,  
22 with an average payment per physician of \$20,000.

1 Cardiology accounted for 7 percent, with an average payment  
2 per physician of almost \$6,000. Internal medicine and  
3 family practice each accounted for 6 percent of payments  
4 but had relatively small average amounts per physician.  
5 Further down the list, neurosurgery and endocrinology had  
6 relatively high average amounts per physician.

7           And we will conclude with some next steps that  
8 you may wish to discussion.

9           So the Commission may want to suggest  
10 improvements to the Open Payments program. There are  
11 technical changes that would improve usefulness of data,  
12 for example, indicating in the database whether it was a  
13 GPO or a manufacturer that made the payments, as well as  
14 the type of manufacturer that made payment, for example, a  
15 device or a drug manufacturer.

16           There are also potential changes that would  
17 require a change in statute, for example, requiring  
18 manufacturers to report payments to other health  
19 professionals and organizations.

20           We also have some ideas for future analyses. We  
21 could examine the relationship between physicians'  
22 prescribing behavior and the payments they receive from

1 manufacturers. We could also explore trends as more years  
2 of data are released.

3 This concludes our presentation, and we would be  
4 happy to take any questions.

5 DR. CROSSON: Thanks, Ariel and Anna. A very  
6 interesting beginning, I think, of a process to look at  
7 this.

8 I have one question I'll start with myself. So  
9 with respect to other health professionals who are not  
10 required to report, is that true irrespective of whether  
11 that individual is self-employed and practicing  
12 independently or is in fact an employee of a physician or  
13 group of physicians or a hospital?

14 MR. WINTER: That's true in either case that you  
15 said.

16 What could be happening is if a manufacturer  
17 buys, let's say, lunch for an entire practice, and there  
18 could be NPs and PAs in the practice who partake in the  
19 lunch, but their names will not show up in this database.  
20 It will only be the names of the physicians in the  
21 practice.

22 DR. CROSSON: Okay. Clarifying questions. Let's

1 start here. Alice?

2 DR. COOMBS: I looked at the graph in the paper,  
3 and I was having a hard time for the food because --

4 DR. MILLER: Are you hungry?

5 [Laughter.]

6 DR. CROSSON: Is this another Starbucks thing?

7 [Laughter.]

8 DR. COOMBS: No, because I think the doctors are  
9 being cheated. They just get coffee.

10 Well, what I wanted to know is that do you have  
11 actual names of doctors listed as having received a meal?  
12 Because when I go to conferences now, I mean, if I have my  
13 badge on that says ASA or Society of Critical Care and I  
14 talk by a booth and they have a coffee, they say, "Oh,  
15 you're from Massachusetts. You can't come here," because  
16 of the rules in Massachusetts.

17 But I'm wondering how --

18 DR. BAICKER: So Alice would like a cup of  
19 coffee.

20 DR. CROSSON: It is about Starbucks.

21 [Laughter.]

22 DR. COOMBS: So I'm wondering how they really

1 reconcile this. I mean, you only have 750,000 actively  
2 practicing doctors in the country. That means everybody  
3 has been fed. I mean everybody is actively practicing. So  
4 I'm just trying to reconcile that.

5 MR. WINTER: So, in the hypothetical, the example  
6 you gave where if the manufacturer gave money to an  
7 organization for a conference or to sponsor a booth at a  
8 conference and a physician walked by and took a meal and  
9 the manufacturer has no way of knowing the identity of that  
10 physician, that payment is not reported. If it is only  
11 reported -- if the manufacturer or the GPO is aware of --  
12 either pays -- gives that meal directly to a physician or  
13 does it indirectly but is aware of the identity of the  
14 physician who gets the meal. So these are more likely  
15 cases where they are taking physicians, buying them dinner,  
16 buying them lunch, for an individual physician or a group  
17 or a practice, that sort of thing.

18 Clearly, it is widespread. In the more limited  
19 cases that are captured in the data, that is, that practice  
20 is widespread.

21 DR. HOADLEY: Thank you. This is very useful. I  
22 was trying to get some different ways of thinking about the

1 numbers.

2           On slide 10, you have what I think -- the bottom  
3 right is the overall average payment per physician across  
4 everything. It would just be useful, I think, to sort of  
5 express that as a share of income, even if you just have to  
6 use average kind of incomes to get a sense.

7           And then when you talk on slide 9 about the top 5  
8 percent are getting this much of the payments, again, it  
9 would be kind of interesting, even if you just sort of are  
10 doing it as more of a back-of-the-envelope type of  
11 calculation of what share of income those high receivers  
12 are getting, because again it helps to tell the story. If  
13 somebody is getting an increment of 1 or 2 percent, you  
14 interpret that one way. If somebody is getting 30, 40  
15 percent of what's their normal income in additional gifts,  
16 that's going to tell us a different story, so it's just a  
17 way to help to enlighten what the numbers are meaning to  
18 us.

19           MR. WINTER: I think that would be easier to do  
20 for the average or median physician perhaps by specialty --

21           DR. HOADLEY: Something like that, yeah.

22           MR. WINTER: -- or groups of specialties, but at

1 the top of the distribution, I think that would be tougher  
2 to get. I just don't think the data are that granular to  
3 look at, what's the income of the top fifth percentile of  
4 physicians. I'd have to talk to Kevin and Kate more about  
5 that. But I assume by income, you mean sort of total  
6 income for --

7 DR. HOADLEY: Right.

8 MR. WINTER: -- revenue from their practice and  
9 everything else.

10 DR. HOADLEY: But even if you look how much total  
11 payments in this dataset the average physician in the top 5  
12 percent is getting, you say they account for 86 percent of  
13 the dollars -- that's just a different arithmetic -- and  
14 then look at that relative to the median physician and  
15 whatever. I mean, just -- again, give us just a sense of  
16 the magnitude.

17 DR. CROSSON: Cori.

18 MS. UCCELLO: So there's a website that you can  
19 go to and type in a doctor and find out all of their  
20 payments, so I looked up some of my doctors.

21 [Laughter.]

22 MS. UCCELLO: And one of them had a lot of food,

1 and I was actually wondering, "My God, it's like every  
2 other week. How is this" -- and some of them were -- I  
3 mean, it was like \$20, \$5. And so I couldn't tell if some  
4 of this was even just sending stuff to the office that was  
5 for an office because I know in my office, sometimes some  
6 of our contractors or whoever will send like a basket of  
7 chocolate or something.

8 DR. MILLER: Say more about that.

9 [Laughter.]

10 DR. MILLER: For the record, just keep talking.

11 MS. UCCELLO: So I just thought that was -- I  
12 thought it was kind of interesting, looking up people.

13 I hate to do this, but you know that this is who  
14 I am. So, on page 8 -- slide 8, the average ownership  
15 investment interest per physician, 163,000. Slide 10, the  
16 number on the right-hand column for ownership interest is  
17 53,000. So I'm just trying to reconcile what that is.

18 MR. WINTER: Right. You raise a good point.  
19 This is a question we asked CMS about.

20 So the payments on slide 10 are from a file  
21 called general payments, and there is a separate file for  
22 ownership and investment interest. And there is a category

1 in the general payments file called ownership interest, and  
2 what is going on there is that reflects cases in which a  
3 manufacturer gave a physician a stock or some kind of  
4 interest in the company. And you could think of that in  
5 lieu of paying them a consulting fee, "We'll give you a  
6 share in our company." But the ownership file includes  
7 both of those cases where a physician received a share of a  
8 company but also cases where a physician bought shares in a  
9 company or founded a company and they own it or they're  
10 partners with someone else in the company, so it was a much  
11 broader set of the payments in the ownership and investment  
12 file than just the row you see here.

13 MR. THOMAS: A quick clarification, and it's  
14 really tied into Jack's comment, but on page 9 where we  
15 have the top 5 percent, top 10 percent, I know Jack asked  
16 to kind of look at it as the percentage of median. I would  
17 just like to know the average payments in those buckets  
18 versus where you show the average payments for all  
19 physicians. So if we could provide that in the future?

20 MR. WINTER: Yeah. We didn't calculate the  
21 average for each bucket, but I can tell you what the number  
22 is of the fifth percentage, and that's about \$5,900. So

1 that would be at the bottom of that bucket, would be  
2 \$5,900, and the top is, you know, millions of dollars. And  
3 we can do the average and come back to you with that.

4 MR. THOMAS: Yeah. And I think getting back to  
5 it, just what is the average payment per physician for the  
6 top 5 percent, for the top 10 percent.

7 MR. WINTER: Sure.

8 DR. CROSSON: Clarifying questions. Coming up  
9 this way.

10 [No audible response.]

11 DR. CROSSON: No more clarifying questions.  
12 Okay.

13 So we are going to start the discussion now about  
14 where we would like to go with further information, and  
15 Rita has volunteered to start this discussion.

16 DR. REDBERG: Thank you. I wanted to make a few  
17 sort of general comments. Thank you for the analysis.

18 I think we're moving in all ways, I'm hoping, in  
19 medicine to transparency, transparency of clinical trial  
20 data, the clinical trials registry, and I think this is an  
21 important part of it. I think it actually is interesting  
22 because it relates to the drug sending discussion we had a

1 little earlier this morning, and Craig mentioned that the  
2 really important part is prescribing clinicians. Well, we  
3 know the reason there's so much money invested in  
4 physicians is because we do make most of the medical  
5 decisions in control of the drug and device spend, and we  
6 also know there is a very strong relationship between the  
7 money spends on physicians, you know, the meals, even a  
8 pen, and their prescribing behavior. And certainly, when  
9 you said a lot of the payments go for the expense of the  
10 "me too" drugs, from a company point of view, that's a good  
11 investment, because if I have five different drugs I could  
12 prescribe and one is cheap and one is more expensive, to me  
13 it doesn't -- but if I'm getting payment from a certain  
14 company, that could influence behavior.

15           And I'll say I listen. I used to listen on the  
16 way to work to a lot of these CME tapes and when you have  
17 to disclose at the beginning, and everyone I heard on these  
18 CME tapes, they would say, "These are my disclosures, but  
19 it has no influence on what I am going to say." I have  
20 never heard someone say, "This has an influence on what I  
21 am going to say."

22           [Laughter.]

1 DR. REDBERG: However, obviously, companies are  
2 getting a return on their investment because they know it  
3 does have an influence on what we prescribe and how we  
4 practice medicine, and so it's really important.

5 I should point out the obvious, that patients are  
6 really unaware of these, and maybe Cori went and looked it  
7 up. But when doctors are -- for example, orthopedic  
8 surgeons were at the top of that list. You know, it's  
9 known that a lot of orthopedic surgeons will recommend  
10 devices that they happen to be an ownership interest, or  
11 they have a relationship with the company. They may truly  
12 believe that is the best device for that patient, but the  
13 patient is unaware of that, and I think -- you know, I  
14 don't think that leads to the best medical decisions, and  
15 certainly not to inform medical decisions.

16 In terms of the research payments, you know,  
17 there's a lot of discussion over whether that is or isn't  
18 an influence. I would just point out, in the, again, 30  
19 years since I've been in medicine, most funding for  
20 research has shifted from the NIH to industry funding and  
21 that does have an effect because the sponsor has a role in  
22 the kind of question that is being asked, or you can't get

1 an answer if you didn't ask the right question. So, what  
2 you're comparing. Are you comparing to control and not  
3 doing anything? Are you comparing to current treatment?  
4 And then who owns the data? Sponsors, you know, there's  
5 varying policies depending on the academic medical center,  
6 but sponsors have a lot of influence over how the analysis  
7 is done, whether the results are published. You know, we  
8 know that negative results tend not to be published as much  
9 as positive results do, and that all affects, again, the  
10 way we practice medical care.

11           And the other thing about research payments is  
12 that there are these things called seeding trials that, I  
13 think, often go under the research payments, but when a new  
14 drug or device first hits the market, in order to -- it  
15 seems in order to familiarize doctors or develop  
16 relationships, companies will do these research trials, or  
17 sometimes they're post-market surveillance trials, but  
18 there's a per payment per patient for enrolling patients  
19 and using the new drug and device, and all of that appears  
20 under research, but it really starts to overlap with  
21 marketing. When you see trials that have many centers and  
22 one or two patients per center, you know, that's often what

1 we think is going on.

2           The other thing I would say is the samples that  
3 are excluded from use, you know, where I practice at UCSF,  
4 we banned samples many years ago. Again, I first thought,  
5 oh, it's great that there are samples, and then I realized  
6 that there were never samples of those generic drugs.  
7 There were never samples of the inexpensive drugs. All the  
8 samples were of the new expensive and often the "me too"  
9 drugs, again, to try to get a market. And, so, they're  
10 excluded, but they clearly still have an effect.

11           So, I think continued sort of making sure, of  
12 course, that we've gotten all this right, getting more  
13 details, as you suggested on the last page, about who's  
14 making the payments and the type of manufacturers is good.  
15 I think we also need to go a little further in making sure  
16 that patients are aware and that doctors need to disclose  
17 if they have a relationship with a drug or device that they  
18 are prescribing. Thank you.

19           DR. MILLER: Can I ask one thing quickly? When  
20 she mentioned the -- and I can't remember the vocabulary,  
21 but the payment to the physician to put a patient in a  
22 post-marketing trial, would that show up in this database?

1 MR. WINTER: That should be showing up in the  
2 research payments file.

3 DR. MILLER: Okay.

4 MR. WINTER: But they don't distinguish whether  
5 it's phase one, two, three, or four, so we don't know if  
6 it's a post-market trial or not. But, they're not required  
7 to. They might, but they're not required to.

8 DR. CROSSON: Okay, so let's -- remember, we have  
9 kind of two questions here. What potential changes to the  
10 existing program would people think might be recommended?  
11 And, secondly, what further analyses would you like to see  
12 from staff. And we'll move up from Rita, starting with  
13 Warner.

14 MR. THOMAS: Two comments. One, I think we  
15 should continue to reinforce the importance of transparency  
16 around this, because I know a lot of organizations that  
17 went and looked up their own physicians and found that they  
18 didn't know payments that were going to their own  
19 physicians. So, I think that is really important. And I  
20 think it also, getting back to Cori's point around the  
21 patients understanding that. So, I would just encourage us  
22 to continue to focus on the transparency, reinforcing that

1 and making sure that that's something that the more detail  
2 we can have on what these payments are, what they're for, I  
3 think the better off we are.

4           The other thing I'd like to just put on our radar  
5 screen, and it may not have the same magnitude, but I think  
6 it's rather large, are the payments that go to the reps,  
7 especially around device organizations, who are in the ORs  
8 of hospitals and what not. And we find that, in some  
9 cases, the reps are being paid more to assist in a  
10 procedure than are surgeons who are being paid to do the  
11 procedure, and that is not transparent at all in the  
12 process and that may be something that could be  
13 interesting, and it's a hidden cost of the program, quite  
14 frankly, because it's in the cost of the device that's  
15 being purchased by the hospitals. So, just maybe something  
16 to put on our radar screen.

17           DR. CROSSON: Okay. Cori.

18           MS. UCCELLO: Yeah, I agree with the idea of  
19 examining more closely this relationship between  
20 prescribing behavior and these payments. I mean, I  
21 couldn't -- looking at that Slide 10 and looking at the  
22 different payments, like this royalty license and the

1 ownership interest, those are huge numbers, and I just -- I  
2 was just trying to figure out, well, are these red flags or  
3 not? They seem like it, but I don't know what to do with  
4 that. So, just kind of helping me think through that would  
5 be helpful.

6 DR. CROSSON: Jack.

7 DR. HOADLEY: Yeah. I, I think, agree with  
8 Cori's comment and I agree with the other comments. I do  
9 think, again, the relationship between the prescribing  
10 behavior and the payments is really interesting, and the  
11 Lucentis example that was done in the media, you know, is a  
12 real interesting example of that and one that, I think, is  
13 pretty revealing. Trying to frame what that analysis might  
14 look like is challenging. I mean, I think it may be more  
15 interesting to do for very selected drugs than to try to do  
16 something across the board, although it would be  
17 interesting, maybe, the more overall, the more payments you  
18 get, you would generally prescribe more. I think that's  
19 less likely to be revealing, though, than picking on  
20 something like Lucentis or identifying some other cases,  
21 not necessarily among expensive Part B drugs, but even  
22 among some of the Part D drugs that are of more

1 questionable value and see whether their use is accelerated  
2 by the doctors who are getting payments.

3 DR. CROSSON: Alice.

4 DR. COOMBS: So, my line of work has to do with  
5 being in the operating room and seeing a lot of reps and  
6 the impact of reps. But, to be honest with you, a lot of  
7 surgeons feel uncomfortable doing some of the procedures  
8 without the rep being present for fear of opening the wrong  
9 kit. Opening the wrong kit is a big deal. And, so, I  
10 don't know how to reconcile this whole issue, but I know  
11 there's a -- even before the operating room, whether or not  
12 you do a troch nail or you do a more involved procedure,  
13 doing titanium, all that decision making happens a lot of  
14 times with the rep outside of the room. So, once you get  
15 into the operating room, the rep is there to ensure a level  
16 of safety with using the devices that are being used for --  
17 I shouldn't list any ones, but for pacemakers and testing  
18 the pacemakers. The reps are essential for the whole  
19 process.

20 One experience I did have, without too much  
21 identifying data, was a guy who came in to, quote-unquote,  
22 "observe cases." "I just want to come in and observe cases

1 all day." And while in the endos, we suggest that we use -  
2 - you sure you don't want to clip that? You sure you don't  
3 want to -- and that kind of behavior actually changes the  
4 provider, even though the provider doesn't get any -- he  
5 doesn't get anything in return for that. But it does  
6 influence behavior. When that rep came around again, you  
7 know, there was a way in which the rep wasn't involved with  
8 this quote-unquote "observation," because I think the  
9 observation rep that comes in to observe a case has more  
10 influence than just them observing the case, and so I think  
11 that's problematic.

12 I think we have a major problem, because we went  
13 over this whole thing about how drug companies influence  
14 doctors, but, you know, I pick up a New England Journal or  
15 I pick up a JAMA, and guess what, all through the magazine  
16 is this advertisement, and sometimes you'll read that as  
17 opposed to something else and there's influence there, too.  
18 So, I mean, we all have been a part of this in terms of  
19 influence.

20 DR. CROSSON: Kate.

21 DR. BAICKER: I think it's great to have these  
22 data so readily accessible and the technical fixes that you

1 mentioned. I haven't tried to use the data, so I don't  
2 know what fields are missing or could be populated with  
3 information that's already collected, but certainly  
4 anything that could be populated better to make it more  
5 usable, we should be recommending that that information be  
6 merged in and most easily used, and those seem like great  
7 suggestions from people who are expert in trying to use it.

8           It seems like there's bigger return to that,  
9 which might clarify some of the big dollar payments that  
10 Cori mentioned, than trying to parse more finely how many  
11 people in the office got a cup of coffee. Did Alice get a  
12 cup of coffee, because I do not want her to have coffee.

13           [Laughter.]

14           DR. BAICKER: You know, that -- I think finer and  
15 finer slicing of that comes at higher and higher cost with  
16 less and less return, whereas understanding where the  
17 bigger dollar amounts are going, from whom to whom, is  
18 where the return likely is in the data.

19           DR. CROSSON: The Starbucks metaphor is just  
20 running wild here.

21           [Laughter.]

22           DR. CHRISTIANSON: I was going to say pretty much

1 the same thing that Kate said, and we're kind of depending  
2 on you to tell us -- you're working with the data -- what  
3 fixes should we be recommending that will allow you to do a  
4 better analysis, get at some of these issues and so forth.  
5 So, I think that's important, but as Kate said, I think the  
6 next round, I mean, we've got a feel for what's here. You  
7 guys have got a feel for what's here now. So, let's try to  
8 come up with a set of things like that that we can  
9 recommend.

10 MR. ARMSTRONG: I just briefly would affirm this  
11 data is interesting and we ought to make sure it's usable  
12 and we believe it, and if it can be enhanced, we should do  
13 that.

14 I'm still wrestling, though, with, so, what else-  
15 what do we do? Other than make the information available,  
16 what else do you do with this? I think, you know, one  
17 extreme -- Rita mentioned this -- that's true in my system,  
18 we don't allow any of this to happen. We don't let samples  
19 into our buildings or reps into our buildings or payments  
20 of any kind. And, I suppose that's one extreme, that we  
21 impact payments to providers who show up on any of these  
22 lists. I doubt that's easily implemented, and there's

1 probably a lot of ground in between. But, it just seems to  
2 me that's really the question, is, well, what do we -- how  
3 does this influence payment policy, if at all.

4           And then to someone else's point, we need to ask,  
5 is it even worth spending that much time on, given so many  
6 other really big things we have, despite how it just seems  
7 wrong, you know, that this is happening.

8           DR. NAYLOR: I think this is a really important  
9 issue, \$6.5 billion, when we're paying \$65 billion each  
10 year in outpatient costs. I mean, that's ten percent. So,  
11 I think it's really important. It's important for all the  
12 reasons everybody else has talked about, largely because  
13 while we have now a tool, largely the beneficiaries are  
14 unaware of what is happening.

15           I would support all these suggestions, that we  
16 think about the transparency being responsibility for  
17 everyone who receives Medicare payment, and that would  
18 extend to nurse practitioners and PAs. And I would also  
19 support the additional analyses. I am not sure I would  
20 limit the analyses to the top five or ten percent. I would  
21 be very interested in looking at the extent, and this  
22 builds a little bit on earlier comments, when we have a

1 group of providers for whom it is a substantial jump in  
2 their compensation, however that's defined, I think that is  
3 as important as looking at just the five or top ten  
4 percent.

5 I also think this idea of what are the next steps  
6 is really important, and there's a huge body of work around  
7 the relationship between these kinds of incentives and  
8 behaviors and decisions by institutions to stop it. And  
9 I'm wondering if showcasing, you know, those that have  
10 really stepped up to the plate, given the acknowledged  
11 linkages between this spending and behavior. Certainly,  
12 the analyses that you're doing will also bring that to the  
13 fore. But, I think this is an exceedingly important area.  
14 It's not unrelated to the Medicare drug spending. If we  
15 learn that people are using more, prescribing more because  
16 of these relationships, it could affect the bigger bottom  
17 line.

18 DR. CROSSON: Kathy.

19 MS. BUTO: Yeah. This issue really bothers me  
20 because it totally undermines the argument that, you know,  
21 medicines have value and the value should really be the  
22 determining factor of how they're prescribed. So, I think

1 this is a real issue of credibility and trust.

2 I'm assuming that we will look at the  
3 relationship between physician prescribing and payments  
4 from manufacturers. I think some literature has already  
5 been developed in this area, and I would ask that maybe for  
6 the next go-around we get a little synopsis of some of the  
7 findings of -- because I think there has been a clear  
8 relationship shown.

9 And then in addition to that, I think it's  
10 important for us to understand, particularly if you look at  
11 it by specialty, where the growth in Medicare spending is  
12 associated with these specialty services that are tied to  
13 drugs and devices. So, I think it would be helpful to have  
14 that connection to Medicare per se.

15 And, the last thing I would mention, and I hate  
16 to do this because I don't think it's a great piece of law,  
17 but the Stark ownership and referral rules, which have had  
18 -- I think we once described them as Swiss cheese because  
19 they're more defined by the exceptions than by the actual  
20 rules. There are ownership and referral rules that are in  
21 Medicare now, and so I -- I mean, I guess I'm of the belief  
22 that there is something that Medicare could do to move in

1 the direction of more appropriate referral and transparency  
2 issues, and maybe it's worth looking at that. Maybe it  
3 isn't worth looking at it, because it's such a labyrinth.  
4 But, there was an effort made to -- for those who are not  
5 familiar -- to reduce the ownership where there's the  
6 possibility of referrals, for example, in radiology  
7 practices and so on and so forth. So, this is kind of  
8 analogous to that, but not totally, because it involves  
9 specific categories of medications and devices and so on.

10 MR. WINTER: If I could just respond to two of  
11 the points you made, one is that in our 2008 and 2009  
12 chapters on this topic, we did examine and summarize the  
13 literature on the influence -- the link between physician  
14 interactions with drug manufacturers and their prescribing  
15 behavior, and we can certainly update that based on more  
16 recent literature for the next time.

17 The other point I want to make is that as part of  
18 our set of recommendations in 2009, we also recommended  
19 that Congress mandate public reporting of physician  
20 ownership of any entity that billed Medicare, so hospitals,  
21 ASEs, dialysis facilities, independent testing facilities,  
22 and so on. And that recommendation is still out, has not

1 been adopted. But, it does relate, and I think your  
2 comment about physician ownership --

3 MS. BUTO: Of course, physicians, I mean,  
4 manufacturers don't actually bill Medicare. So, I think we  
5 have to think through how would that work or what would the  
6 reporting be. But, anyway, I think your point is well  
7 taken.

8 MR. WINTER: And physician ownership in a  
9 manufacturer is part of the data that is now being reported  
10 as part of this database.

11 DR. CROSSON: Herb, no. Bill.

12 MR. GRADISON: We've talked a lot about provider  
13 behavior, and I certainly support the efforts to get more  
14 information about that, or update the information from  
15 earlier.

16 We haven't, at least in my view, talked enough  
17 about patient behavior, that is to say, what does it take  
18 to influence the patients? I don't mean we haven't talked  
19 about it at all, but I'd be -- and I'm sure there have been  
20 studies of this, maybe by psychologists or behavioral  
21 scientists maybe more than people in medicine, directly in  
22 the practice of medicine. But, another way to say that is

1 how can information best be presented or made available to  
2 influence behavior in the direction we would like to nudge  
3 it, and I'd kind of like to know a little bit about that.

4           In the interest of full disclosure, I was  
5 surprised when I was having a pacemaker installed to see  
6 some guys in blue outfits that were under the employ of  
7 Medtronic, as I recall it. I was also very glad they were  
8 there, to be honest. And I have a vague recollection --  
9 vague because I think I was partially sedated -- that when  
10 I was having some back surgery, there were some guys from  
11 Medtronic there, too, even though that surgery had nothing  
12 to do with it.

13           [Laughter.]

14           MR. GRADISON: So, I say, you know, this is a  
15 mixed situation. It could be that some patients are sort  
16 of proud of their physicians getting invited to conferences  
17 where they're talking about the newest device or -- and I  
18 don't mean to sound naive. I'd like to know more about  
19 which way this works in terms of influence on patient  
20 behavior.

21           More specifically, I would be very interested in  
22 anything you could learn about how other countries are

1 handling this, especially a country like Canada, where the  
2 physicians are in private practice rather than in the  
3 government employ. I think if they're in government  
4 employ, it might be kind of a different situation, although  
5 that would be interesting. But, just in terms of casting a  
6 broad net, I'd be interested in -- I don't usually raise  
7 this question about what other countries are doing, but I  
8 think in this instance, it might be interesting.

9 DR. HALL: So, just full disclosure, I like to  
10 take notes at these meetings and I have two pens here.  
11 They don't bear any names of any drug company. I paid 75  
12 cents each for them at the Rochester airport on the way  
13 down here.

14 [Laughter.]

15 DR. HALL: On the other hand, every time I come  
16 into this meeting, somebody drops a blue pencil or pen up  
17 here that apparently is from the Ronald Reagan Building,  
18 which probably explains my perfect attendance record for  
19 the last four-and-a-half years at this meeting.

20 [Laughter.]

21 DR. HALL: More seriously, I think we should have  
22 zero tolerance for this sort of thing, especially since

1 virtually every specialty society in organized medicine has  
2 very strict mandates against this type of behavior, of  
3 accepting gifts from pharmaceutical companies. The  
4 technical support is a special thing, but it would have to  
5 be looked at carefully. And virtually every academic  
6 center, and I think most reputable hospitals, have -- also  
7 seem to have zero tolerance.

8           And it's possible that your statistics show that  
9 it's one of these five percent/80 percent rules. Five  
10 percent of Medicare patients are responsible for a huge  
11 amount. And I suspect that that's where the money is going  
12 to be to look at that.

13           But, this is a serious problem, even when it's  
14 only the appearance of impropriety, and I think we're doing  
15 a good service to medicine by keeping a close tab on this.

16           DR. CROSSON: David.

17           DR. NERENZ: As this goes forward, I just would  
18 ask you and sort of all of us to always keep right in front  
19 of us what the connection is between this set of issues and  
20 Medicare payment per se. You know, on the surface, we  
21 could say this isn't our problem. These are not Medicare  
22 payments. These are manufacturer payments and it's not our

1 business. But, the reason we're talking about it is that  
2 we see that there's a connection.

3 But, I guess I always want that connection to be  
4 made explicit as a reminder, but also perhaps as a guide to  
5 analysis, because it seems like there are two kinds of  
6 connection with the causal things running in two different  
7 ways. Either we want to understand more clearly what's the  
8 relationship between these payments and Medicare payments,  
9 what's driving behavior change. You know, we know some of  
10 that already, but perhaps there are other questions.

11 But I think even more interestingly, but I don't  
12 see it yet as clearly, is going the other way. What about  
13 Medicare payment change per se could influence any of this,  
14 because that presumably is our purview and that's where we  
15 would take some action. And I guess that's where I would  
16 want to see this going, some way or other.

17 DR. CROSSON: Warner.

18 MR. THOMAS: Just real briefly, commenting on  
19 Alice's commenting about the reps. My claim is not that  
20 they're not important. My point is that the payments to  
21 them ought to be transparent like the payments are here to  
22 physicians, and I think that that would be telling, and I

1 think that there are many organizations that are working  
2 hard now to figure out other models, to move to more of a  
3 rep-less model because of the significant cost of the  
4 system, so --

5 DR. HOADLEY: Just real quickly, we've heard  
6 several examples here of institutions that don't allow  
7 these payments. It might be useful to get a sense of  
8 what's the story across the country. How many practices  
9 don't allow it? Is it mostly just a handful of  
10 institutions? You know, I think Bill said a lot of the  
11 physician societies have suggested they shouldn't be done.  
12 Sort of get a sense of what the -- and if there's any  
13 literature that says how much impact that's had.

14 DR. CROSSON: Okay. Ariel and Anna, I think  
15 you've gotten broad support here for both of your large  
16 bullet points and the areas you've suggested and so we look  
17 forward to hearing from you again later.

18 I see no further questions or comments. I think  
19 that means that we're finished with the agenda and now we  
20 have time for the public comment part of the meeting. So,  
21 if there are any individuals, representatives here from the  
22 public who would like to make a comment at this time,

1 please come forward to the microphone so we can see who is  
2 interested in speaking.

3 [Pause.]

4 DR. CROSSON: Okay. Seeing -- oh, there you go.  
5 Let me just make a couple of comments before you begin.

6 First of all, as I think most of you know -- we  
7 certainly know on the Commission -- the MedPAC staff make  
8 every effort before the meetings to hear from  
9 representatives who are at interest. There are a number of  
10 mechanisms for this, both input onto the MedPAC website as  
11 well as individual contacts with Mark and his staff. So  
12 this opportunity here is not the only opportunity nor  
13 necessarily the best opportunity to provide that input.

14 What I'd ask you to do -- turn on your  
15 microphone. But what I'd ask you to do is state your name  
16 and your organization, and you'll have two minutes to  
17 present. And then when this light comes back on, we'd ask  
18 you to stop. Thank you.

19 MS. SANDEL: Thank you. My name's Rhonda Sandel.  
20 I am the president of the National Association of  
21 Freestanding Emergency Centers, and for full disclosure, I  
22 also own and operate several freestanding ERs in Texas.

1           The National Association of Freestanding ERs  
2 advocates for both the independent model and the hospital-  
3 associate model of freestanding emergency rooms. We feel  
4 that all freestanding emergency centers should have the  
5 right to be reimbursed by CMS for the services we provide.  
6 That's both the independent and the hospital model. I  
7 believe if independent models were able to receive payment  
8 for services provided, you would see many more of these  
9 facilities open and operate in underserved areas.

10           Blue Cross/Blue Shield has already performed its  
11 own study and published the data that they recognize that  
12 the freestanding model, both the independent and the  
13 hospital model, are a less expensive alternative to the  
14 hospital-based emergency room, both for the payer and for  
15 the beneficiary. It's on their website.

16           Freestanding ERs are not cherrypicking from the  
17 hospital emergency room. In Houston, where you see more  
18 freestanding ERs than any other place in the country, all  
19 hospital visits have increased greatly, both in the  
20 freestanding model and the hospital model. The numbers are  
21 up.

22           ACEP supports this with their own study that

1 we're at an all-time high for emergency room visits across  
2 the country, despite numerous freestanding ERs opening  
3 across the country.

4           There's certainly a place for urgent cares, but I  
5 think it's very difficult for you to drive patients to the  
6 urgent cares. And I think part of our issue is that urgent  
7 cares are nothing more than an extension of a primary care  
8 physician's office or services with extended hours. But  
9 both primary care and urgent care services are open for  
10 very short hours of time. Therefore, when patients have  
11 their emergency, your beneficiaries, where do they go to?  
12 They go to the hospital emergency room, or they go to the  
13 freestanding emergency room. That's the issue that needs  
14 to be addressed, is the hours. If you want to push someone  
15 to urgent care, they've got to have some extended hours.

16           That's all. Thank you very much.

17           DR. CROSSON: Thank you very much.

18           MS. SANDEL: Absolutely.

19           DR. CROSSON: Appreciate that.

20           Now, seeing no other individuals at the  
21 microphone, we are recessed until next month. Thank you so  
22 much.

1                   [Whereupon, at 11:38 a.m., the meeting was  
2 adjourned.]

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