MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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9:48 a.m.

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1 P R O C E E D I N G S

2 [9:48 a.m.]

3 DR. CROSSON: Okay. Good morning. For our first
4 session, we're going to have a discussion about provider
5 consolidation from the perspective of its effect on our
6 directions for Medicare policy. Jeff, lead us off.

7 DR. STENSLAND: All right. Today I'm going to
8 discuss the literature that we've seen on consolidation,
9 and before I start, I want to thank Sydney McClendon for
10 her work on this project.

11 The first type of consolidation is horizontal
12 consolidation, where hospitals consolidate into systems and
13 physicians consolidate into larger groups. Last month,
14 Kate talked about physician groups, so today I'll talk
15 about hospitals consolidating into systems.

16 The second is the purchase of physician practices
17 by hospitals.

18 The third is the merging of providers into an
19 organization that accepts insurance risk, and this can
20 occur when provider groups take on insurance risk through
21 ACOs. It can also happen when insurers purchase physician
22 practices. And both these two things have been happening.

1 As we go through this presentation, I will
2 discuss how each of these types of consolidation in the
3 health care industry are linked to Medicare policy. I will
4 also point out how they are linked with other presentations
5 you're going to hear today and tomorrow.
6 First, we'll discuss hospital consolidation. And
7 as we stated in your paper, hospitals generally have
8 significant market power. In about a third of markets, a
9 single system has more than 50 percent of all discharges.
10 In many small metro areas, there is only one hospital
11 system. And there's no expectation that the FTC is going
12 to materially unwind consolidated systems. Therefore,
13 hospital market power is expected to be retained and
14 possibly grow. So market power is simply part of our
15 health care environment, and that has important
16 implications for Medicare policy.
17 The literature cited in your mailing materials
18 presents strong evidence that market power leads to higher
19 commercial rates, and there's not any clear evidence that
20 the higher costs are justified by higher quality.
21 On average, when we look at prices we see two
22 things. First, the rates commercial payers pay hospitals

1 vary wildly from market to market and hospital to hospital.
2 As we showed in your mailing materials, a high-cost
3 hospital may have a negotiated rate for a head CT that's
4 five times the rate at a low-cost hospital. What this
5 suggests is that the markets are not working to bring
6 prices down to a consistent level.
7 On average, we see commercial rates are about 50
8 percent above cost and well above Medicare. Now, we'll
9 talk about these implications for the Medicare program.
10 So we and others have shown in the past that when
11 nonprofit hospitals have more money, they tend to spend
12 more money. And so higher non-Medicare profits are then
13 often associated with higher costs of care. And the high
14 costs of care mean larger losses on Medicare patients.
15 Now, this creates pressure for Medicare to increase its
16 rates.
17 However, we should note that, despite the losses,
18 hospitals still have an incentive to continue to see
19 Medicare patients, in part because Medicare rates continue
20 to exceed their marginal costs. So there does not appear
21 to be a near-term access problem. But over the long term,
22 this growing gap between the commercial rates and the

1 Medicare rates is troubling.

2 The bottom line is that, at least in the short

3 run, Medicare's administratively set prices partially

4 insulate the taxpayers and the beneficiaries from the

5 market power of hospitals.

6 Now I'll shift to talking about vertical

7 financial integration. Recently, we've seen an increase in

8 hospitals purchasing physician practices. When a hospital

9 buys the practice, it then often starts billing for the

10 services as a hospital outpatient service. This means that

11 the program and the beneficiary will receive two bills.

12 Instead of just getting a physician bill, they'll get a

13 physician bill and a second bill for the hospital facility

14 fee. The result is Medicare spending goes up.

15 In the commercial world, some hospitals are also

16 paid facility fees for physician services. On average,

17 this increases costs. However, the research by Neprash and

18 Capps cited in your mailing materials suggests that

19 hospitals may also negotiate higher prices for services

20 after they acquire the physician practices.

21 One hope is that maybe once their practices are

22 acquired, there will be better coordination of care and

1 maybe volume will go down to offset the price increase.
2 But the Neprash article shows that overall outpatient
3 spending goes up, meaning there wasn't a volume offset to
4 the price increase, and there was no volume offset on the
5 inpatient side either to make up for the price increase.
6 So, in net, spending up.
7 In some cases, this vertical integration may
8 generate efficiencies. But the way the Medicare program
9 and the commercial payment worlds are set up, there is an
10 incentive to merge even when there will be no efficiencies
11 gained. In fact, even if some inefficiencies are created
12 by the conversion of physician practices to a hospital
13 outpatient department -- possibly having to meet hospital
14 life safety codes, for example -- hospitals may still
15 convert to obtain the facility fees and the higher private
16 rates. Even in that environment, slightly less efficient
17 care.
18 This slide shows the growth in hospital-based
19 physician services. Hospitals are increasingly billing for
20 E&M services, echocardiology, and nuclear cardiology at the
21 hospital rates.
22 E&M services grew 22 percent in three years

1 compared to a decline in physician offices. Echocardiology
2 and nuclear cardiology also shifted to the hospital site of
3 care. So, in general, what we're seeing here is a shift in
4 the location of services to the higher-cost site of care,
5 and the current policy of differential rates across these
6 sites encourages this shift.
7 In 2015, Medicare paid about $1.6 billion for
8 hospital-based evaluation and management services, above
9 what it would have paid in a physician office. This
10 reflects the hospital facility fee. Similarly,
11 beneficiaries paid an additional $400 million in cost
12 sharing because they were paying the hospital-based rates
13 rather than the physician office rates.
14 Now, Congress has started to address this issue.
15 Going forward, at some point off-campus hospital outpatient
16 departments will be paid the same rates as freestanding
17 offices. This is part of the Bipartisan Budget Act of
18 2015. However, there are some exceptions to this new
19 policy.
20 First, on-campus practices will continue to be
21 aid the facility fees. In addition, there will be a
22 grandfathering clause where existing practices continue to

1 be paid the facility fees.

2 In addition, facility fees will continue to be
3 paid for all off-campus emergency departments, and Zach
4 will talk about this later this morning.

5 Finally, there is some risk of gaming. Because
6 the hospitals can still obtain facility fees by moving
7 hospitals to the main campus, we could see some of these
8 shifts. The financial incentive is there. There could
9 also be the setting up of mini hospitals, and the mini
10 hospitals would then qualify for the facility fees on
11 outpatient and emergency services.

12 The Commission's recommendation was slightly
13 different than what Congress passed. It would have set up
14 a level E&M price and a level price for many other services
15 across all sites of care. Under that recommendation,
16 payments would not favor the higher-cost way of delivering
17 care.

18 Now we turn to the third type of integration.
19 There have been managed care plans in Medicare for 40
20 years. In many cases the managed care plans are aligned
21 with or own physician practices. The single entity then
22 has responsibility for insurance risk and the provision of

1 care. As we discuss in your mailing materials, we see some
2 providers acquiring insurers and some insurers acquiring
3 providers. It is not clear that this model has large
4 enough advantages to always win in the marketplace. In
5 some cases, providers have divested their insurance arms in
6 the past. In other cases, insurers have divested their
7 physician practices.
8 Another option is the accountable care
9 organization, or ACO. There is increasing interest among
10 providers in being rewarded for managing population health.
11 Providers can take responsibility for the health of their
12 patients, and in models with two-sided risk, they can also
13 take responsibility for the annual cost of care.
14 We now look to see how integration of insurance
15 risk and provision of care in MA plans and ACOs has
16 affected outcomes and costs.
17 First, the literature suggests that integrated
18 models do have some small benefits.
19 First, HMOs do tend to provide better -- or
20 perform better on process measures such as mammogram rates.
21 But they are about equal on patient satisfaction.
22 HMOs can reduce use of services, but it is not

1 clear that reduction in the number of services will offset
2 the plan's higher administrative costs on average.
3 Certainly in some high-use markets, like Miami, we've seen
4 that MA plans have been able to reduce the service use by
5 enough so that they can bid below fee-for-service, meaning
6 the reduction in service use was bigger than the extra
7 administrative costs. In low-use markets, we haven't
8 always seen this is the case.
9 In 2016, Medicare paid MA plans on average about
10 5 percent more on a risk-adjusted basis than fee-for-
11 service. The 5 percent reflects MA bids, the extra cost of
12 benefits, and the coding differences between MA and fee-
13 for-service. So let's walk through this.
14 First, if we just ignored the coding issue and
15 just looked at the cost of the basic A/B benefit and the
16 bids provided by MA plans, we would estimate that the
17 taxpayer paid MA plans 102 percent of fee-for-service costs
18 for the A/B benefit and the extra benefits going to them,
19 or 2 percent more. But as we discussed in the March
20 chapter, last year MA plans also code more extensively than
21 fee-for-service, and this increases the risk score of their
22 patients and increases taxpayer spending. Or past

1 estimates suggest that this coding increased spending by
2 another 3 percent above fee-for-service. So the net effect
3 is a 5 percent higher payment from the taxpayer for MA care
4 than fee-for-service care. Now, Andy will give you an
5 update on this coding issue tomorrow. And in December,
6 Scott will update the 5 percent figure. It's possible that
7 MA plans have started to become more competitive with fee-
8 for-service in 2017 because there have been some changes to
9 bring the benchmarks down a little bit. That might bring
10 the relative cost of MA compared to fee-for-service down in
11 2017, and Scott will update you next month.
12 With respect to ACOs, in general there is
13 evidence that ACOs have been improving their quality
14 metrics, so some positive signs on quality. From a cost
15 standpoint, it has been about breakeven for the taxpayer.
16 And I want to emphasize that when we say the ACO and MA
17 costs for the taxpayer we've presented here are averages,
18 there are some markets where MA plans and ACOs do save
19 taxpayers money. These are often high-use markets.
20 Both the MA plan and the fee-for-service program
21 in general have had some success in reducing costs in these
22 high-use markets and even reducing overall regional

1 variation of care. I think you'll remember about ten years
2 ago when Elliot Fisher came here to talk about ACOs, he led
3 off with we have all this reduce regional variation, maybe
4 ACOs could scrunch some of this regional variation. And we
5 have seen some scrunching of that both in the fee-for-
6 service program and certainly MA bids are tighter than fee-
7 for-service.
8 So the policy question, the key policy question
9 is: Do we pay for the structure or do we pay for outcomes?
10 Now, there's a longstanding interest and widespread
11 interest in improving care coordination, and the
12 expectation is this will lead to higher-quality care and
13 lower costs.
14 However, it is not always clear that the legal
15 and financial integration will lead to true clinical
16 integration or to efficiencies. The research indicates
17 that it's hard, but not impossible, to generate
18 efficiencies from these integrated models. And it may be
19 difficult for us to distinguish which models are really
20 providing value for the beneficiaries.
21 As we said, one thing we could do is level the
22 playing field between the models and just set standards for

1 the outcomes. And then the most efficient model would be
2 able to attract patients and win market share. In essence,
3 we wouldn't have to determine up front what's a good model
4 and what's a bad model or what the criteria for a good
5 model or a bad model is. We could just set a level playing
6 field and let competition illuminate which is the best
7 model.
8 For each of the three types of consolidation,
9 MedPAC has historically had a policy response.
10 Horizontal consolidation can result in higher
11 commercial rates and higher hospital costs. Traditionally,
12 MedPAC has not recommended following the growth in private
13 prices. In fact, update recommendations in the past have
14 been constrained in part to the stated objective of keeping
15 pressure on for hospitals to constrain their costs.
16 With respect to vertical integration, the
17 Commission recommended site-neutral pricing for E&M visits
18 as well as certain other services. Site-neutral would mean
19 a level playing field. Therefore, vertical integration
20 that truly does generate efficiencies would still happen
21 with site-neutral pricing, but integration that is driven
22 purely to capture larger Medicare facility fees or higher

1 commercial rates would not. As long as the merged entities
2 are paid -- if we don't have site-neutral pricing and the
3 merged entities are paid more, it will be hard for
4 independent entities to be viable.
5 With respect to insurer and provider
6 consolidation, one approach is to level the playing field
7 between MA and fee-for-service and let the models compete
8 with each other. Later today Eric will discuss how a
9 premium support model could allow competition that would
10 illuminate which is the most efficient model in each
11 market.
12 Now, another consideration I'll just talk about
13 briefly is ACOs. Some may argue that ACOs will be used as
14 an excuse for providers to consolidate and generate market
15 power. As described in your paper, in the St. Luke's case
16 in Idaho, there was an example where providers argued that
17 they needed to merge to improve care and move from volume
18 to value. However, the FTC has clearly stated that anti-
19 competitive mergers are not appropriate even in an ACO
20 world. In cases where ACOs are not former for mergers and
21 they're actually competing with each other, they may
22 actually have some positive effects on prices in markets.

1 For example, in Boston there are several ACOs that compete
2 with each other. Physicians in these ACOs have an
3 incentive to refer patients to lower-cost providers in the
4 Boston market. And there is some evidence in the
5 literature that this has led to lower prices paid for these
6 ACO patients, at least in the commercial ACOs. By aligning
7 physician and patient incentives to look for less expensive
8 providers, there may be a greater elasticity of demand
9 where more patients shift to the lower-cost sites of care
10 given any level of consolidation.
11 Now we shift to some possible discussion
12 questions.
13 First, there is the overarching question of how
14 to structure payments in the Medicare program. Should we
15 structure the program to pay for a certain corporate
16 structure or to pay for outcomes?
17 Second, should we continue to work on site-
18 neutral payment issues, such as our site-neutral E&M
19 recommendation?
20 Third, should we be moving toward a premium
21 support model that provides equal support for all models?
22 MA or ACO models would gain market share if they actually

1 provide more value to the beneficiary. But they would not
2 gain market share -- or they would not gain higher payments
3 or higher market share just due to having a particular
4 legal structure. This will be discussed in more detail by
5 Eric when he discusses premium support this afternoon.
6 I'll turn it over to your discussion.
7 DR. CROSSON: Thank you, Jeff.
8 We'll take clarifying questions.
9 DR. SAMITT: So when you talk about -- actually,
10 why don't I pass? Then I'll come back.
11 DR. CROSSON: Okay.
12 DR. HOADLEY: So I just wanted to ask you to go
13 back and remind me a little more about what we covered in
14 our site-neutral recommendations in the position. We
15 talked about E&M, and we went further than that on some
16 other areas. And then if there's a way to characterize
17 sort of how much of what we recommended was picked up in
18 congressional action, it seems like it's a pretty small
19 piece by only focusing on the new entity. I wonder if
20 there's a way to characterize sort of how much is done and
21 how much has been done.
22 DR. STENSLAND: So we initially said there should

1 be a site-neutral payment for E&M visits, the idea being
2 that evaluation and management visit in the physician
3 office is going to be pretty much the same as a management
4 and evaluation visit in a physician office that's owned by
5 the hospital. That was the first recommendation.
6 Then later there was a second recommendation to
7 add in some other services, and these were generally
8 services that were not needed on an emergency basis, like
9 maybe you'd do some echocardiography or something like
10 this. But this would be paid the same in both sites. And
11 our general recommendation was service-based, so for all of
12 these services, we're going to pay the same no matter where
13 it is. So level the playing field, let the volume go to
14 whatever happens to be the most efficient site of care, I
15 think is the general idea.
16 The Congress had a different approach, and they
17 were actually broader on the services. So whatever these
18 services are, you're not going to get the full outpatient
19 department rate if you set up a new off-campus hospital
20 outpatient department. So they're saying the on-campus
21 ones, for everything they still get the hospital outpatient
22 department. The existing hospital outpatient departments

1 that are off-campus still get it for everything. But those
2 new ones would face something that would be similar to the
3 physician office. And there was new regulations that came
4 up by CMS this week, so we haven't digested them all, but
5 it's not clear exactly how soon they'll make that
6 transition until you really have site-neutral between the
7 new outpatient departments and the physician offices.
8 DR. HOADLEY: The ones that would be covered on
9 these new off-campus ones would be their full array of
10 services?
11 DR. STENSLAND: Yes.
12 DR. HOADLEY: So that's where it differs also
13 from our recommendation.
14 DR. STENSLAND: Yes, unless there's some
15 exceptions, and maybe if you have an emergency room, you
16 can still get the hospital outpatient departments for a
17 certain number of services.
18 DR. HOADLEY: Okay.
19 DR. STENSLAND: If you set up as a hospital, a
20 mini hospital, you still get the higher.
21 DR. CROSSON: Craig, do you want to come in now?
22 DR. SAMITT: Yeah. Thanks very much.

1 Jeff, my question is on Slide 9. When you talk
2 about MA plan performance, you paint it with a very broad
3 brush, but the topic of this presentation is about the
4 consolidated or integrated plan provider models. Is there
5 a way for us to actually tease apart MA plan performance of
6 the subset of MA plans that actually are consolidated or
7 integrated to see if the way that you are describing the
8 plan performance translates from that broader pool to that
9 narrow pool of plans?
10 DR. STENSLAND: There was a study by Austin Frakt
11 and Roger Feldman, and one other co-author I don't
12 remember, where they looked at all the different MA plans.
13 And they categorized them into two groups, the MA plans
14 that purely contract out with the providers and the MA
15 plans that own the physician practice or own the hospital,
16 and then they looked at what their bids were and what their
17 performance was in the quality metrics. And their general
18 finding was the performance in the quality metrics was a
19 little bit better and the bids were a little bit higher, so
20 there was kind of the hope that these integrated systems
21 would somehow be able to reduce cost. At least in that one
22 study, they didn't find it.

1 DR. CROSSON: And, Jeff, roughly, when was that?
2 DR. STENSLAND: I think this is about 2013 or
3 2014. 2013. It's in the --
4 DR. GINSBURG: Their study wouldn't have looked
5 at contracts with integrated organizations. It was with
6 only if the MA insurer owned the provider.
7 DR. CROSSON: Okay. Thank you for that.
8 David.
9 DR. NERENZ: On the bottom of Slide 2 -- thanks,
10 Jeff -- there's a semantic question. You talked about
11 providers taking an insurance risk, and ACOs, you used as
12 an example. I thought in this discussion, there was a
13 distinction that should be made between insurance risk and
14 efficiency risk. At least others have made this
15 distinction where insurance risk really has to do with a
16 large pool of people and the kind of needs that come up
17 from that pool of people, and that's why insurance
18 companies have financial reserves, and they're regulated.
19 Efficiency risk would start with a finite burden
20 of illness or need in a group, and then the risk is about
21 the cost of meeting that need. And it's just different.
22 So the question is, Is that distinction

1 meaningful for this discussion this morning? I kind of
2 think it is, but maybe it's not. And if it is, are the
3 ACOs really taking on insurance risk, or are they only
4 taking on efficiency risk? And should we use those words
5 that way?
6 DR. STENSLAND: Maybe we should. I don't know
7 how I could operationalize the difference. I think I
8 understand what you're saying in the difference, but when I
9 try to look at the data, if I can try to figure out whether
10 the higher costs or the lower costs are due to inefficiency
11 or due to some random variation in needs of the patient
12 that I would -- you would kind of term as efficient
13 insurance risk, at least on the surface, I can't see how I
14 could use those -- use the data I have and separate it into
15 those two different buckets.
16 DR. NERENZ: Others who have written about this -
17 - I have not myself, so I'm just reflecting things I've
18 read. One of the distinctions, for example, would be the
19 degree of risk adjustment and the frequency of risk
20 adjustment, so that if it's built into the ACO program, for
21 example, presumably variations in the illness burden of the
22 population are already factored out, so that you're not

1 actually at financial risk for that, that, I guess, to me
2 would be the main distinction.
3 Now, in either case, we're only talking about a
4 tiny fraction of risk, no matter what, whatever words we
5 use, but I just was curious about is -- I would have
6 thought, for example, that as an example of this idea,
7 groups taking broader capitation payment, less risk
8 adjusted would be a pure example of the concept. But I
9 just want to make sure I was understanding the words
10 correctly.
11 DR. CROSSON: Paul, are you on this point or just
12 in queue?
13 DR. GINSBURG: On this point.
14 You know, I think I agree with Jeff as far as --
15 I think the concept is very meaningful. I've often used --
16 heard the term "performance risk" versus "insurance risk" -
17 - impossible to separate it quantitatively.
18 But, really, I think what people would like is
19 for providers to be at risk for performance but not for
20 insurance risk. So, in a sense, that's where how much you
21 put into better risk adjustments or probably a lot of other
22 implications of that principle. So I think it's a really

1 important principle to think about.

2 DR. CROSSON: Kathy.

3 MS. BUTO: Jeff, do we have any data on volume

4 changes or, I guess, in particular Medicare volume changes

5 for hospital systems that undergo consolidation, kind of

6 before and after? Do we see a volume effect where the

7 volume goes up?

8 I see on Slide 4 that you talk about losses on

9 Medicare admissions, I guess, in relation to commercial

10 rates and the pressure on price, but I didn't see where we

11 think there's a harmful -- as I'm thinking about what's the

12 harm of consolidation, I think about two things. One would

13 be potentially higher prices, and the other would be

14 potentially some sort of additional admissions or

15 additional costs that aren't justified, so anything we have

16 on that.

17 And then my second question is, on the next

18 slide, vertical integration, whether there are any

19 instances where services provided in a physician's office

20 and an outpatient department, where we think there might be

21 justification for a facility fee, or in every case, is it

22 our assessment that those services can be provided site

1 neutrally and a facility fee is really not justified? I
2 don't know if you've looked at that.
3 DR. STENSLAND: First, on the volume effect, I'm
4 not aware of any data, and I'm not aware of how the
5 incentives would shift materially when they consolidate for
6 the volume. If anything, the incentive for volume of a
7 horizontal integration, it would probably go down to have
8 more cases because you may have less excess capacity.
9 There is some evidence with vertical integration.
10 At least when we did physician ownership of hospitals, we
11 saw volume go up when the physicians own the hospital.
12 With the services, that there might be some
13 justification, and Dan can just jump up and correct me if
14 I'm wrong. But we did say there's certain things that we
15 didn't want to have equal, and there were certain services
16 that were used often for emergency cases. And so we didn't
17 want to have those equal, and some of the idea there was
18 that these hospitals have real emergency standby capacity
19 costs, and so we want to pay for some of those standby
20 emergency capacity costs by having higher fees for those
21 services that might be needed in an emergency. But we
22 wouldn't want to do that, say, for an E&M visit, which we

1 don't see as --
2 MS. BUTO: So have we specified what those are
3 somewhere in our work?
4 DR. STENSLAND: Yes. There's a --
5 DR. ZABINSKI: [Off microphone.] [Inaudible.]
6 Also if the hospital had sicker patients, [inaudible.]
7 MS. BUTO: Right. But that would be a specific
8 hospital as opposed to a policy that says --
9 DR. ZABINSKI: [Off microphone.] Well, as a
10 general rule [inaudible] hospitals on average have a sicker
11 set of patients [inaudible.]
12 DR. STENSLAND: I think he's talking about
13 specific APCs, specific services. If the hospital tends to
14 --
15 MS. BUTO: To see sicker patients in that
16 category.
17 DR. STENSLAND: Yes. So, for this particular
18 service, if the sick ones tend to go to the hospital and
19 the healthy ones tend to go to the physician office, okay.
20 Then maybe there's a differential in payment.
21 MS. BUTO: Okay. Well, it's helpful, I think,
22 for us to be -- if we have any specificity around that, to

1 be clear, because I think the verbiage comes sort of across
2 as if it's provided in the physician office, an OPD, and
3 could be site-neutral, it ought to be, at least the
4 implication.
5 DR. CROSSON: Okay. Rita and then Brian and
6 Warner and Jon and Amy. Go ahead.
7 DR. REDBERG: Thanks for an excellent chapter.
8 I just started thinking a little bit more about
9 facility fees when I was reading this, and sort of
10 following on from what -- can you enlighten me a little
11 more on sort of the history of facility fees and exactly
12 what they are supposed to cover? Because I can't see a
13 difference between a hospital outpatient department doing a
14 lot of these services and a physician office.
15 DR. STENSLAND: So I'll give you my quick review,
16 which probably is not that great, but initially, hospitals
17 were paid on the basis of costs. So you were just --
18 whatever your costs are, we'll pay you that. And then they
19 move the inpatient side to prospective payment, but the
20 outpatient was still on cost. And then they moved the
21 outpatient to prospective payment. So then they looked at,
22 well, what are the relative costs of these services in the

1 hospital, and then they set the relative weights based on
2 the estimate cost of those services.
3 So the estimated cost of the services, it must
4 have been amount that hospitals are spending on these
5 things is estimated to be greater on average than what's
6 estimated in the physician office. And I think because we
7 kind of started in that cost-based mentality, I think we
8 kind of moved to that, the payment rates that kind of
9 stemmed from those estimated costs, and then you could
10 almost see this as moving more in a prospective direction
11 of saying now we'll be moving more in a site-neutral
12 direction, where if something can be provided for less cost
13 in a physician office than it can in the hospital, even if
14 the hospital has more cost, we wouldn't necessarily say we
15 want to pay them more, because we don't want to keep the
16 care in the higher-cost site. I don't know if that helps.
17 DR. MILLER: And, Rita, we've run into these
18 conversations all over the place. You guys will remember
19 when we got into the post-acute care world. SNPS are
20 different than IRFs, which are different than -- and all of
21 these things have their own little histories, and so you
22 end up with this situation where you can have the same

1 patient in both settings and be paying very differently.
2 And this is another version of that.
3 DR. REDBERG: Consistently favoring a site-
4 neutral sort of structure, I think.
5 DR. MILLER: Well, I think in the last few years
6 in the Commission and to your point, Kathy, we went through
7 the criteria repeatedly and laid it out in the chapter and
8 discussed this, and we can make sure that we come back to
9 all that. But in the last few years, this is a problem
10 that the Commission decided to take on.
11 I mean, for 20 years in Medicare, everybody would
12 point to this problem, and you have to be very thoughtful
13 about how you go about it. I mean, Jeff was pointing out
14 there's certain excess capacity you do want to pay for.
15 The exchange, just to get it on the transcript, between
16 Kathy and Dan is that, systematically, I'm taking the more
17 complicated patients; maybe you want to recognize it, that
18 type of thing. But, really, just in the last few years,
19 we've been taking this on, and part of it was stimulated by
20 an uptick in the purchase of the physician practices, and
21 then clearly, there was -- there may have been other
22 motivations, but there was also that revenue motivation

1 there. And that kind of drove the issue. The E&M was the
2 first version, and then we've gone from there over the last
3 few years.
4 DR. CROSSON: Okay. We're still on clarifying
5 questions. Let me check. I have Bill Hall, Brian, Warner,
6 Jon, and Pat. Did I miss someone? Paul.
7 DR. GINSBURG: [Speaking off microphone.]
8 DR. CROSSON: Yeah. I had you earlier, but --
9 DR. GINSBURG: [Speaking off microphone.]
10 DR. CROSSON: Okay. Bill.
11 DR. HALL: I have a question on Slide 9, if you
12 can put that up just for a second. I'm sorry. Twelve.
13 So the first bullet point there kind of stuck
14 with me: Should we pay for results or corporate structure?
15 There are a lot of unintended side effects of any form of
16 consolidation, particularly if we look at what's happening
17 around the country where large efficient systems start to
18 acquire practices in surrounding areas, including rural
19 areas. There's some hospital closures that did inevitably
20 take place, and presumably, on the positive side,
21 specialists might be available to go to these communities
22 to provide services.

1 So I don't know how we work that balance out, but
2 my clarification question is that are there any data
3 anywhere to suggest that the overall health of an older
4 population is either influenced positively or negatively by
5 the degree of consolidation, which is, I guess, the
6 endpoint that we're all seeking?
7 DR. STENSLAND: I think it depends on the type of
8 consolidation. The horizontal hospital consolidation, I
9 think that's really a mixed literature, but a little bit of
10 the literature, if it leans any way, it's kind of leaning
11 toward competition is maybe good for quality. It is better
12 to have three hospitals competing with each other on
13 quality rather than just have one where they don't have to
14 compete, but the evidence there, I think, is very weak in
15 either direction.
16 I think in the vertical integration evidence, at
17 least when you're talking about providers integrating with
18 the insurer, there I think you have some evidence of some
19 possible quality benefits that we've talked about, at least
20 on the process measures, tending to have better performance
21 on process measures for these entities where the insurer
22 and the providers are aligned.

1 DR. HALL: So I think this is an area we might
2 want to take a look at. Particularly, on the one hand,
3 we're constantly talking about improving population health
4 in Medicare, and I don't think we know the answers to these
5 questions right now.
6 DR. CROSSON: Brian.
7 DR. DeBUSK: If I can take us back to Chart 4.
8 Your point here, losses on Medicare admissions creating
9 pressure to increase Medicare rates, as that gap occurs
10 between commercial and Medicare rates, I know we have our
11 annual survey, but presumably, an increasing gap would
12 result in access issues. And I know we have our annual
13 survey, but do we have any longer term market-by-market --
14 is there a systematic way that we could measure when in a
15 given geography that gap becomes problematic and creates
16 access issues, again, particularly long term and
17 particularly in a more focused way?
18 DR. STENSLAND: I think there's a couple things
19 we could look at. The one is we could look at the
20 occupancy in each market, and we tend to do that, to look
21 across the different markets and see is there -- where the
22 occupancy is full and maybe where you have some for-profit

1 hospitals that decide not to take Medicare. That would be
2 your two things going together, kind of a two-part test.
3 Is that happening? And we don't really see that happening
4 because we see generally occupancy around 60 percent in
5 most markets. So, in most markets, if you have excess
6 capacity and your marginal revenue is still bigger than
7 your marginal cost, you want to admit people, and so they
8 seem to be getting admitted. And we don't hear of any
9 problems of any hospitals saying, "No, we're not going to
10 take Medicare."
11 There's a few for-profit hospitals that have
12 decided, "Okay. We're just going to focus on non-Medicare
13 patients," some physician-owned hospitals, but they haven't
14 actually done that well financially.
15 So I think looking out there, when we look at the
16 data, occupancy and the incentives, we don't see any near-
17 term risk, but as you say, as that gap grows bigger and
18 bigger, it could be concerning.
19 DR. DeBUSK: Would we have a way or do we have a
20 process in place to detect that, to measure that, or is
21 that something that we'll just have to periodically check
22 on?

1 DR. STENSLAND: I don't know what we would do
2 other than look at is there this excess capacity and do we
3 hear any reports of hospitals not accepting Medicare
4 patients, and we don't really hear of any of that happening
5 at all, except for a few for-profit hospitals -- and
6 they're never the dominant provider in the market -- so
7 that that would come about.
8 DR. MILLER: The only thing I was going to say,
9 you're answering the question directly. From a process
10 point of view, every time we go through the update process,
11 which I don't think you've been through yet -- it seems
12 like you've been here forever, Brian.
13 [Laughter.]
14 DR. DeBUSK: I'm going to take that as a
15 compliment.
16 DR. MILLER: It is a compliment. It was intended
17 entirely as a compliment.
18 I think you're about to hit your first update
19 process, and we do have a situation when we look at
20 finances, we look at access. To the extent that we can, we
21 look at quality. We can look at that, and I think some of
22 the metrics that Jeff was saying there are the kinds of

1 things that you'll find in that analysis.

2 DR. DeBUSK: I've read that report before, and I
3 see the data presented in an aggregate level. I'm
4 interested, say, at the MSA level, particularly among
5 physicians. When you find a group of physicians that, say,
6 has checked out of the Medicare program, I worry about is
7 there a way -- I don't think we're going to be able to
8 bring them back in with the same amount of money. I think
9 there's some hysteresis there, and I would hate to see that
10 gap create that effect.

11 DR. MILLER: Now, I think that's a somewhat
12 different point, because the conversation you two were
13 having back and forth was very hospital-related. So, on
14 the physician side, we can obviously look at utilization
15 data and kind of break that down geographically, and then
16 we have a survey, a phone survey. But that doesn't break
17 down well by geography because it's very expensive, and
18 it's a phone survey type of thing.

19 And so we have other ways we look at hospitals --
20 or physicians who are deciding not to take up Medicare or
21 getting out of the program. There's a couple of different
22 metrics that we try and look at. When we come up to that

1 next month, if you think there's some other places we
2 should be looking, that would be a good time.
3 DR. CROSSON: Yeah, I mean, it's an interesting
4 point, because I remember a few years ago when we were
5 doing the update process and we went through the physician
6 payment recommendation, we had sort of the same discussion.
7 And I remember Glenn sitting here saying, well, okay, so
8 there's not an access problem, but I live in south-central
9 Oregon, and there are no primary care physicians accepting
10 new patients. So that's just one example.
11 So I think there are -- most likely there are
12 pockets around the United States where this comes into
13 play.
14 DR. MILLER: And I don't want to overstate this
15 too much. This is somewhat dates. There was a period when
16 there were a lot of arguments being made that, you know,
17 physicians were exiting the program in a big way, and it
18 was Medicare rates that were driving it. And there was an
19 attempt both by CMS and our efforts to look at markets that
20 were indicated at hot spots for this kind of problem. And
21 most of the analysis that came out -- all of the analysis
22 that came out of it said it was more an issue of access for

1 anybody to get to a physician. So it would be a community
2 that had a rapid increase in population, and the notion was
3 that it wasn't so much that a Medicare person couldn't get
4 a physician, it was anybody.
5 And then also you've seen some phenomena -- and
6 Jack may remember this. There was the discussion about
7 concierge types of activities, and, again, there, to the
8 extent that they do it, they often say I'm not taking
9 anybody's insurance, whether it's Medicare or otherwise.
10 And so the other little fault line I want to put
11 into your thinking is that if there's an access issue, is
12 it an access issue related to Medicare or is it an access
13 issue related more broadly to some other demographic
14 phenomenon? And, again, we'll get into all that next
15 month.
16 MR. THOMAS: So, Jeff, it seems like you're
17 talking a lot about consolidation. Did you look at or can
18 we look at actual integration and clinical integration of
19 services? I mean, you think about models like, you know,
20 Kaiser, and there was a reference to Mayo Clinic in the
21 ratings. But have you looked at -- especially as we look
22 at the bundled payments or as we look at ACOs, that to me

1 there's a difference between consolidation and integration
2 of, you know, clinical services and clinical care. Any
3 thoughts about that as it relates to your thinking on
4 consolidation and the differences between those?
5 DR. STENSLAND: My thought is from a researcher
6 perspective or from a CMS perspective, it's very difficult
7 to distinguish from a truly integrated entity where people
8 are really talking to each other and cooperating and
9 improving care and an entity that just looks on the
10 surface, like they taught to the test to make it look like
11 they're doing this, but they really aren't doing it
12 underneath. And I think that is -- that difficulty of
13 distinguishing between truly good integrated entities that
14 are coordinating care and reducing costs and improving
15 quality and integrated entities that say they're doing that
16 but really aren't, it seems almost -- from at least my
17 perspective of trying to dig through the data, almost
18 impossible to distinguish between those two. And that gets
19 to the idea of, well, then let's just level the playing
20 field and say we're going to pay equal amounts across all
21 these different sites or different models. And then if one
22 model actually is more efficient and provides better care,

1 it will gain market share because its costs are lower, its
2 output is better, the patients will come to it. And so, in
3 a way, it's, I think -- from a researcher standpoint or a
4 CMS standpoint of saying what are the good integrated
5 entities versus the bad integrated entities is probably an
6 impossible question to answer. But I think the good news,
7 it's a question we don't have to answer because we can let
8 the market sort it out.
9 MR. THOMAS: Did you see any types of
10 characteristics like common electronic medical records for
11 the entire continuum or things like that that would lead
12 you to think differently about the types of integration or
13 not that occur in these types of systems?
14
15 DR. STENSLAND: No, I think on the surface it
16 always sounds really good to have everybody integrated on a
17 common electronic medical record, and I think I would like
18 that. And you certainly see high quality scores, like you
19 said, from the Mayo Clinic, fully integrated for, you know,
20 a long time, a hundred-plus years as an integrated group
21 practice, and you see great quality scores there.
22 But some of the literature, when they look at it

1 to say, oh, do these large integrated multi-specialty group
2 practices really have better outcomes than more of the
3 smaller practices? And, you know, when I first started
4 this, I thought, okay, this is what I'm going to find. But
5 then you look at the literature, and it's really not so
6 clear, and some of the researchers, like Larry Casalino,
7 even arguing some of the small practices are doing better
8 than some of the big practices.
9 So the research probably did not come out as I
10 expected it would, and it didn't come out as clear as I had
11 hoped.
12 DR. CHRISTIANSON: I just had a quick question, I
13 think, for you, Jeff, on Slide 11, page 20 in the report.
14 So these are the possible policy responses, and the last
15 one seems to be a little murkier. It kind of falls under
16 the category of other considerations, and the policy
17 response seems to be we should encourage ACOs even more
18 than we have in the past, because they're going to make
19 physicians more price conscious.
20 And then I'm looking back in the paper, and
21 there's a two-step process here, that ACOs are going to
22 seek out and contract with more efficient lower-cost

1 providers. And then the second part of that is that
2 providers are going to start competing with each other on
3 price in order to be selected by the ACOs to contract with.
4 So the evidence that's provided here is
5 basically, in the paper, the first step of that process for
6 commercial ACOs. And for that one ACO in Boston, the
7 researchers have evaluated a lot, and they find some
8 evidence that that commercial ACO in that location has
9 sought out lower-cost physicians -- not necessarily the
10 second step, which is what we really sort of care about in
11 terms of making physicians more price conscious. So
12 that's, I guess, to be determined.
13 But has anybody in their evaluations of ACOs
14 looked at these issues? Do we have any specific Medicare
15 ACO data on whether this is happening? Because, obviously,
16 this ACO that's being evaluated in Boston has a
17 particularly kind of unique structure in a lot of ways
18 relative to the way Medicare ACOs are structured. So how
19 much evidence is really there on this topic that's really
20 relevant to sort of this policy discussion point?
21 DR. STENSLAND: I think on the price side, really
22 I think all we have in the commercial world that I'm aware

1 of is the Boston example of, yes, things are gravitating
2 toward lower price. And it's a unique market because
3 there's so many ACOs.
4 DR. CHRISTIANSON: But not necessarily that we've
5 seen physician responses in that market to compete on price
6 and drive price down.
7 DR. STENSLAND: That's only anecdotal, like
8 people saying, oh, now the doctors don't necessarily want
9 to be so high because then they won't get the volume.
10 DR. CHRISTIANSON: That's Rob Mechanic's work.
11 DR. STENSLAND: I don't remember. You probably
12 know it better than I do. But, yes, his study. I think on
13 the Medicare side it's much more limited because then the
14 price savings is not by going to a lower-price provider but
15 going to a lower-cost site. And I think we do see some
16 movement there, at least people trying to do things like if
17 the post-acute care is more expensive in a SNF than in home
18 health, we're going to try to reduce our SNF days and maybe
19 use home health rather than SNF. Maybe some shifting from
20 some of the higher-cost sites of post-acute care to lower-
21 cost sites of post-acute care.
22 DR. CHRISTIANSON: This is a discussion of making

1 physicians more price conscious.

2 DR. STENSLAND: Yes, and I think you can get the

3 physicians to be more price conscious in the sense of I'm

4 price conscious about how these different sites of care

5 cost a different amount. And we're certainly seeing that

6 by talking -- at least talking to some physicians saying,

7 okay, now I'm in this ACO, I'm really quite conscious about

8 how much it costs to send my person to an LTCH versus to a

9 SNF.

10 DR. CHRISTIANSON: Which is a little different

11 because in this discussion it's more about physicians being

12 more price conscious relative to their own services that

13 they're providing. It just seems like there's not a lot of

14 firm evidence related to the Medicare program that -- I'm

15 not saying that the story is wrong. It's just that the

16 evidential base is not very strong to support it, maybe not

17 as strong as some of the other policy considerations you're

18 asking us to talk about. Do you think that's accurate or -

19 - because you don't mention anything about Medicare ACOs in

20 this context.

21 DR. STENSLAND: I think I probably didn't write

22 it up as well as I should have, because when I was thinking

1 of being price conscious, I'm thinking of their price
2 conscious of the services that they're recommending,
3 whether they're referring somebody to this service or that
4 service and being price conscious about how much those
5 services cost as opposed to being price conscious about my
6 own prices and how those --
7 DR. CHRISTIANSON: Yeah, those examples are not
8 in the write-up at all, the ones you just provided.
9 MS. WANG: Just a quick question. I think
10 there's a theme, I think, from what I've heard a little
11 bit. Let me ask it a different way, you know, with the
12 caveat that Medicare ACOs are still a work in progress, you
13 know, there's a lot of different reasons for providers to
14 consolidate. And I think what we're discussing is kind of
15 parse what those are and whether [microphone static]. Has
16 anybody looked at it and does it make any sense to look at
17 whether there is any correlation between some of the types
18 of consolidation that you studied and an intent or
19 participation in Medicare ACOs? And is there anything
20 about the nature of the consolidation that, you know, could
21 be informative? I mean, you know, is using participation
22 in an ACO or stating a Medicare ACO indicative that

1 consolidating providers have an intent at least to move
2 into the direction of coordinating care and so on and so
3 forth, versus, you know, consolidation for other reasons?
4 I mean, does it even make sense to look at it?
5 DR. STENSLAND: I am not aware of anything that's
6 been published. There has been at least one paper
7 presented at meetings, you know, where they're kind of in
8 the process of looking at is there more consolidation in
9 markets with -- is there a correlation between the ACO
10 penetration in a market and the amount of consolidation in
11 the market? And I think they generally aren't finding
12 that. The general idea is there's already, prior to ACOs,
13 some reasons to integrate and consolidate, and the marginal
14 effect of the ACO might not be that great. But that has
15 not been published, and I'm just saying that's a little bit
16 of preliminary data.
17 DR. GINSBURG: As I have been mulling in my mind,
18 my clarifying question has grown bigger, so I'll get him
19 the next round.
20 [Laughter.]
21 DR. CROSSON: Okay. We'll call that a
22 "conditional mulligan" because you might find your first

1 shot turned out to be better than your second one.

2 Okay. So we are a little bit tight here. We've

3 got about 20-plus minutes to go, and I want to have a good

4 discussion here. But I'm going to ask for conciseness and

5 -- although I think there are a lot of good points to make,

6 if we can focus on emphasis here, "As a consequence of

7 these findings, we should emphasize with respect to

8 Medicare policy or payment the following," if you can do

9 that. And we're going to start with Warner.

10 MR. THOMAS: So a couple of broader comments

11 before I jump into that. I think one of the things that I

12 would like to see us consider as we put together the

13 chapter is to take a little bit of a step back and think

14 about the context of what is driving provider consolidation

15 and to think about consolidation in the industry in a

16 broader context than just in providers.

17 So, for example, you know, what are the inputs

18 that go into the cost structure of providers that are

19 creating pressure for them, such as drug or device pricing?

20 And what type of consolidation is happening in those types

21 of pieces of the industry and/or the areas such as in the

22 GPO and how that drives some of the pricing pressure? That

1 coupled with the fact that we see, you know, pricing
2 pressures in, you know, Medicare pricing, the reductions in
3 the MA premiums, which then pushes pricing down.
4 So I think all of those factors to me are
5 critical as we think about what is driving this versus just
6 that provider consolidation is happening. I think that we
7 need to understand what the drivers are.
8 Similarly with physicians. I mean, it's not a
9 situation where physicians necessarily want to join
10 hospitals or necessarily want to come together. They're
11 doing it out of the -- because of an industry challenge and
12 because, you know, essentially through Medicare payment
13 policy, ACO development, risk contracts under Medicare
14 Advantage, that's driving more of this integration and
15 consolidation. So I would like to see us think about, as
16 we frame the chapter, that we frame it in the context of
17 what's happening in the industry.
18 A couple other components, and then I'll get to
19 the Medicare payment policy. So I do think that trying to
20 make a bigger distinguish -- or trying to distinguish more
21 between integration and clinical integration versus just
22 consolidation would be important. You know, I think about

1 the work that folks have done in the industry and that I've
2 seen in my experience. We are seeing quality outcomes get
3 better as we move to a common electronic medical record
4 across our entire system or across a large population of
5 physicians. You see reduction in duplication of diagnostic
6 testing because the availability of the information is
7 there for physicians, so they don't repeat a CT study, they
8 don't repeat an MRI or lab testing. So I think those types
9 of components are very important for us to think about, as
10 well as I think when you see a small organization join a
11 large organization, you do see expansion of services in
12 local markets as those larger organizations help them.
13 As it comes to payment policy, I would ask us to
14 think about how we can continue to accelerate changing the
15 incentives and getting away from the fee-for-service model
16 into more of the ACO model and make those policies more
17 robust. Obviously, there's new guidance and rules under
18 MACRA, but I come back to that the ACO regulations are so
19 burdensome that it is very difficult for smaller or mid-
20 sized organizations to get into those type of payment
21 models. I think if we really want to see a change in
22 payment models and the way that the payment system is

1 approached, we have to change the incentive from a fee-for-
2 service to more of a global pay model. I think we've heard
3 Craig say this a couple of times.
4 But, you know, certainly it is -- to me,
5 ultimately that's where you're going to see more clinical
6 integration. That's where you're going to see more team
7 orientation creating a better outcome for patients and a
8 reduction in utilization and cost. But to me, until we
9 make those global payment models and those incentives
10 around the ACOs more robust and more attractive, we're just
11 going to be working on the fringes. And I think if we were
12 really going to put a lot of time and energy into this, I
13 would really encourage us to continue to refine and make
14 recommendations in the ACO world and make them more
15 attractive for a broader swatch of physicians and
16 hospitals, and to really incent more larger systems that
17 are consolidated to go into more of the risk payments and
18 the downside models of the ACOs.
19 DR. CROSSON: I think that's very well said. So
20 can I see hands for comments? Okay. We've got a
21 significant number, so we're going to start with Jon and go
22 this way, and conciseness is next to holiness.

1 [Laughter.]

2 DR. CHRISTIANSON: Which I've never been accused

3 of being --

4 DR. CROSSON: Which of those.

5 DR. CHRISTIANSON: Yeah, which of those. Yeah,

6 either one.

7 So, under 11, I think we do continue with our

8 response that we should not follow commercial prices.

9 There's just a whole lot of evidence supporting that as a

10 Commission.

11 I think I firmly support the site-neutral

12 pricing, and as a vertical integration response, I think

13 the premium support with a level playing field as the

14 provider insurance integration response, it's less clear to

15 me that we're ready -- should be ready to do that. There's

16 a whole lot of things that go along with premium support,

17 and I'm not sure we go down that road specifically as a

18 response to provider insurance integration.

19 Then I'm still a little confused about what

20 exactly the policy response is on the fourth bullet point,

21 which is, I guess, be more in favor of ACOs because of this

22 possible effect on making physicians more price conscious.

1 And then just as a way of finishing my thoughts,
2 I think one of the things that we have to think about at
3 some point is -- and it's hard in Medicare primary -- is
4 our responses may have to -- what we would want to do might
5 vary depending on the overall nature of market
6 consolidation and not just the consolidation in each
7 sector.
8 DR. CROSSON: Okay. David and then moving down.
9 DR. NERENZ: Yeah. This is on the second bullet
10 point on Slide 12. I would say yes, with a couple caveats.
11 I think there is, I'll say, a bare possibility
12 and no more than that, that we could get into some penny-
13 wise, pound-foolish sort of problems if there actually are
14 some offsetting efficiencies in truly clinically integrated
15 systems. I know the evidence for that is very meager at
16 the moment, but it's at least plausible.
17 So we could conceivably think about some
18 exceptions to site-neutral rules in situations, for
19 example, where an organization could prove to CMS's
20 satisfaction that the episode-level costs or per-capita
21 costs were actually not higher. But even better yet, I
22 think, would be to move to a two-part choice situation, and

1 this, say, could be offered to hospitals, since it's
2 hospitals who mainly are in the up-down side of this HOPD
3 site-neutral issue.
4 So here's the deal. Either you get fee-for-
5 service payment, but it's got a site-neutral component, so
6 you're going to get fee schedule payment for the outside
7 clinic -- that's a deal you can take -- or you can take
8 true prospective bundled payment, fixed price for an
9 episode, and you can take that. And if you think you have
10 offsetting efficiencies that you can step up to because
11 you're clinically integrated, maybe you want to take that
12 deal.
13 So I think as a broad policy direction, I would
14 feel that that might not be a bad set of options. Either
15 way, it kind of calls the question: Are there offsetting
16 efficiencies, or are there not?
17 DR. MILLER: Can I just say one thing? In
18 setting the bundle, what price you use to set that bundle
19 would be crucial because, if you just have the site-neutral
20 and a payment in there and then you build it into the
21 bundle, then you haven't necessarily captured the
22 efficiency.

1 DR. NERENZ: Yeah. I think in situations where
2 there are a couple options that are really very rare now, I
3 think CMS could be more aggressive in setting the bundled
4 price because if it's set too low for an organization, the
5 organization can make the other choice. So you wouldn't
6 have to necessarily bake in the higher price into the
7 bundle. You could take it down, and that essentially is
8 how you call the question. You say, "You guys think you
9 have offsetting efficiencies? Fine. You should be willing
10 to take this price, because we've taken the higher
11 component out of it," and let's step up and prove it, then.
12 DR. CROSSON: Alice.
13 DR. COOMBS: Thank you. I'll try to be brief.
14 First of all, bullet No. 1, I basically don't
15 think we should follow commercial prices.
16 For the vertical, for No. 2, the site-neutral
17 pricing. I just want to call us back into remembrance of
18 what we did with the ambulatory surgical centers. What we
19 pointed out there was that hospitals did take on sicker
20 patients, patients that ambulatory centers were not willing
21 to take on, and so there were some -- not just typical
22 standby capacity issues. There was improved access to

1 other supporting services that were really important for
2 what we thought was important. This is very different in
3 that it's physician offices moving directly on campus in
4 that sense, but it might be that in some areas that those
5 physician practices gain access from improved quality by
6 them being on the very campus. I'm not sure that that's
7 the case. I'm not sure we've actually looked at the
8 quality outcomes of what happened when you have vertical
9 integration that allows there to be the direct clinical
10 coordination and ties to an elite situation doesn't result
11 in what kind of outcomes for the panel of patients.
12 I do want to say that we're talking about ACOs as
13 though doctors are just in the ACO or just in a PHO, but in
14 certain parts of the country, there's a physician health
15 organization, whereby physicians who are also in an ACO may
16 be participants in both. And so you might have a small
17 collection of 12 doctors who are formulating an ACO, but
18 they also may be very engaged at a PHO at the local
19 hospital that they admit to. So they're not separate, and
20 so when we think about the fourth bullet about how you make
21 people more price conscious, it might be that physicians,
22 per se, are in an ACO and have a relationship directly with

1 a PHO, physician hospital organization.

2 The thing that I was thinking about after reading

3 this chapter -- and thank you, Jeff; I think you did a

4 phenomenal job dealing with some very hard areas -- was

5 that is it possible that we can look at, the Secretary --

6 have the Secretary look at some of the things, culture of

7 excellence with an ACO provider in terms of physician

8 engagement, provider-driven initiatives, look at what is a

9 successful -- what looks like success, and also to look at

10 what looks like poor performance, because I think so many

11 times, we're geared up at MedPAC to take the top five and

12 say this is the poster child for good works.

13 But I think at some point, we have to begin to

14 say let's look at the low performers -- or maybe the

15 Secretary can look at the low performers and say what's a

16 best practice to move these people into a better

17 performance, and I don't think we -- we talked along the

18 lines of looking at the low performance and health care

19 delivery systems, because if we do this, we actually

20 improve the transparency regarding cost and quality,

21 earlier intervention. We can focus on the mid-tier and

22 lower-tier performers. We can move patients into

1 environments from some optimal care to optimal care, and we
2 can improve cost and efficiency of the general population.
3 And there's some robust health care delivery system, like a
4 few that I don't need to name, but they've actually done
5 that. They've actually looked at the sites where they had
6 poor performance and said, "How can we move this situation
7 to a better" -- and they're very robust health care
8 delivery systems. Some are in the Southwest Corridor, and
9 they've actually looked at how the low performers can move
10 to a better situation. Then is when we really make a
11 difference with the sea of patients that we have.
12 In terms of -- one other factor is the
13 beneficiary cost sharing when you have the facility charge,
14 and I really have a problem with that part of the facility
15 charge, that the beneficiary having to pay that excess, so
16 if we could actually develop some policy around the
17 beneficiary cost-sharing piece of the facility charge.
18 DR. CROSSON: Okay. Moving down, Paul and then
19 Kathy.
20 DR. GINSBURG: Yeah. I do hope the Commission
21 will focus more on the site-neutral payment issue. I think
22 the Medicare current policies have been a major contributor

1 to the degree to which hospitals are employing physicians,
2 and I think it's a trend that really concerns me.
3 What I often here is that physician productivity
4 falls when they become employed by the hospital, and that
5 when you talk to hospitals about their motivations for
6 employing physicians, a lot of times, it's really about
7 capturing referrals. It's not about providing higher
8 quality care or lower cost.
9 I think Jeff mentioned early on in his
10 presentation echocardiology as one of the examples of a
11 site-neutral issue, and it's a fascinating story how all of
12 a sudden in 2010, cardiologists wanted to be employed by
13 hospitals. Hospitals were pleased to have them. What
14 happened in 2010? It was an update of the Medicare
15 Physician Fee Schedule based on a new survey, which lowered
16 substantially the payment to cardiologists not employed by
17 hospitals, doing it in their own facilities.
18 So, in a sense, which I want to point out, from
19 payment rates based on different data sets, different
20 approaches, I don't know which one is more accurate, but it
21 really says it's not just a matter of a facility charge as
22 something to defray the hospital overhead. There really

1 are a lot of these -- probably a lot of other areas where
2 the cost difference, the payment differences are
3 substantial and are inadvertently motivating how the old
4 delivery system is organized.
5 So I think it's a broad thing. I don't think
6 what Congress did late last year was really that much
7 compared to what the Commission had worked out before in
8 its policy recommendations, and I'd like to see us get back
9 to that.
10 DR. CROSSON: Thank you.
11 Kathy.
12 MS. BUTO: So I want to agree with Warner's
13 opening comments that it would be good for the chapter to
14 cover more about the drivers of consolidation.
15 I would add to the list the complexity of the
16 reporting system, the reward system, and the data system.
17 So, I mean, we can talk about reimbursement, but I think
18 there's a great deal of additional complexity that's
19 driving the desire by physician practices to belong to
20 larger organizations that can take on some of that
21 responsibility. And that's something in our wheelhouse in
22 the sense that every time we talk about a payment system

1 change and we add some additional reward system or new
2 collection of data, whatever it is, we're adding to that
3 fuel, and I think, again, it's just a matter of our being
4 aware when we talk of some of the implications, unintended
5 implications of what we're talking about.
6 I'd like to see the chapter broadened to our
7 recommendations, and I agree with them for the most part,
8 although I agree with some of the comments on site neutral,
9 one, that we could do more on the one hand, but, two, we
10 should be careful that we're not in an unintended way
11 harming access to emergency or other associated services in
12 such a way that it's detrimental to access. So proceed
13 carefully but thoughtfully in that area. I think it makes
14 a lot of sense.
15 But our recommendations are mostly aimed at
16 mitigating what I guess I'd call bad consolidation or bad
17 integration, and I'd like to see the chapter at least touch
18 on or open up the question of promoting good consolidation.
19 What is it we think is desirable? We've said it in other
20 ways, ACOs, potentially alternative payment models.
21 Bundling, I agree with Dave. There's some opportunities
22 there for efficiencies, better management. What are some

1 of the good consolidation that we'd like to see promoted,
2 made easier, not more difficult, not cumbersome, but
3 actually something that can be done, and try to touch on
4 that as well? And just be aware again that our
5 recommendations have at every turn some implication for
6 either driving more consolidation or promoting a greater
7 fragmentation. So just that awareness, I think, would be
8 helpful.
9 DR. CROSSON: Jack.
10 DR. HOADLEY: So I thank you really for this
11 analysis. It really leaves me pretty convinced that
12 consolidation -- we have to think of consolidation as a
13 fact of life at this point in the health system, whether
14 we're talking at the specific provider areas you talked
15 about or some of the other aspects of the broader market
16 level. And I think our goal is to try to address the
17 downstream effects of that.
18 And it is discouraging, I think, that as your
19 literature review shows that market forces are not creating
20 some of the kinds of good results that we might have
21 expected or hoped for.
22 On the specific sort of items here, I think I

1 totally agree with we don't want to follow commercial
2 prices, and as we go into our update discussions next
3 month, I think that's just something that will be important
4 to keep in mind as we think about the Medicare update.
5 I very much want to see us continue to address
6 the site-neutral. We've done it well, I think. In the
7 earlier discussion, it referenced what we've done in trying
8 to identify services where there should not be a negative
9 consequence has been well framed, and I don't know whether
10 in terms of this year's report whether there's a value in
11 kind of just -- as we often do, just referencing our old
12 recommendations, reprinting them, or whether there's
13 actually a case to be made for restating them more
14 affirmatively, reframing them, maybe somehow in the light
15 of what Congress did, which clearly is pretty limited, but
16 something that will call attention, because I think that's
17 -- I think dealing with this issue of site-neutral pricing
18 is pretty important.
19 I'll stop at those.
20 DR. CROSSON: Thank you, Jack.
21 Rita.
22 DR. REDBERG: I'll be brief because I think my

1 colleagues have made a lot of good points already.

2 I think, for example, Paul's point and also in

3 the mailing materials, the example of Idaho, I think the

4 reasons for consolidation were not always to improve

5 quality and lower cost. And for that reason, on Slide 10,

6 I think we should be thinking more about paying for

7 outcomes and not so much for structures.

8 So, in terms of our policy responses, I also

9 agree we should not be following commercial prices. I do

10 support site-neutral pricing. As Jon said, I'm not clear

11 on how the premium support plays out.

12 And when we talk about ACOs, I think two-sided

13 risk ACOs, as we have stated before, offer the best

14 possibilities for being consistent with our other goals of

15 paying for outcomes.

16 DR. CROSSON: Thank you, Rita.

17 All right. We'll start down this end here.

18 Brian.

19 DR. DeBUSK: I, too, feel that you shouldn't

20 chase the commercial rates. I think there are a number of

21 issues there, should we choose to go down that route. It

22 does concern me that I think, ultimately, that commercial

1 rate escalation does become a problem, and I'd like to see
2 a systematic way to find those issues when they occur
3 market by market. But I do think their problems become our
4 problems.
5 What I'd also like to do is hope that we can
6 separate the concept of financial integration and clinical
7 integration, and maybe this is just wishful thinking, but
8 not necessarily give financial integration a free pass to
9 collectively bargain and negotiation for payer rates. And
10 I think we can separate those two concepts in how
11 organizations engage payers.
12 And then, finally, I'd like to ask that we really
13 double down on our site-neutral payment policy. I think
14 providing ongoing estimates of what it costs to not
15 implement site-neutral payments would be very powerful
16 because I think that attaches a number to a problem.
17 And I'm concerned about it because it creates a
18 payment issue, but I'm also concerned at how it misdirects
19 the flow of capital. And even if we fix the immediate
20 payment issue, this will misdirect flows of capital that
21 can last for, in some cases, decades. So I think the
22 sooner we engage and the sooner we address this, I think

1 the shorter the time that we'll have to live with this mis-
2 deployment of capital.
3 DR. CROSSON: Craig.
4 DR. SAMITT: So I would echo several of my
5 colleagues' endorsement of each of these responses.
6 Certainly, we should not be following commercial prices.
7 It was very disconcerting for me to read the
8 report about a site-neutral pricing and how the watered-
9 down adoption of our prior recommendations really has
10 created a gaming phenomenon. That the most concerning part
11 is that we may be incenting the construction of new
12 hospital capacity or facilities when we feel that actually
13 we should be moving in the exact opposite direction. So we
14 certainly should at least resubmit our prior
15 recommendations and find a way to double down on it.
16 In terms of the provider insurance integration,
17 as you know, this is the world that I've predominantly
18 lived in, and I still believe that we're going to see
19 further development and improvement and results that come
20 from this form of integration. To touch on Kathy's
21 comments about sort of good integration versus bad
22 integration or good consolidation versus bad consolidation,

1 it feels that we need to go deeper to understand what good
2 consolidation or healthy consolidation looks like, and so I
3 would argue that we should redo that analysis that compares
4 MA performance.
5 And I would say that I'd like to see it in three
6 categories. One are MA plans that pay provider's fee-for-
7 service. The second would be MA plans that pay risk-based
8 or global payment to providers, and the third would be
9 integrated, truly integrated plan provider. And I'd be
10 interested in knowing for those three different categories,
11 how does the quality differ, how do the bids differ, which
12 you describe, but even more importantly, how does the
13 encounter data suggest that practice patterns may be
14 different between those three dimensions? And my hope is
15 that what we would see is some of the more consolidated or
16 integrated solutions would truly show a quality improvement
17 in cost reduction.
18 And then, finally, it hasn't been touched on yet
19 is I think one of the unhealthy forms of consolidation has
20 been primary care practice acquisition, and it goes back to
21 our prior discussions about reinforcing primary care. If
22 primary care sort of feels unsafe, financially unstable,

1 then primary care will be one of the first groups that
2 actually gets absorbed in this consolidation frenzy, when I
3 think finding a way to assure primary care independence
4 will be very important as we want to shift to population
5 health.
6 So it comes back to our prior recommendations,
7 which we may need to reiterate yet again, about finding a
8 way to allow primary care to not have to be beholden by
9 larger systems in the future.
10 DR. CROSSON: Sue.
11 MS. THOMPSON: I'll be brief. I know we're
12 running over time. Jeff, thank you for the chapter.
13 I want to just underscore the comments made by
14 Warner, agreeing entirely with taking a look at a broader
15 geography around other types of consolidation, additionally
16 around site-neutral payments for reasons already well
17 stated.
18 I also want to just comment on transparency, and
19 obviously it's moving hospitals and other providers to move
20 toward a common denominator. I'm wondering in terms of
21 keeping the focus on that what additional impact a focus on
22 transparency will make, so just want to call out

1 transparency.

2 Also, in terms of other types of consolidation, I
3 think it would be very, very interesting to take a look at
4 markets especially where the commercial payers have tightly
5 consolidated the impact that's having on providers' ability
6 to negotiate and continue to see the kinds of increases
7 that were reflected in your paper.

8 And last, but not least, in the world of ACOs, it
9 just seems like we could spend a lot of energy trying to
10 understand and support those systems that have integrated
11 vertically for purposes of clinical integration and
12 improving quality and reducing costs and continuing to
13 support the ongoing new policies that we see coming
14 forward, for example, bundled payments, certainly a form of
15 consolidation, but in the context of the Next-Gen contract,
16 the conflicts that are emerging there with new payment
17 systems.

18 So those would be my comments.

19 MR. PYENSON: Yeah, thank you very much, Jeff,
20 for a terrific report. I would echo most of the comments
21 of my fellow Commissioners. There's one point that I'd
22 like to have considered, which is the emergence of --

1 potential emergence of new systems of care such as
2 telehealth which are not geographically constrained, and
3 the potential for those to contract in different ways with
4 physicians or other organizations that are not beholden to
5 a local market power; and that as we think about the
6 unintended consequences of our recommendations, that we
7 think about that emerging possibility.
8 DR. HALL: I am very much in concurrence with
9 what's been said here, and I just want to make one
10 additional point, if I may, very briefly, that we haven't
11 talked about, and that is that we're kind of in a crisis in
12 terms of providers of health care, I think, that's very
13 ubiquitous, and that is that most providers think that they
14 have no control over the system that's taking place and
15 there's a lot of bewilderment about it.
16 One of my observations after 30 or 40 years in
17 this business is that we are not able to really feel that
18 we are as close to our patients as we once thought we were.
19 At the same time, as has been mentioned, there are other
20 ways of communicating with patients.
21 I think that the only way we can take advantage
22 of all of the advances that have come along in medicine,

1 relieve some of the angst that physicians have, is to have
2 a more integrated system, period. It's the only way we can
3 go, and so I hope that we will track, as we go through
4 this, very carefully a variety of quality indicators, not
5 necessarily physician satisfaction but things that
6 represent more the population health of a community. And I
7 don't think there's any other way of achieving this.
8 An expression that has come into medicine now is
9 that, as providers, we are strangers taking care of
10 strangers, and it's getting worse and worse and worse. And
11 I don't think, unfortunately, that the fee-for-service
12 system can be fixed in a way to improve that.
13 DR. CROSSON: Thank you, Bill. I'd just like to
14 make one point with respect to the last bullet point, and
15 it is duplication, because I think Warner brought this up
16 in the beginning. I heard it from Craig, I heard it from
17 Sue, I just heard it from Bill. And this is personal
18 perspective. To me, an ACO is a delivery system structure,
19 and there's nothing about that structure, honestly, that by
20 itself is going to produce the changes that we're looking
21 for. It's that structure or the best of those structures
22 combined with the appropriate payment that is the secret

1 sauce, if you will. And I think one of the problems we
2 face is that the construction of various ACO-like
3 structures and forms of integration and perhaps even
4 consolidation have raced far ahead of reform of payment.
5 And, you know, my own thought is, you know,
6 whatever we can do, if we believe in this delivery system
7 and payment reform approach to solving our problems, is to
8 accelerate -- in our recommendations at any rate, try to
9 accelerate payment reform. Then I think maybe we'll see
10 some of the changes that we've all hoped for.
11 Thank you very much, Jeff, for excellent work,
12 and we'll move on to the next presentation.
13 [Pause.]
14 DR. CROSSON: Okay. Now we are going to turn to
15 the topic of stand-alone emergency departments, and Zach
16 and Sydney are going to take us through this deliberation.
17 MR. GAUMER: Okay. Thank you. Good morning.
18 Today we return to the topic of stand-alone
19 emergency departments, a topic we talked about last at our
20 September 2015 meeting. Stand-alone EDs are facilities
21 located off of hospital campuses and may or may not be
22 affiliated with a hospital. Before we dive in, I'd like to

1 first thank Jeff Stensland for his work. He's been helping
2 us out all the way along here.
3 We first looked at stand-alone EDs about a year
4 ago, and at that time, we were evaluating whether stand-
5 alone EDs could be a possible solution for isolated rural
6 areas with concerns about access to care. In our June 2016
7 report to Congress, the Commission suggested, yes, stand-
8 alone EDs might be a solution for these rural areas.
9 The context for today's discussion is a little
10 different. Today we're focused on the urban and suburban
11 versions of these facilities or those in areas that largely
12 do not have access to care concerns.
13 There are a few specific items driving us to
14 revisit stand-alone EDs. In the last year, the number of
15 these facilities has continued to increase. In fact, their
16 growth has been significant enough that the industry has
17 organized a national association. We also have seen a few
18 new academic studies on the subject. In addition,
19 contained within the site-neutral law is a provision that
20 exempts off-campus stand-alone EDs, and we've been talking
21 a little bit about that already today.
22 There are two types of stand-alone EDs, just to

1 remind you. The first is off-campus emergency departments,
2 and I'll just refer to these as "off-campus EDs." These
3 facilities are owned and operated by hospitals, and in the
4 fall of 2016 we counted approximately 363 off-campus EDs.
5 These facilities offer a limited set of services amounting
6 to ED, imaging, and lab services. They do not provide
7 trauma care, largely, and they do not have operating rooms,
8 so high-acuity cases get transferred to the affiliated
9 hospital. They also tend to be located 5 to 10 miles from
10 their affiliated hospital, in suburban areas. Off-campus
11 EDs tend to not have many patients arrive by ambulance.
12 However, they range in size, and some of the larger
13 facilities do take some ambulance patients.
14 The important thing to remember here about off-
15 campus EDs is that they are permitted to bill Medicare and
16 Medicaid because CMS has deemed provider-based entities,
17 and they bill under both the hospital outpatient system and
18 the physician fee schedule.
19 Payments they receive from private payers are
20 often in-network rates, but some also charge out-of-network
21 rates to some patients.
22 Then there are independent freestanding emergency

1 centers. This is the second type of stand-alone ED. These
2 are not affiliated with a hospital. I will refer to these
3 just as the "independent EDs." There are about 200
4 independent EDs; most of these are in Texas. Similar to
5 off-campus EDs, the independents offer ED services,
6 imaging, and labs, and they take few patients by ambulance.
7 They also tend to locate in urban areas and tend to have
8 low patient volumes per day.
9 Independent EDs differ from off-campus EDs in
10 that they are not deemed provider-based entities and,
11 therefore, cannot bill Medicare.
12 Independent EDs are typically paid out-of-network
13 rates by insurers, which data from Colorado have shown to
14 be at least 10 times higher than payments made to urgent
15 care centers for the same conditions. Anecdotally, we have
16 heard that some insurers have begun negotiating lower
17 payment rates with some independent EDs.
18 As you would expect, the patient payer mix of the
19 independent EDs is heavily dependent on privately insured
20 patients.
21 State law plays a significant role in regulating
22 stand-alone EDs because states control the licensing of

1 these facilities. However, the licensure of these
2 facilities is highly variable across states in terms of
3 where they locate, the services they must offer, and the
4 ownership of the facility. For the sake of simplicity, we
5 can summarize this variation by saying that most states
6 permit only the off-campus ED variety. Ohio is a good
7 example of that. A few states permit both types, the
8 independents and the off-campus, and Texas is the best
9 example of that. And only one state, California, prohibits
10 both types of stand-alone EDs.
11 Medicare's regulation of these facilities is
12 largely indirect. In order to bill Medicare, like I said,
13 off-campus EDs must be deemed provider-based, and to gain
14 this status facilities must meet several requirements,
15 including that they are within 35 miles of the affiliated
16 hospital.
17 As a part of the recent site-neutral legislation,
18 off-campus EDs are exempt from the law's prohibition on
19 off-campus facilities billing under the higher-paying
20 hospital outpatient payment system. This includes the ED
21 services and the non-ED services provided in these
22 facilities.

1 It is also important to note that CMS does not
2 separately identify claims provided in stand-alone EDs.
3 These claims are subsumed into the claims of the affiliated
4 hospital, making it difficult for us to identify these
5 facilities.
6 MS. McCLENDON: So between 2008 and 2016, the
7 number of off-campus EDs increased by approximately 97
8 percent. During the same period, all of the more than 200
9 independent EDs were developed.
10 We believe more stand-alone EDs are about to
11 begin billing Medicare. Like Zach mentioned earlier, there
12 are currently 363 off-campus EDs. These off-campus EDs can
13 bill Medicare if deemed provider-based, but the 203
14 independent EDs cannot. In the last two years, though,
15 independent EDs have found ways to bill Medicare for ED
16 services, which will likely increase the number of
17 facilities billing Medicare in the coming years.
18 One of the most common ways that independent EDs
19 are trying to bill Medicare is through affiliation with
20 hospitals and hospital systems.
21 There are multiple ways that independent EDs have
22 created these affiliations, the first of which is by

1 partnering existing hospitals with existing independent EDs
2 in order to turn these into off-campus EDs.
3 In other instances, hospitals and independent EDs
4 partner by building an entirely new hospital near
5 preexisting independent EDs. The independent EDs then
6 affiliate with the new hospital, turning them into
7 provider-based entities. This has happened in places like
8 Colorado.
9 We have also observed independent ED companies
10 partnering with existing hospitals. This means that when
11 new stand-alone EDs are built, they then become off-campus
12 EDs instead of independent ones, which has happened in
13 states like Arizona and Ohio.
14 In addition to finding ways to affiliate with
15 hospitals, some groups have changed the model of the stand-
16 alone ED. One type of these facilities' main focus is ED
17 services and imaging, but they also have inpatient beds,
18 which allows some of them to bill Medicare.
19 In sum, we expect to see more providers billing
20 Medicare for ED services in the coming years.
21 MR. GAUMER: There are at least four reasons
22 stand-alone EDs have grown and may continue to grow. The

1 first couple of these may be quite obvious.
2 First, stand-alone EDs can be used as a mechanism
3 for affiliated hospitals to capture patient market share
4 from their competitors. These facilities are small and
5 they require less capital to develop than a full-sized
6 hospital. Therefore, in a sense, they can be dropped into
7 competitors' service areas on the other side of town.
8 Second, stand-alone EDs can extract higher
9 payment rates from private payer when they bill as an out-
10 of-network provider. In effect, stand-alone EDs can charge
11 insurers top dollar when they do not have pricing contracts
12 in place with insurers. For the independent EDs, this
13 appears to be the primary strategy. However, we believe
14 off-campus EDs may also engage in this to some degree.
15 Third, under Medicare and other insurance,
16 providers have the incentive to serve lower-acuity patients
17 in an emergency department setting because payment rates
18 for ED services are higher than at urgent care centers or
19 physician offices. For example, a hospital system will be
20 paid more by the Medicare program when a beneficiary with a
21 relatively low-severity condition is served in one of the
22 system's EDs rather than in their urgent care centers.

1 Now, the most important reason might be the last
2 one. This is the main takeaway from this slide. The new
3 site-neutral law, which prohibits off-campus departments
4 from billing Medicare at higher hospital outpatient payment
5 rates, does not apply to stand-alone EDs. These facilities
6 are specifically exempted within the site-neutral law. You
7 could think of this as a loophole to the site-neutral law.
8 As a result, off-campus EDs can continue to receive higher
9 hospital outpatient payment rates for the ED services they
10 provide. In addition, they can continue to receive higher
11 outpatient rates for the non-ED services provided in their
12 facilities. This means that off-campus EDs can continue to
13 develop and expand ED and non-ED services under the site-
14 neutral law.
15 The stand-alone ED industry asserts their aim is
16 to fill the void in the community health care delivery
17 system and offer convenience to patients.
18 What we observe is that a few stand-alone EDs are
19 located in areas that have recently lost a hospital
20 emergency department or are in rural areas. But many
21 stand-alone EDs have opened in urban and suburban areas
22 where they are in close proximity to competitors or in

1 suburban areas with rapid population growth.

2 Data from a recent academic study, as well as our
3 own analysis, demonstrate that stand-alone EDs tend to
4 locate in ZIP codes with disproportionately higher
5 household incomes and also in ZIP codes with more privately
6 insured patients. For example, in Denver and Houston, more
7 than 60 percent of stand-alone EDs are located in ZIP codes
8 with incomes above $90,000 a year.

9 Recent data from Colorado and Maryland suggest
10 that stand-alone EDs serve lower-acuity patients, similar
11 to urgent care centers and different from hospital
12 emergency departments.

13 In a study comparing the top ten most common
14 conditions of patients served at hospital EDs, stand-alone
15 EDs, and urgent care centers in Colorado, researchers found
16 that seven of the ten most common conditions treated at
17 hospital EDs in Colorado were for life-threatening
18 conditions. At the other end of the spectrum, researchers
19 found that none of the top ten conditions at urgent care
20 centers were for life-threatening conditions. Both of
21 these are in line with what we might assume here. However,
22 at the nine stand-alone EDs which data were available for,

1 the researchers found that three of the top ten most common
2 conditions of patients served at stand-alone EDs were for
3 life-threatening conditions. Because only three of the top
4 ten most common conditions at stand-alone EDs were
5 categorized as life-threatening, it suggests patients
6 served at these facilities are generally lower-acuity
7 patients than those served at hospital emergency
8 departments.
9 A separate analysis evaluated the severity level
10 of ED patients served at three stand-alone EDs in Maryland
11 and the nearest three hospital emergency departments.
12 These researchers found that between 46 and 64 percent of
13 the patients served at hospital EDs were classified by the
14 facilities as being in one of the three lowest-severity
15 categories of ED services. By contrast, at the three
16 stand-alone EDs, between 68 and 80 percent of the patients
17 were in one of the three lowest-severity categories for ED
18 services. Therefore, a larger share of patients fell into
19 one of the three lowest-severity ED categories at stand-
20 alone emergency departments.
21 We've put together a couple initial ideas to
22 guide your discussion on this topic.

1 First, the Commission could consider if CMS could
2 begin tracking off-campus EDs in Medicare claims data.
3 Administrators and researchers now are largely unable to
4 see what services are being conducted in facilities.
5 Second, the Commission could consider examining
6 incentives which encourage providers to serve patients in
7 the emergency department setting.
8 And third, the Commission could consider
9 reexamining the off-campus emergency department exemption
10 included in the site-neutral law.
11 Thanks for your time, and we look forward to your
12 guidance and your questions.
13 DR. CROSSON: Thank you, Zach and Sydney.
14 We'll take clarifying questions. We'll start
15 over here with Amy, Bruce, Bill, Rita, and Jack.
16 DR. BAICKER: I know that States are licensing
17 these facilities, but generally speaking, what designates a
18 facility as an ED versus urgent care? Are there minimum
19 services offered?
20 MR. GAUMER: So it does vary in each State. I
21 think there are some consistent things that kind of have to
22 be there. Capacity to take certain levels of trauma

1 patients usually are one of the thresholds used by State
2 governments to do this.
3 To designate yourself as an emergency department,
4 often people have to take ambulance visitors, those types
5 of things. Yeah. But it does vary quite a lot from State
6 to State.
7 DR. CROSSON: Okay. Bruce.
8 MR. PYENSON: Just to follow up on Amy's
9 question, I think most States have a certificate of need
10 process that an applicant has to go through. My question
11 is in the regulatory infrastructure. Does the Medicare
12 program have standing within the certificate of need
13 process, or do you think it should?
14 DR. MILLER: It does not, and in a general sense,
15 I mean, to be -- you have to meet EMTALA requirements in
16 order to get Medicare reimbursement, but Medicare doesn't
17 have direct input into certificate of needs, either at a
18 federal or State level.
19 The second part of your question, should it,
20 would be a question for you, not for Zach, although we
21 could ask Sydney and see what she thinks.
22 [Laughter.]

1 DR. MILLER: It would be a significant shift in
2 policy in the sense that, generally, the way Medicare works
3 is if you license your doctors, if you license your
4 hospitals, and if you license your emergency rooms at the
5 State level, there's certain conditions of participation,
6 Medicare pays. So it would be a real shift in sort of
7 where supply policy sits. That's mostly at the State
8 level.
9 DR. CROSSON: Yes. On this point, Kathy?
10 MS. BUTO: Just a point of clarification on this,
11 Medicare does certify things like heart transplant
12 facilities, bariatric centers, and so on, so there is a
13 basis. It's tended to be based on not medical necessity so
14 much as a specialized center designed to meet certain
15 clinical needs of beneficiaries. But the way it's done
16 this is to say in order to be covered for services, you
17 need to meet certain criteria. So there is a way that if
18 Medicare wanted to limit the number of these, they could
19 proceed down that route or modify conditions of
20 participation to accommodate any additional out-station
21 facilities. It's a pretty cumbersome process, but there is
22 a way, not through certificate of need, but other

1 mechanism.

2 DR. CROSSON: Sue, did you want to come in on

3 this point or just on the list?

4 MS. THOMPSON: I'll wait.

5 DR. CROSSON: Okay. Bill.

6 MR. GRADISON: I'd be interested, as you pursue

7 this issue, if you'd take a look, particularly at Texas,

8 where there are quite a few off-campus EDs, to see what

9 effect, if any, they have had with regard to utilization

10 and particularly waiting times at the normal hospital EDs

11 or urgent care centers, to see what kind of interplay there

12 might be.

13 One other rather specific question -- I know it

14 varies from State to State, but are there States where an

15 independent ED could add three or four beds and then that

16 makes them a hospital? There are a lot of States that

17 don't have CON laws anymore.

18 MR. GAUMER: Yeah. And we've seen some of that.

19 There are some examples. I think we read about one in

20 Kansas the other day where -- I think it was a rural

21 facility that was essentially a stand-alone ED, added a

22 couple of beds, once they established themselves in the

1 community, and they were responding to demand in the
2 community.
3 This has happened also in Ohio, I think I read
4 recently, where a small stand-alone ED added four more ED
5 ports, essentially, to their facility. So there is kind of
6 initial setup as a stand-alone ED, and then they become a
7 hospital, small hospital, something Sydney and I have been
8 talking about as micro hospitals that you've maybe read
9 about.
10 MR. GRADISON: I guess the other final question
11 has to do with a 35-mile rule. I understand it applies. I
12 have occasionally had questions about the wisdom of a 35-
13 mile rule on its own if we're talking about telemedicine
14 and trying to break down geographic barriers.
15 I once was working with a children's hospital
16 that was asked to develop a children's facility and run it
17 in a hospital which was in a town just a little over the
18 35-mile rule, and they were told, "You can't do it because
19 you won't get any reimbursement for certain programs."
20 In this instance, I think it might just be
21 interesting to see. This isn't for or against EDs that
22 aren't attached to big hospitals, but I just wonder whether

1 the -- from the point of view of -- particularly the rural
2 issue, whether the 35-mile rule might be an impediment to
3 substituting facilities like this to hospitals in rural
4 areas which might otherwise close.
5 DR. CROSSON: Yeah. Mark.
6 DR. MILLER: Yeah. I'm going to intervene here
7 for just a second because I think there's also a
8 clarification I want in your minds and in the minds of the
9 public who have may have been listening to us over multiple
10 meetings.
11 So we're talking today about the growth in
12 emergency departments, the relationship to site-neutral
13 payment, and all that stuff that's been happening in front
14 of you, and a concern of growth, particularly as it relates
15 to kind of urban areas or suburban areas, if you want to
16 think about it that way.
17 New thought. Don't forget we had conversations
18 about -- you know, a freestanding emergency room in an
19 isolated rural area may make a lot of sense. It may be
20 hard for an isolated rural area to maintain a hospital,
21 inpatient hospital operation. Admissions are declining,
22 all that data that you guys are well aware of. So there

1 has been some talk in a separate way around reconfiguring
2 rural subsidies to support rural emergency room,
3 freestanding emergency rooms, and what triggered it is
4 Bill's comment, this sort of question of how isolated you
5 want that, the concern being that if you allowed just
6 anybody to do it, then you get a bunch of freestanding
7 emergency rooms that don't have enough volume to kind of
8 support themselves.
9 But there is something of a distinction in the
10 conversation here between what's going on in a rural and a
11 suburban area versus an urban area. A freestanding
12 emergency room may make a lot of sense in a situation where
13 you can't maintain an inpatient hospital.
14 I just wanted to do that little commercial before
15 we went on.
16 MR. GRADISON: But what I was really getting to
17 was the ability -- I've been in politics. I can project my
18 voice. What I was really getting to was the possibility of
19 a major hospital overseeing, running these things, as part
20 of their operation, which they often can't do because of
21 the 35-mile rule, rather than just having the option in the
22 small town, this hospital, of having to have a whole

1 structure entirely de novo, so to speak.

2 DR. CROSSON: Okay. So I have Rita -- sorry.

3 Did you want --

4 DR. MILLER: No. You should go on. I just want

5 to talk to Jeff for a second.

6 DR. CROSSON: Okay. Rita, Jack, and Sue. Is

7 that right? Rita.

8 DR. REDBERG: Thanks for an excellent chapter on

9 an important topic.

10 Just actually, in your response, I guess, to Amy,

11 it struck me when you were defining the ED law, you said

12 they should have trauma patients, be able to take trauma

13 patients and ambulance visitors, but it seems like most of

14 the new off-campus EDs don't actually take trauma patients

15 or get a lot of patients by ambulance, so that is of

16 concern, I would say.

17 Maybe we're coming back to this in Round 2, but I

18 was curious if you could enlighten us on why there was an

19 exemption in Section 603 of the BBA for off-campus

20 emergencies and non-emergencies.

21 MR. GRADISON: They have a new association.

22 [Laughter.]

1 DR. REDBERG: Just have it now.
2 MR. GAUMER: Well, actually, the exemption has
3 been there. In defining what a dedicated ED is and in
4 defining off campus, this has been out there a little
5 while, and so this didn't happen in just the latest
6 rulemaking process. But why this exists, I can only assume
7 that this is to protect emergency department access in
8 certain areas, but I'm not sure of the original intent.
9 DR. REDBERG: A few more clarifying questions. I
10 would be interested in another time if you have data on
11 sort of use of services at these off-campus services,
12 because they seem to have a lot of imaging services, and I
13 think most -- a lot of EDs now have a lot of CT scans
14 associated. And I'd be interested in the volume because
15 we've seen a big growth in imaging that hasn't correlated
16 with any improvement in outcomes, and it's of concern
17 again.
18 MR. GAUMER: I, too, would love to see the volume
19 in these facilities, but it's not something that we can
20 look at in Medicate data and in most private data because
21 there's no identifier on claims that says that these are
22 happening in an off-campus ED.

1 This is something that we have brought up in the
2 rulemaking process. In our comment letter, we made a point
3 about this, with this recent site-neutral outpatient rule.
4 Just this week, CMS finalized that rule and in doing so
5 said that they weren't going to. They responded directly
6 to us and said, "We're not going to make a modifier on the
7 claim so that we can identify this." They were a little
8 short on their explanation for why.
9 So I guess I can only assume it's to protect
10 access, but I'm not sure.
11 DR. REDBERG: That's very disappointing because
12 it's a lot of data and important data that would be helpful
13 for us to analyze.
14 I also had a question on page 20 of the mailing
15 materials. When you were talking about differences in
16 different MSAs on ED visits, there seemed to be a few like
17 Richmond, Virginia, that dropped in ED visits, and I was
18 wondering in others, in Texas and other places, that
19 increase. Do you have any insight into what was going on,
20 then, that would drive that?
21 MR. GAUMER: So this is referring, I think, the
22 private payer emergency department data, and speaking to

1 that -- so we looked at Medicare data, and we looked at
2 private payer data for emergency department visits to try
3 to see if there were any obvious volume changes in markets
4 with and without stand-alone EDs. And there were slight
5 differences between markets with and without freestanding
6 or stand-alone EDs.
7 One of the complexities of this analysis is there
8 is a lot of possible noise about what's causing these
9 trends, and we went into this fully acknowledging that a
10 lot of factors could have influenced emergency department
11 use, up or down.
12 With regard to the private payer emergency
13 department data on page 20, I think, in my mind, there's
14 even more noise on this, and so, in a market where the
15 emergency department visits went down, even where they had
16 stand-alone EDs, I don't have a good explanation. I think
17 that's why we tried to take an aggregated approach.
18 So there were outliers on both sides of things,
19 but in aggregate, the volume was slightly higher -- or the
20 growth in volume was slightly higher in these markets that
21 had stand-alone EDs, so that's also another reason why we
22 chose not to really highlight it in the slides. It's so

1 complicated, and there's so much variation potential.
2 DR. REDBERG: Thanks. That's helpful.
3 My last is just a clarifying comment. I was glad
4 you included Table 6 on the life-threatening conditions,
5 but I would just comment that, as I'm sure everyone here
6 knows, most fevers and viral infections and headaches,
7 which are listed under life threatening are not life-
8 threatening conditions. So I wouldn't want to like assume
9 every time someone had a headache, the ED would be the
10 appropriate place to go. And that's a problem.
11 DR. CROSSON: Good. Sue.
12 MS. THOMPSON: Mark, you clearly articulated one
13 of my original concerns around the issue of rural and the
14 discussion that we had in our last session.
15 But my clarifying question, Zach, is the off-
16 campus EDs must be located within 35 miles of the hospital
17 that's overseeing, okay, in contrast to, at the last time,
18 critical access hospitals were allowed. They must be 25
19 miles away from the next -- okay.
20 So, as we take the issue of rural and then the
21 issue of these off-campus EDs and thinking about that
22 geography, is there anything about the independent

1 facilities, any mileage restriction that can't be closer
2 than X number of miles to an existing ED?
3 MR. GAUMER: No. So there's really -- that would
4 be a State decision, and the States that have independent
5 EDs or the freestandings, such as Texas, they don't have
6 zoning restrictions like that, largely.
7 I think we heard anecdotally that in Houston,
8 there are no zoning restrictions, and I think someone said
9 to us it's like the Wild West. They can go out and start
10 these facilities wherever they'd like to, and we have seen
11 that they do open up across the street from a hospital
12 emergency department.
13 So, yeah, there are very few restrictions is the
14 answer.
15 DR. CROSSON: Jon.
16 DR. CHRISTIANSON: Okay. This is really a
17 clarifying question for me. So there are these two kinds
18 of EDs. There's those affiliated with hospitals and those
19 that are independent. So the exemption applies to the ones
20 affiliated with hospitals, and so they're able to build a
21 new emergency department and then have two doors. One
22 door, you come in and you can have a primary care practice

1 located there. Another door, you come in; you go to the
2 emergency department. And if you go in the door to the
3 primary care practice, you get the higher hospital billing
4 rate. Is that what the exemption is?
5 MR. GAUMER: What we've seen mostly to date is
6 that the off-campus EDs are emergency departments. The
7 have imaging. They have an imaging department. They have
8 a lab department, and that's largely it. Sometimes they'll
9 have maybe other medical offices in the building, if it's a
10 large variety.
11 DR. CHRISTIANSON: So, if they come into an
12 emergency, freestanding emergency, and it happens to be
13 that the service is primary care that's provided, then it
14 gets billed at the higher rate, or is it --
15 MR. GAUMER: Well, the way this works with the
16 site-neutral exemption is if the stand-alone ED wanted to
17 have or did actually have the medical office building in
18 the walls of the facility and billed with the same billing
19 IDs, then they could use the higher hospital outpatient
20 department rates. But I think largely what we've seen so
21 far is that the medical office part of this is not a
22 central component of this business model, but with the --

1 kind of the final rule set out by CMS this week, which
2 states specifically that the non-emergency department
3 services provided in those facilities can be billed the
4 hospital outpatient department rates, it would make sense
5 that --
6 DR. CHRISTIANSON: So this is a concern about the
7 future --
8 MR. GAUMER: It's almost a future concern, more
9 than anything.
10 DR. CHRISTIANSON: And another quick question,
11 the ownership of the independent ones, I mean, we've seen
12 some large health plans buy urgent care centers now. Have
13 you seen any ownership by large health plans of these
14 freestanding emergency setups?
15 MR. GAUMER: I have not seen any insurers buying
16 freestanding emergency departments.
17 DR. HOADLEY: A couple of quick, simple
18 questions. One, the exchange you were having with Mark or
19 the point Mark raised about the rural kinds of things where
20 maybe a hospital has converted to an ED, does that get
21 counted in your definition of an off-campus ED?
22 MR. GAUMER: Where the hospital goes out of

1 business and becomes an emergency department? Yeah, that
2 would get picked up in ours. Those are probably the
3 hardest ones to track, but they pop up on our radar as a
4 result of the closure analyses that we do. And that's
5 actually how this began. In our world, we kind of said,
6 "There's a lot of these going on." And so yes.
7 DR. HOADLEY: And when you talked, I think it was
8 on Slide 7, the term "partner," I'm wondering what that
9 really constituted. I assume that's something less than
10 ownership, but how high a bar or how low a bar is it? Can
11 you just write a memorandum of understanding and now we're
12 partnering?
13 MR. GAUMER: So the way I've seen it happen,
14 anyway, is you have a freestanding emergency department
15 company that gets together with a hospital or hospital
16 system and says, "Let's build a new facility," and it will
17 be under the hospital's brand, but the freestanding
18 emergency department company will essentially be a part
19 owner and will do a lot of the work to, you know, implement
20 their model. And, you know, maybe they staff it. Maybe
21 they run it. That's unclear to me. And it may vary. But
22 there is -- it's almost like a joint venture, so partnering

1 and joint venture in my mind is kind of the same thing in
2 this regard.
3 DR. HOADLEY: I guess I wonder whether at some
4 point whether partnering could be used in a less connected
5 level than that. That might be something to keep an eye
6 on.
7 Do we have any information on whether Medicare
8 Advantage plans are sort of following the same policies in
9 terms of how they might be paying either the freestanding -
10 - I mean, the off-campus or the independent EDs?
11 MR. GAUMER: That's a really good question. I'm
12 going to look into that and get back to you.
13 DR. HOADLEY: And the last question is: Payment
14 for urgent care centers, is that all paid under physician
15 fee schedule, or is there a facility fee involved for an
16 urgent care center? Or does it simply depend on ownership
17 again?
18 MR. GAUMER: It is complicated, also, and it
19 depends on ownership. And so if there's an urgent care
20 center that's owned by a hospital, they receive both the
21 hospital outpatient and the physician fee schedule rates.
22 And if they are a freestanding urgent care not owned by a

1 hospital, then they get the physician fee schedule rates.
2 And I'm going to look at Kate -- who just gave me the
3 thumbs up, so I didn't like to you. Thank you.
4 DR. HOADLEY: Okay. Thank you.
5 DR. MILLER: Yeah, and I think the general
6 thought is we've been thinking of the urgent care stuff as
7 kind of running through the physician side of things. And
8 to the extent that you kind of build one of these and then
9 urgent care people start running through one of these
10 things, then you're going to get that rate shift that you
11 saw, you know, in other circumstances. What he said, which
12 was confirmed by Kate, was correct.
13 DR. CROSSON: Okay. So we're going to -- sorry,
14 Brian.
15 DR. DeBUSK: So knowing that we can't separate
16 out these claims from these off-campus departments, as we
17 develop new quality measures like the potentially
18 preventable emergency department visit, this new business
19 model could completely contaminate that parameter.
20 MR. GAUMER: It would complicate the measure, I
21 think. Yeah, it could. But I would want to ask Ledia
22 about that, too, which you'll get a chance to do.

1 DR. MILLER: And, remember, I think what we're
2 about to shift to in this second round -- right? We're
3 moving into --
4 DR. CROSSON: Moving into it, yeah.
5 DR. MILLER: I mean, one recommendation you could
6 end up with here is to direct the Secretary to start
7 tracking these claims separately so it isn't such a blind
8 spot.
9 DR. CROSSON: As a matter of fact, let's move to
10 Slide 11. So I'm going to have a general discussion here,
11 and I'm going to ask for hands in a minute. But first I'm
12 going to point out that we're tight again on time.
13 So there are good points to be made here, and
14 please make them. But I would emphasize also the potential
15 -- because I'm thinking about the tenor of the discussion
16 so far, which is generally in support here. So I would
17 also ask you if you want to make a comment and you disagree
18 with either one of these three directions, to make that
19 point. Otherwise, we'll assume -- I'm going to assume
20 general agreement. Okay. So hands for discussion. Okay.
21 Let's start with Jon -- I did it the last time.
22 DR. CHRISTIANSON: Yes.

1 DR. CROSSON: Start with who? All right. Let's
2 start with Rita.
3 DR. REDBERG: Thank you. So I wanted to talk a
4 little bit about the role of primary care and emergency
5 department visits, because as I was alluding to, I think a
6 lot of these conditions are not clearly emergencies and
7 could be handled with perhaps more or better incentives to
8 keep them in primary care. And, again, I don't imagine we
9 have this data, but I would be interested in how many of
10 the patients who go to the freestanding emergency
11 departments or, whatever, emergency -- off-campus EDs, have
12 talked first to their primary care doctor, because as I
13 said, certainly a lot of these issues could better, for the
14 patient and I think for the overall system, be handled in a
15 primary care office. It's always better to be seeing
16 somebody who knows you and more efficient and less
17 unnecessary testing and less time. Most patients -- at
18 least my patients don't really enjoy going -- a lot of our
19 emergency rooms have waits. There are some sick people
20 there. It's just not that pleasant an experience.
21 And so along that line, I'm just wondering also
22 when we talk about primary care whether, you know, we could

1 favor groups that had perhaps incentives to keep those
2 visits, because when I admit some patients, you know, from
3 the emergency room, they say they tried calling their
4 primary care doctor first but nobody was available. They
5 were told -- you know, sometimes there's not capacity for
6 extra visits, and it's a lot simpler to refer someone. And
7 I think if we kind of reoriented the incentives for primary
8 care at the same time we're addressing the emergencies, it
9 would be better overall for beneficiaries and for the
10 program.
11 DR. CROSSON: Thank you. It appears I've done it
12 again and forgot the individuals who had volunteered to
13 begin. Those were Rita and Alice. I'm going to take Alice
14 next.
15 DR. COOMBS: Thank you very much. A couple of
16 things I wanted to address.
17 In my area, a for-profit group came in, took over
18 a bunch of hospitals. One of the hospitals involuted and
19 became an ED, a freestanding ED. So what now happens is
20 that in that ED the capacity to actually take care of true
21 emergencies in that region has become basically attrited
22 and there's a referral process where they refer to other

1 emergency rooms, even though they formerly were able to
2 take care of those patients.
3 One of the issues I have is what does the
4 workforce look like in those different entities, either the
5 off-campus ED versus the independent EDs, because this is
6 really a concern of mine in terms of even if, say, the
7 independent EDs did want to eventually take care of those
8 Medicare beneficiaries, are they really able to on a
9 workforce basis? So that would be one concern.
10 So I support one, two, and three, and even for
11 three I thought of this, and I thought it was very
12 interesting that, going forward, if even we would consider
13 an exemption -- a revocation of the exemption of the
14 independent EDs, because that's something we could
15 recommend to Congress going forward in terms of this
16 growing trend, just as there was a moratorium on LTCH
17 development at some point in the past because of the
18 development of LTCH in regions that were income-associated
19 and seemed to be more of a business plan kind of
20 arrangement, so that the demographics here kind of speak to
21 a similar type of pattern.
22 For the rural, Sue brought up the rule with the

1 rurals, and I think that's one issue that we should
2 probably be really squeaky clean on. With the independent
3 EDs developing in close proximity to urban areas, it might
4 be that with those situations, if they said, oh, these are
5 needed, that you might have a different -- an anti-distant
6 kind of requirement in thinking about that.
7 And so the one thing I want to talk about is, you
8 know, the conditions of participation and what that looks
9 like, and the role of all the accrediting agencies with
10 these independent EDs. What role does the Joint Commission
11 play and all of the things that a typical hospital kind of
12 abides by, and how does CMS interface with making sure that
13 those standards are being upheld?
14 And the conditions of need is such a difficult
15 area to get your arms around because of state mandates.
16 Those accrediting agencies might be a secondary window
17 where we could actually ensure proper certification and
18 accreditation.
19 And someone brought up that there are floating
20 EDs, where the ED opens today and tomorrow it closes, I
21 think that presents a problem for Medicare beneficiaries if
22 they were ever to be involved in that system in that they

1 may come to rely on something that may not have the
2 assurance -- you know, they may say that we can actually
3 open and close as we see fit based on capacity. So that
4 they can be open 24/7 and they have the capacity to be open
5 24/7, but can they actually handle emergency?
6 And I agree with Rita about the diagnosis. All
7 those diagnoses are clearly able to be treated in a doctor
8 setting, but some of them, if they're accompanied by
9 hypotension, a fever with hypotension, acute influenza type
10 syndromes, those are very different kind of natures in
11 terms of the presentation. And that in and of itself
12 speaks to some kind of site neutrality intervention. And
13 so I would be in favor of that arrangement.
14 DR. CROSSON: Yeah, I'd just like to make one
15 point here myself, which is, with respect to the loophole
16 that you referred to and Zach described, I mean, one
17 approach would be to say we should just close that. But
18 then we have, as Mark pointed out, this other set of ideas,
19 which is that we may want to promote the use of hospital-
20 affiliated or even independent emergency rooms in certain
21 rural situations. And it might well be that we would find
22 out that in order for those to be financially viable and to

1 respect genuine needs for support services, we would have
2 to be paying some additional funds.
3 So I think it may turn out--
4 DR. COOMBS: I agree with that. I agree that
5 rurals, as its market is alluded to, the discussion we had
6 with rurals, very separate. This discussion with
7 independent EDs, very separate. And so that we can
8 actually put a menu, there's veal marsala and then there's
9 chicken cordon bleu, and this is veal marsala and that's
10 it.
11 DR. CROSSON: Just to be clear, the ERs that
12 serve ham, they're over on this side, those that don't --
13 [Laughter.]
14 DR. CROSSON: Sorry. On that note, we're moving
15 up this way.
16 DR. GINSBURG: You know, this was a very good
17 presentation, very informative for me. I wasn't familiar
18 with it. Actually, as I started thinking about it, I
19 realized that I'm quite familiar with a situation in Ohio
20 which might be representative of a lot of others where a
21 hospital system acquired a failing low-volume hospital and
22 made a commitment to the community that it would expand

1 outpatient services and have an ED. So this, you know,
2 seemed to be something that's probably useful for the
3 community. But let me get to my point.
4 I think what we're grappling with is that we're
5 setting the payment on the basis of the structural
6 characteristics of a provider, and the freestanding EDs are
7 a case where, as we saw the data, most of the services are
8 way below those structural requirements, but the payment is
9 still high.
10 So I started to think about what we could do, and
11 maybe it could be that for Medicare to continue paying in a
12 freestanding ED, it would have to see evidence that the
13 acuity of the patients treated is high enough to be worth
14 the higher rates. So in a sense, the facility could lose
15 its Medicare designation and then just be paid as an urgent
16 care center if too small a proportion of its cases are
17 acute.
18 Another thing which would be more complicated to
19 administer is you could even try to vary the payments.
20 DR. CROSSON: By diagnosis.
21 DR. GINSBURG: By diagnosis or some way. But
22 whatever you want to do, we really need that data that CMS

1 decided not to collect.

2 DR. CROSSON: Okay.

3 MS. WANG: I agree with all of the

4 recommendations on page 11. I think that there are -- I

5 view this as a continuum. There's primary care, there's

6 urgent care, there's emergency departments. The analysis

7 that is presented here is basically demonstrating that the

8 freestanding emergency departments that you've examined are

9 urgent care centers who are getting paid at a higher rate

10 because of varying state licensure laws. They're not

11 providing the same services, they're not meeting the same

12 life safety codes, but just because they are licensed as

13 something called an ED, they are getting a higher payment

14 rate for something that an urgent care center is treating

15 and getting lower payment rate, and urgent care centers,

16 you know, are also treating things that could be in a

17 primary care setting. So we've got to continuum here of

18 the same conditions being provided in different settings

19 that, because of the different status label, are being paid

20 at different payment rates.

21 I think that Medicare should -- needs to early on

22 sort of have a position on this, and that's why I agree

1 with all three bullet-point recommendations here. I think
2 that in the issue of the menu, rural access is clearly a
3 situation that needs to be treated as kind of its own -- I
4 think from a policy perspective, people want to see access
5 improved through approaches like this.
6 I think another area is also the hospital
7 closure. There are communities where hospitals do need to
8 close, and the way that you can sort of support the needs
9 of the community and make them okay with taking that costly
10 overcapacity out of the system is by replacing it with a
11 freestanding emergency department.
12 But other than those two circumstances, I think
13 that what you've presented is kind of edge of the wedge
14 dangerous. And so I think that tracking Medicare claims is
15 very implement, and maybe ultimately moving towards -- I
16 mean, the site neutrality doesn't help; if you're licensed
17 as an emergency department, you're an emergency department.
18 I think you're getting paid that way.
19 I think that what I'd like to suggest is that
20 there's some sort of tracking and further analysis and
21 maybe even for a hospital-based off-site emergency room,
22 that there maybe be some critical mass of emergency room --

1 real emergency department services that are being provided.
2 The table that you compiled shown on page 16 to me would
3 not cut it. I would not view a freestanding, hospital-
4 based or otherwise, providing this menu of services as
5 being worthy of being treated as a true emergency
6 department.
7 So, you know, that's a little murkier. That's
8 not a bright-line thing there. But I think that there
9 needs to be some sort of judgment, I guess, about whether
10 something that is off site, that is, you know, really
11 within a hospital infrastructure, particularly, is really
12 more of an urgent care center or is truly an emergency
13 department. You know, it seems that the study group of
14 facilities, the business model as Brian described it, that
15 you've examined here is motivated maybe more on the private
16 payer side, but I think it's very important for Medicare
17 not to -- to be clear about whether it's going to encourage
18 or discourage or try to shape the development of these
19 organizations.
20 DR. CROSSON: Thank you.
21 DR. CHRISTIANSON: Yeah. Just a quick comment on
22 the third bullet point. I think this exemption is clearly

1 contrary to our -- or principle is contrary to what we've
2 recommended. It's unfortunate. I would like to see us
3 take a strong position and reexamine on this.
4 DR. CROSSON: Bill.
5 DR. HALL: I agree with Jon that this is sort of
6 the antithesis of what we talked about this morning about
7 the desirability of integration of health care services
8 across a spectrum. They're referring to the freestanding
9 emergency rooms. This would seem to be a curious exemption
10 to that rational approach to integration.
11 On the other hand, they probably do provide a
12 community service, but we don't really know that. But I
13 think a few additional things might be looked at. For
14 example, do we know much about staffing patterns in these
15 freestanding? On any given day, would you see a physician?
16 Would you see an advance practice provider or none of the
17 above? It just makes me very nervous that there don't seem
18 to be any clear regulations in that direction.
19 What I find at least in our community where we do
20 have these things that we call "doc in a box" -- that's
21 sort of the general term for these freestanding programs --
22 is that if they make a mistake or potentially an error and

1 not recognizing the severity of something, the mechanism
2 for following up on that is completely nonexistent.
3 They're told to go to the emergency room of some hospital.
4 So maybe that's rare or maybe it's common. We
5 don't know. But if it's truly an emergency and that's the
6 sequelae, it probably requires another one or two hours to
7 get to a place that actually can handle an emergency. So I
8 think we need to have some kind of scrutiny of at least
9 manpower and the ability of these institutions, depending
10 on the staffing levels, to refer promptly and properly.
11 That's the definition of emergency medicine.
12 DR. CROSSON: Thank you.
13 Amy.
14 DR. BAICKER: So the clarifying question I asked
15 around really the minimum standards for ED, I, too, found
16 that chapter enlightening, and it had me thinking along the
17 lines of what Paul had suggested around either
18 prospectively these facilities really vetting their role in
19 the community, expecting to care for trauma patients where
20 there is a need or having arrangements with ambulance
21 facilities to understand that they would be a source of
22 care for patients in the community. It obviously seems

1 quite opportunistic, given the laws it's outlined here.
2 I wonder if there is an opportunity for us to
3 look further at urgent care as well as -- you referenced
4 briefly the retail clinic sort of models. I just know from
5 my personal experience, retail, like referenced Minute
6 Clinics in CVS or Walgreens has these, they're actually
7 very unprofitable by themselves.
8 So the fact that you mentioned the urgent care
9 centers, if they're affiliated with the hospital, they're
10 able to get the hospital fee and also then the physician
11 fees, if we could just better understand the role of those
12 entities and what we believe to be the motivating factors
13 for establishing ED versus urgent care versus clinic, these
14 sorts of things would be helpful to further the discussion.
15 DR. CROSSON: Sue.
16 MS. THOMPSON: I'll be quick.
17 I really did appreciate this chapter, Zach.
18 Thank you.
19 Additionally, I like the point that -- I'm not
20 sure if it was Jon -- thinking about emergency urgent care
21 -- primary care, emergency urgent care, and now these
22 freestanding in some sort of a continuum, but even in a

1 broader context of how we're working to clinically
2 integrate and trying to understand where do these patients
3 end up and who are they handed off to and who is overseeing
4 the broader care in terms of our Medicare beneficiaries.
5 And then one last comment, as we think about
6 policy here, to be cognizant of the potential for
7 unintended consequences as we think about the issues we
8 have previously raised around rural, so just a last call.
9 DR. CROSSON: Craig.
10 DR. SAMITT: So I'm in support of all three
11 recommendations as well. What I also like about them is it
12 doesn't compromise the establishment of freestanding EDs,
13 where the true need exists. So, if there really is need
14 for a high-acuity ED care in a certain community, I don't
15 think there's anything that's been recommended here that
16 would compromise that, which is why we would allow those to
17 happen. We would want those to happen.
18 I also agree with the notion about the rural
19 exceptions that we need to -- as we have in other
20 circumstances, assure that there's a rural exception in
21 this case.
22 The only one modification and then one question

1 that I would have pertains to the second one. We talk
2 about examining incentives that may be encouraging
3 providers to serve patients in the ED. I would supplement
4 that by saying should we have incentives for primary care
5 and other providers to preserve care that is lower acuity
6 within their practices or in urgent care settings.
7 So, for example, are the ACO incentives
8 sufficient to encourage ACOs to really keep urgent care and
9 non-emergent care within practices, and should that even be
10 a separate quality variable that is measured with ACOs?
11 And my question is about beneficiaries. So, if
12 I'm a beneficiary -- and let me take a diagnosis. I simply
13 have pharyngitis. I have a sore throat. Is there
14 differential implications to me if I go to my primary care
15 doctor, an urgent care facility, or a freestanding ED? And
16 I'd love to understand as well to see, because beyond just
17 provider incentives, if it's otherwise neutral to me as a
18 beneficiary, then I may just go to the freestanding ED that
19 may be right next door. But the question is, Is that the
20 right incentive that we should have?
21 MR. GAUMER: So I can answer that in part here.
22 If the patient goes to any of those facilities -- the

1 physician's office, the urgent care, or the ED of any type
2 -- it's 20 percent copay or thereabouts. So, if the
3 payment in the ED is higher, that 20 percent results in a
4 larger out-of-pocket expense.
5 DR. SAMITT: Unless I have Medigap.
6 MR. GAUMER: Unless you have Medigap.
7 DR. MILLER: And that's the big deal is that if
8 there was a signal there, "Gosh, did you know that the 20
9 percent in this setting was higher than that setting?" with
10 a wraparound, employer, Medigap, or a supp from Medicaid,
11 you're not feeling any of that.
12 DR. CROSSON: Hold on.
13 DR. COOMBS: I just want to respond quickly, but
14 there is as nonfinancial piece of it, and it's the fact
15 that it's a disruptive innovation that allows a much more
16 efficient handling of a pharyngitis. That's why it works.
17 That's why it's successful. You can get in and get out.
18 That time factor is really important.
19 DR. CROSSON: Kathy, do you have a point on this,
20 or are you just getting in line?
21 MS. BUTO: Separate.
22 DR. CROSSON: Okay. Going down here, we've got

1 Bill.

2 MR. GRADISON: Quickly, on the second point, if
3 these facilities -- if a given facility actually does what
4 an ED in a hospital says it does -- and does -- then the
5 incentive structure may be based either on the ability of
6 the remote ED to operator, lower cost, or perhaps that the
7 hospital-based ED has been overpaid and therefore setting a
8 basis for payment that is excessive. So I'm just saying we
9 ought to look at both sides of that question.

10 DR. CROSSON: Okay. I've got Brian, Warner, and
11 Kathy, and then that will be the end. Brian.

12 DR. DeBUSK: It seems like we keep bumping up
13 against the same issues over services and the corporate
14 structure and all these nuances around payment, and I just
15 wonder if we could explore. This may be a terrible idea,
16 so I'm going to qualify that. But what if we explore --
17 what if they were all clinics? What if we took everything
18 back to these were clinics and we tried to address some of
19 this through the physician fee schedule?

20 Mark expressed a concern earlier about, say,
21 rural locations. Well, couldn't we do that through a site
22 of service through the physician fee schedule, and would

1 some of these things correct themselves, then? If you had
2 a suburban -- an allegedly off-campus emergency department
3 in a suburban shopping center in the middle of an affluent
4 neighborhood handling sniffles and sneezes, it would be and
5 look and act like a clinic, irrespective of the corporate
6 structure. And I just wonder if this is one of the few
7 situations where the granularity of the physician fee
8 schedule might actually work to our advantage and be able
9 to cover a broader hose of these services and not get into
10 splitting hairs about how sick or how ill is this patient
11 coming into this facility and who owns it.
12 DR. MILLER: Well, the ones, without buying into
13 they're all clinics and they're all through the physician
14 fee schedule, just with two seconds of thought, I want to
15 think about that. But what principle I would take from
16 that and would ask you all to think about is there is a
17 couple of times people have said, well, maybe we should --
18 I think Alice said maybe there's as moratorium. You can
19 take approaches like that, but what the Commission has
20 tried to do more traditionally in these areas is set a
21 uniform payment and then say if this is a viable model --
22 or a more rational payment -- if this is a viable model,

1 then it will continue to deliver, so, in a sense, take out
2 the revenue-generating opportunity and say this is a fair
3 price for this, whether it comes off the fee schedule or
4 whether it comes off the OPD or wherever it comes from and
5 says now you all can play whatever structure you want, but
6 this is the payment.
7 And I just don't know -- well, I'll stop there.
8 DR. DeBUSK: Well, the comments earlier about
9 rural emergency departments were very well made. I mean, I
10 think that's a legitimate concern and a separate topic.
11 I'm thinking more along, again, these very
12 suburban, very clinic-looking -- again, it would be nice to
13 be able to peel back all that and maybe address it with
14 something that's a little more granular.
15 DR. CROSSON: I mean, that's my sense of where
16 we're going is if we're going to solve the problem we have
17 identified before, which is as Pat elucidated, giving rural
18 communities the option of moving down from a hospital to
19 something else, call it a freestanding emergency room --
20 and that's a legitimate effort, and I think we all sensed
21 that that was -- then somehow we have to do that but not
22 have it contaminated with this other problem. And so we're

1 going to have to have some sort of a nuanced approach,
2 which will be kind of hard to get it right, but that's
3 probably the direction we need to take, or we take Paul's
4 suggestion and we do it through paying differently, which
5 is another way of doing it, because then you wouldn't be
6 paying extra funds for a cold, but you wouldn't be paying
7 it in that rural setting for the legitimate purposes that
8 the thing was established for.
9 So there's a couple of, I think, ways that we
10 could split this, and hopefully, we'll come back at some
11 point with those teased out better.
12 DR. DeBUSK: Well, in theory, rural could be a
13 site of service.
14 DR. CROSSON: We could make it a separate site of
15 service. Yeah.
16 Okay. Warner.
17 MR. THOMAS: Just two quick comments. I think
18 tracking the data would be important to kind of see what is
19 the trend on this.
20 On examining the incentives, the only comment I
21 would make there is I agree with Sue and all the comments
22 on looking at the rurals because I think, certainly, being

1 able to provide an opportunity for hospitals to transition
2 to being a freestanding ED or an ED only with ambulatory is
3 a great opportunity.
4 On the urban setting, the only comment I would
5 have is there are areas where we see five-, six-, seven-,
6 eight-, nine-, ten-hour ED waits, and to me, that is not
7 okay from a beneficiary perspective. And in those markets,
8 perhaps some of these -- not that they've got to be
9 hundreds of them, but perhaps there should be some of these
10 as an alternative to a patient waiting five to ten hours
11 for an ED visit.
12 So I just think getting back to the incentives,
13 that's probably one of the incentives you see here, and I
14 think that ought to be studied at the same time that we're
15 just looking at visits. I think we ought to be looking at
16 how many people are getting up and walking out of EDs and
17 things like that. So I just think it's another comment to
18 consider in the paper.
19 DR. REDBERG: Just to comment on that, Warner, as
20 you know, ED patients get triaged. So, if someone is
21 waiting five to ten hours, to me that suggests they were a
22 lower acuity, and it goes back to the discussion we were

1 having about perhaps they should be better treated in
2 urgent care or physician office.
3 DR. CROSSON: Pat, same point or different point?
4 MS. WANG: Yeah. It was just urgent care centers
5 have really sprung up, develop relationships with
6 hospitals, ambulances waiting outside of them to relieve
7 the bottleneck that you described. I think what we're
8 talking about here, from my perspective, keeping
9 beneficiaries out of the emergency department should be a
10 high priority, no matter what. So if there are step-down
11 kinds of settings, urgent care, primary care -- but urgent
12 care, I think, is filling a tremendous need right now for
13 the points that you just mentioned.
14 But what alarms me about this is this is an
15 urgent care center wearing a cloak of an emergency
16 department. I think you have to be really careful about
17 sort of recognizing it as that, but maintaining the urgent
18 care sort of capacity, I think is important.
19 MR. THOMAS: So I totally agree. I'm a big fan
20 of urgent care, and I think they play a very, very
21 important role. I just think as we look at the situation,
22 I think we ought to look at the wait time situation as

1 well.

2 I mean, I get that, Rita, there's triage. I
3 think there's probably some that are better at it than
4 others, so I just think it's something that ought to be
5 thought about. That's all.

6 DR. CROSSON: Okay. Kathy, last comment.

7 MS. BUTO: Okay. So I think we have a rare
8 opportunity to be a little more proactive in this area
9 because I sense that this is -- I think you used the term
10 "edge of the wedge." This is the beginning of potential
11 big proliferation of something that's not particularly
12 needed, recognizing that it is needed in some areas.

13 So I think we might be able to -- and I don't
14 think it would take much to reframe this as more than CMS
15 tracking the claims data and looking at incentives, but
16 really taking a much more proactive role in trying to,
17 first of all, collect the data, then develop criteria and
18 use whatever approaches they have, whether it's conditions
19 of participation, conditions of coverage, site-neutral
20 payments, a number of other mechanisms at their disposal to
21 try to get a handle on this, because if they -- all of
22 these are great, but if they do this, I guarantee we're

1 going to see a ballooning of these facilities, and it will
2 be too late to really pull them back. So the question is,
3 Can we suggest a course of action that's a little more
4 proactive where we urge the agency to get on top of this
5 through a variety of mechanisms that we could talk about
6 later, but including incentives, criteria, conditions, even
7 some certification maybe, if necessary?
8 DR. CROSSON: Okay, Paul. Paul, last comment.
9 DR. GINSBURG: Yeah. Kathy, I also think that we
10 should be aggressive in this area, and I'm wondering if we
11 should consider going one step further, which would be
12 recommending to Congress or maybe to CMS that there be a
13 moratorium on additional hospital freestanding ED
14 facilities.
15 MS. BUTO: While they do all this other stuff.
16 DR. GINSBURG: Yeah.
17 DR. CROSSON: Okay. Good discussion. Good
18 discussion.
19 We're now at an end. Zach and Sydney, thank you
20 very much.
21 We have the opportunity for public comment. If
22 there are any individuals in the audience that wish to make

1 a public comment, please come to the microphone so we can
2 see who you are.
3 [No response.]
4 DR. CROSSON: Okay. Seeing none, we are then
5 adjourned until 1:15.
6 [Whereupon, at 12:24 p.m., the meeting recessed
7 for lunch, to be reconvened at 1:15 p.m. this same day.]
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1 AFTERNOON SESSION

2 [1:19 p.m.]

3 DR. CROSSON: We're actually missing a few people

4 who were fascinated with the tiramisu, so I think,

5 nevertheless, to stay on schedule we need to start.

6 Okay. So we're going to take on the question

7 again about payments from drug companies and this time also

8 device companies to physicians and teaching hospitals. And

9 we have Ariel and Amy, and it looks Ariel is going to start

10 off.

11 MR. WINTER: Good afternoon. Amy and I will be

12 discussing payments from drug and device manufacturers to

13 physicians and teaching hospitals that were reported under

14 the Open Payments program. And we intend for this work to

15 appear in an appendix to the physician update chapter in

16 the upcoming March report.

17 Before we begin, I want to thank Sydney McClendon

18 for her help with this project.

19 So here are the points we'll be covering today.

20 I'll start with some background on this issue. Then I'll

21 describe the Open Payments public reporting program. We'll

22 present results from our analysis of new data from 2015.

1 And, finally, we'll talk about potential changes to Open
2 Payments program and future analytical work.
3 In 2009, the Commission recommended that Congress
4 mandate public reporting of financial relationships between
5 drug and device manufacturers and providers and other
6 health care organizations.
7 The goal is to help Medicare, other payers, and
8 the general public better understand the scope of these
9 financial ties and the relationship between drug and device
10 company payments and physician practice patterns.
11 In PPACA, in 2010, Congress created a public
12 reporting system. CMS implemented this program in 2013 and
13 called it Open Payments. As we expected, the media and
14 researchers have been using this database to shed light on
15 physician-industry ties.
16 There is a growing literature describing the
17 relationship between drug and device industry payments and
18 physicians' prescribing behavior.
19 For example, a recent study published in JAMA
20 Internal Medicine used data from the Open Payments program
21 on meals provided by drug companies to physicians. They
22 looked at meals that were related to brand-name

1 medications, such as Crestor, in one of four drug classes.
2 The authors found that physicians who received
3 such meals prescribed brand-name drugs within each class at
4 a higher rate than other physicians.
5 Another recent article used data from the
6 Massachusetts public reporting program and found that
7 physicians who received industry payments prescribed brand-
8 name statins at a higher rate than other physicians.
9 Earlier studies also found that physicians'
10 financial interactions with manufacturers are associated
11 with prescribing of newer and more expensive drugs.
12 Under the Open Payments program, manufacturers
13 and group purchasing organizations must report certain
14 payments and transfers of value to physicians and teaching
15 hospitals. The law applies to manufacturers of drugs,
16 devices, biologics, and medical supplies.
17 The category of physicians includes medical
18 doctors, osteopaths, dentists, optometrists, podiatrists,
19 and chiropractors. But the law excludes other health
20 professionals, such as advanced practice nurses and
21 physician assistants; it also excludes professional
22 organizations such as medical societies and patient

1 advocacy organizations.

2 Manufacturers are required to report most
3 financial interactions, for example, speaking fees,
4 royalties, meals, research funding, and investment
5 interests.

6 Some types of payments and transfers are excluded
7 from reporting, such as drug samples, educational materials
8 for patient use, and discounts on products, such as
9 rebates.

10 In addition, manufacturers can request that CMS
11 delay publication of payments related to research or
12 development of a new product for four years or until FDA
13 approval of the product, whichever date comes first.

14 In 2014, $1.3 billion in research payments were
15 subject to delayed publication. In other words, they were
16 reported to CMS but not published on the website. CMS has
17 not yet released the number of delayed research payments
18 for 2015.

19 So far, CMS has released Open Payments data that
20 cover the last five months of 2013, all of 2014, and all of
21 2015.

22 And now Amy will provide more detail about the

1 data.

2 MS. PHILLIPS: The Open Payments database

3 contains three main files:

4 First, the research file, which contains payments

5 for basic research, applied research, and product

6 development. These payments go to teaching hospitals,

7 directly to physicians, or to research institutions that

8 list physicians as principal investigators on a project.

9 Research payments may cover costs associated with patient

10 care, time spent managing the research, or the drugs or

11 devices that are studied.

12 Second, the ownership file contains information

13 about physicians with ownership or investment interests in

14 a manufacturer or GPO. This could include information

15 about a physician's stake in his or her own company.

16 Third, the general payments file includes

17 payments that are not in the other categories, such as

18 payments for promotional speaking, royalties, and

19 consulting.

20 Last year, we analyzed 2014 data and published

21 results in our March 2016 report. After we published our

22 analysis, CMS released additional payment records for 2014

1 that were worth about $1 billion.

2 This table compares total payments from 2014,

3 including the newly released records, with 2015. Overall,

4 total payments only increased by about 0.4 percent from

5 2014 to 2015 -- the bottom row.

6 There were small decreases in general payments

7 and ownership interests and a small increase in research

8 payments. But we have not yet examined the new 2014 data

9 in detail. Today's presentation is focused on 2015 data,

10 which I will discuss next.

11 This chart shows the proportion of payments in

12 2015 that fall into each category. The total payments sum

13 to about $7.5 billion.

14 If you look to the orange sections on the right,

15 you'll see that research payments make up about half of the

16 total value of payments. Please note that values are

17 displayed in millions. Within the research payments

18 category, $3.2 billion went to physicians and $724 million

19 went to teaching hospitals. It's important to note that

20 these payments exclude those that are subject to delay in

21 publication, and we do not yet know the value of those

22 payments.

1 The green sections on the left show the general
2 payments category, which makes up 40 percent of the total
3 value of payments. Among general payments, about $2
4 billion went to physicians and $605 million went to
5 teaching hospitals.
6 The light blue section shows physician ownership
7 or investment interests, which, at around $1 billion, make
8 up the remaining 10 percent of the total value.
9 Around 80 percent of the payments went to
10 physicians, while the other 20 percent went to teaching
11 hospitals.
12 Across all three payment files, about 618,000
13 physicians received payments. Eighty percent of physicians
14 receiving payments were MDs and DOs, 20 percent were
15 dentists, optometrists, podiatrists, or chiropractors.
16 Of those physicians who received a general
17 payment, the average payment per physician was $3,242
18 dollars, and the median payment was $157. This means the
19 distribution of payments is highly skewed with a few
20 physicians receiving a high proportion of the dollars.
21 Of those physicians with ownership or investment
22 interest in a drug or device company, the average value of

1 interest per physician was about $265,000 and the median
2 value was $4,651.
3 We did not calculate the average research payment
4 per physician because research institutions may list
5 multiple physicians as principal investigators, so we are
6 not able to attribute these payments to specific
7 physicians.
8 In 2015, across all three payment files, 1,110
9 teaching hospitals received payments. Among the payments
10 made to teaching hospitals in the general payments file,
11 one hospital accounted for half of all payments.
12 Payments to hospitals were mostly via royalties
13 or licenses which accounted for 70 percent of general
14 payments made to hospitals.
15 Gifts were the most prevalent type of payment
16 with 78 percent of hospitals receiving them, despite only
17 accounting for 2 percent of general payments to hospitals.
18 For the next four slides, we will be focusing on
19 general payments.
20 The distribution of general payments among
21 physicians is highly concentrated at the top. The top 5
22 percent of physicians who received payments account for 86

1 percent of total payments.

2 Looking at the demographics of these physicians,

3 we found that five specialties -- internal medicine,

4 cardiology, orthopedic surgery, psychiatry/neurology, and

5 oncology/hematology -- account for half of the physicians

6 in the top 5 percent, and we found that 10 states account

7 for 60 percent of these physicians.

8 MR. WINTER: Okay. Next we examined general

9 payments to physicians by the type of payment. So the

10 first row shows that royalty or license payments accounted

11 for about one-quarter of general payments and had the

12 highest average amount per physician -- about $233,000.

13 Only about 2,300 physicians received one of these payments.

14 Next, going down the list, is compensation for

15 services other than consulting -- which includes

16 promotional speaking fees. This also accounted for about

17 one-quarter of general payments to physicians.

18 About 31,000 physicians received one of these

19 payments, which is 5 percent of all physicians who received

20 at least one general payment. And the mean payment per

21 physician in this category was about $16,000.

22 Then moving on down, we'll look at food and

1 beverage, which accounted for 12 percent of the total
2 payment amount but was received by about 589,000
3 physicians, or 96 percent of all the physicians who
4 received at least one general payment. And this reflects
5 the widespread prevalence of industry-provided meals to
6 physicians. The mean value of food and beverage per
7 physician was $400.
8 We also examined the distribution of general
9 payments to physicians by physician specialty, and this
10 table shows the top ten specialties by total payments.
11 Since we mailed out the paper, we have refined
12 our analysis by dividing internal medicine into smaller
13 specialty categories, so this table is different than
14 what's in your paper.
15 Orthopedic surgery accounted for the highest
16 share of payments: 21 percent, or $410 million. The
17 average payment received by orthopedic surgeons was
18 relatively high: over $19,000, with a median of $418.
19 The large difference between the mean and the
20 median indicates that the distribution is skewed towards
21 physicians who received very high payment amounts.
22 Internal medicine is second on the list,

1 accounting for 15 percent of the total, with a per
2 physician mean of $2,400.
3 And cardiology was third, accounting for 8
4 percent of the total, with a per physician mean of almost
5 $8,000.
6 Next, we look at the distribution of general
7 payments to physicians by the type of company that made the
8 payment. Because the data list the company's name but not
9 the type of company that made the payment, we had to look
10 at each company name and decide how to categorize it. To
11 do this, we used company websites and other sources.
12 We found that device manufacturers accounted for
13 48 percent of general payments to physicians and drug
14 manufacturers accounted for 46 percent. The category that
15 includes manufacturers of both drugs and devices was third,
16 accounting for 5 percent of the total.
17 So for the last four slides, we've been focusing
18 on the general payments files, but now I'm going to switch
19 gears and look at the physician ownership or investment
20 interest file.
21 This table looks at physician ownership interest
22 by type of company. Device manufacturers accounted for

1 almost $900 million in physician ownership interests, or 86
2 percent of the total. Drug manufacturers accounted for
3 only 7 percent.
4 As noted on the slide, POD stands for physician-
5 owned distributor, which is an entity owned by physicians
6 that sells implantable medical devices used by the
7 physician owners in surgeries. We broke out these
8 companies separately because they have been criticized by
9 the OIG and the Senate Finance Committee for potentially
10 creating a conflict of interest.
11 I'll conclude by discussing potential changes to
12 the Open Payments program, as well as future analytical
13 work. The potential changes listed on this slide and the
14 next were part of our March 2009 recommendations on public
15 reporting.
16 First, we could reiterate our recommendation that
17 manufacturers should be required to report payments to
18 advanced practice nurses and physician assistants.
19 Currently, the law requires reporting of payments
20 to physicians but not APNs or PAs, and this creates an
21 incentive to shift payments to these clinicians because
22 they are not subject to reporting.

1 The number of APNs and PAs billing Medicare has
2 been growing steadily. According to ProPublica, these
3 clinicians wrote about 10 percent of all Part D
4 prescriptions in 2013.
5 Second, we could reiterate our recommendation
6 that manufacturers should be required to report payments to
7 patient advocacy organizations. There was a recent news
8 story about funding from drug companies to patient advocacy
9 groups.
10 For example, the story noted that half of the top
11 donors to a large patient organization were drug companies;
12 each one contributed at least $1 million.
13 Third, we could reiterate our recommendation from
14 2009 that manufacturers and distributors should be required
15 to report information about drug samples to the Secretary.
16 This information would include: each recipient's name and
17 address; the name, dosage, and number of units of each
18 sample; and the date of distribution.
19 The rationale for this recommendation is that the
20 drug industry provides free samples to providers worth
21 billions of dollars every year.
22 Although these samples offer benefits to many

1 patients, they may also lead physicians to rely on more
2 expensive drugs when cheaper drugs may be equally
3 effective.
4 Requiring manufacturers to report this
5 information would enable researchers to examine the impact
6 of samples on physicians' prescribing patterns.
7 According to this recommendation, the data on
8 samples would be available through data use agreements for
9 research purposes but would not be available on a public
10 website.
11 So here are some ideas for future work:
12 We plan to examine the relationship between
13 payments from manufacturers and physicians' use of drugs
14 and devices.
15 We plan to link Open Payments data to Part D and
16 Part B drug data.
17 One question we could explore with this is
18 whether the top prescribers of new drugs are more likely to
19 receive industry payments. We also hope to explore
20 trends in payments to physicians as more years of data are
21 released.
22 This concludes our presentation, and we'll be

1 happy to take any questions.

2 DR. CROSSON: Thank you, Ariel and Amy.

3 We're now doing clarifying questions.

4 MR. GRADISON: Okay. I noted and you pointed out

5 that after the initial disclosure of 2014 data, an

6 additional $1 billion was reported. What was that all

7 about? It just seemed, frankly, a little bit strange that

8 they would put out something incomplete or that it would be

9 that much that they'd pick up later. What happened?

10 MR. WINTER: We're not sure

11 MR. GRADISON: Okay.

12 MR. WINTER: That's the short answer. We did our

13 analysis using data that was released in January 2016 for

14 2014, and that totaled about $6.44 billion. And then when

15 they released the 2015 data, they also released a fuller

16 data set from 2014 that summed to $7.5 billion. But we

17 have not been able to get into that database, the 2014

18 database, in more detail to figure out, you know, where

19 these additional -- what these additional -- we know what

20 these additional payments were for in terms of research --

21 most of them were for research. About $300 million were

22 physician ownership, and about $120 million were for

1 general payments, but we don't know distribution by
2 specialty or type of general payments.
3 DR. CROSSON: It reminds me of Senator Dirksen
4 years ago saying, "A billion here, a billion there. After
5 a while it adds up to real money."
6 MR. PYENSON: Thank you very much. A great
7 report. A couple of questions.
8 It seems as though pharmacy benefit managers are
9 not required to report. Is that correct?
10 MR. WINTER: That's right. But that was part of
11 our recommendation, that they should be required to report.
12 MR. PYENSON: Okay. Thank you. And it seems as
13 though rebates being paid associated with Part B drugs are
14 also not reported. Is that right?
15 MR. WINTER: That's correct. They are excluded
16 by statute.
17 MR. PYENSON: Okay. And then the third question
18 on the stock ownership. I assume that doesn't mean a
19 physician buys common stock on the market. It means a gift
20 of common stock?
21 MR. WINTER: So the physician ownership file
22 excludes -- I believe it excludes stocks owned in publicly

1 traded companies, but not -- but it would include stock
2 ownership or other investments in privately held companies.
3 If a manufacturer gives common stock to a physician in a
4 publicly held company, that would probably appear in the
5 general payments files, and there's a category called
6 "Ownership Interests." It's about the fourth row from the
7 bottom. And that reflects when the manufacturer gives an
8 ownership interest in a company to a physician, and that
9 could include common stock, but I could look into that and
10 get back to you.
11 MR. PYENSON: Thank you.
12 DR. HOADLEY: So one follow-up on Bill's
13 question, is there any indication or any way to know if
14 additional dollars that -- the additional billion dollars
15 could reflect some of the delayed payments for research?
16 MR. WINTER: That's a good question.
17 DR. HOADLEY: Or we don't know?
18 MR. WINTER: We don't know, and I'm not sure if
19 we'd be able to figure that out because I don't think
20 there's a variable that indicates whether a payment that is
21 now being disclosed was originally subject to the late
22 publication. We can take a look at the file in more detail

1 and see, but that is certainly a possibility.

2 I think what's more likely is that there were

3 payments that were disputed or that CMS had questions

4 about. For example, they couldn't always match the

5 physician identifier that was reported by the manufacturer

6 with the physician identifier in CMS's own systems, and so

7 they had to go through the process of cleaning the data,

8 and that could reflect some of the missing records that

9 were eventually added. But we don't know for sure.

10 DR. HOADLEY: It seems like those are questions

11 that CMS ought to be willing to answer in general.

12 My other question, my original question was about

13 the reporting delay for the research and development. Was

14 that something that we had anticipated in the Commission's

15 recommendation?

16 MR. WINTER: Yes. Our recommendation was to

17 allow for a delayed publication for up to two years or

18 until the product was approved or cleared by the FDA,

19 whichever came first, and in the statute, the statute said

20 they could delay publication for up to four years or until

21 the product was approved, whichever came first. So they

22 have a longer period in the statute than we recommended.

1 DR. HOADLEY: I mean, I'm sort of curious about
2 the rationale because it seems like the -- it wouldn't be a
3 lot of identification of exactly what product is being
4 tested in the research. Obviously, you would know that a
5 particular cardiologist was linked to Merck or whatever
6 company, but it wouldn't be identifying that it was to
7 develop this particular new product.
8 MR. WINTER: If the payment is related to a
9 specific product, they are required to report that.
10 DR. HOADLEY: Okay.
11 MR. WINTER: But if it's sort of general research
12 and they don't have a product yet, then they can't report
13 it, and they wouldn't.
14 According to CMS, the purpose of this provision
15 was to balance the manufacturer's interest in keeping its
16 research efforts proprietary and balance that with the
17 public's interest in having access to this information, so
18 --
19 DR. HOADLEY: And we appreciate the broad
20 rationale. It seems like you could accomplish that by
21 maybe suppressing the identity of the drug being studied
22 but not the fact that payments were made, and then there

1 should be a clear way, it seems like, to identify later on
2 why that was added or something like that.
3 DR. CROSSON: Brian --
4 DR. REDBERG: Just related to that, have any of
5 those been -- the delayed been announced yet?
6 MR. WINTER: I don't know. They have not been
7 publicly announced. CMS has not said the release for 2015
8 includes X amount of dollars that were delayed for 2013.
9 We can ask them if they have this information, but I don't
10 think the file includes a variable that identifies whether
11 --
12 MS. PHILLIPS: There is a delay in publication
13 variable.
14 MR. WINTER: Okay. There is a delay in
15 publication variable, but I'm not sure if that would tell
16 you that a payment that's being reported now was originally
17 delayed for publication. We'd have to look at that some
18 more and talk to CMS.
19 DR. CROSSON: We have Brian, Bruce, Craig.
20 DR. DeBUSK: Regarding payments to academic
21 medical centers, if say an implantable medical device
22 company made a payment to do research on a very specific

1 device, obviously that would fall under open payments.
2 What if instead they funded, say, three fellowship
3 positions, didn't specify what the research was to be, but
4 basically, those three fellows chose to do research in that
5 area? For purposes of open payments, how would that be
6 treated?
7 MR. WINTER: If it's a payment to a teaching
8 hospital -- you said academic medical center, so --
9 DR. DeBUSK: I apologize. As a teaching
10 hospital.
11 MR. WINTER: If it's a teaching hospital, right,
12 and they're often the same but not always. So, if it's an
13 teaching hospital from a drug or device manufacturer, that
14 has to be reported, even if it's not related to a specific
15 drug or device. And so if it's for a fellowship, that
16 would probably be reported under the education category,
17 and they would not report a name of a drug or device
18 because it was not linked to a specific drug or device, but
19 they would have to report the payment itself.
20 DR. DeBUSK: And then I had one other question.
21 I noticed you showed 21 PODs. Just from your own intuition
22 -- physician on distributors. I apologize. For your own

1 intuition, do you sense that that number is underreported?
2 I don't feel like there are only 21 PODs in the entire
3 country.,
4 MR. WINTER: That's a very good question. So we
5 identify PODs through looking at companies' websites, which
6 were often -- and you could talk about this in more detail.
7 They were often very vague about what the company did or
8 produced or sold.
9 But we also got names of some PODs through OIG
10 report and a Senate Finance Committee report, and then Amy
11 can talk more about how they identified some of the other
12 ones.
13 But the Senate Finance Committee report did say
14 they have anecdotal evidence that these pods are
15 structuring their financial relationships with physicians
16 to obscure the relationships. So they don't have to report
17 it under open payments or report it to the physician's
18 hospital. So there's certainly a possibility of
19 underreporting.
20 DR. CROSSON: Okay. Bruce.
21 MR. PYENSON: Just a follow-up question on the
22 research funding. Much research is conducted through

1 contract research organizations, and those organizations
2 perhaps pay physicians. Is that captured through open --
3 this process?
4 MR. WINTER: If the research agreement that's
5 being run by the CRO lists a physician as a principal
6 investigator, that has to be reported, and that would
7 appear in the research file. And the name of the
8 organization would be there. So if it's a CRO, we could
9 see the name of that organization, and we'd also see the
10 name of the physicians who are listed as PIs.
11 MR. PYENSON: So is that the entire payment? Not
12 all of the funds go to physicians, but is it the entire
13 payment?
14 MR. WINTER: It's the entire research grant or
15 funding. It's not broken down by the payment to the
16 physician for their time managing the trial. It includes
17 the cost of managing the trial. It includes the cost of
18 the drugs or devices. It includes patient care as well as
19 compensation to the physician, so it includes everything.
20 MR. PYENSON: Do you think this is a good
21 estimate of industry spending on research and development
22 or a portion of it, except for the time lag?

1 MR. WINTER: I'm not sure I could answer that
2 immediately. I'd have to think about that some more
3 because there certainly could be research grants that don't
4 have physicians as PIs. They could be PhDs and not be MDs
5 or DOs and so they would not have to report that
6 information. So I'd have to think about that some more.
7 That's a good question.
8 DR. CROSSON: Craig.
9 DR. SAMITT: Back to Slide 13. You had talked
10 about the ownership interest category, and I think you had
11 mentioned that personally purchased stock interests are not
12 included. Why would they not be considered --
13 MR. WINTER: This would be stock in a publicly
14 traded company.
15 DR. SAMITT: Stock in a publicly traded company.
16 MR. WINTER: Right.
17 DR. SAMITT: So why would that --
18 MR. WINTER: I'm not sure if they were excluded
19 by statute or by regulation. I'd have to go back and
20 check. I think the notion there is that -- I'd have to
21 think. I don't know. I don't know why that might be
22 excluded, but my sense is that it is. And we can go back

1 and look into what the rationale is.

2 DR. CROSSON: Okay. I think we're ready to move

3 on to the discussion. I would just point out that we kind

4 of have two things on the table at the same time. One is a

5 proposal to --

6 Thank you. I'm just being reminded to remember

7 to call on Alice and Rita. Thank you.

8 We have got the notion here on page 17 and 18

9 that we have prior recommendations, and one is from 2009,

10 and the other two are more recent. The idea here is we're

11 looking for support because we'd like to reissue those

12 recommendations.

13 And then the second part, which is on the last

14 slide, is thoughts about future work, particularly the

15 issue of linking open payments data to Part D and Part B

16 drug data or other ideas for future work.

17 So, Alice, we'll start with you and then Rita.

18 DR. COOMBS: Thank you very much.

19 So, for starters, for future work, I agree with

20 our former recommendations about pursuing reporting of the

21 other advance nurse practitioners and PAs, and also the

22 requirement for payments to patient advocacy organizations.

1 Several areas that I am particularly interested
2 in, Ariel, based on my own personal experiences, the
3 validity of the data that's recorded. So I personally went
4 to the website. I looked up my data, and on the website,
5 way over in the corner on the right-hand side is dispute.
6 So there's an opportunity for a physician to actually
7 dispute the findings that are within the content of the
8 report, and just my personal interview with multiple
9 physicians, they're not even aware, first of all, of the
10 information on the website that's concerning them, so that
11 to actually talk about whether or not this has been
12 validated with the provider, that doesn't happen.
13 And I was thinking of what way in which MedPAC --
14 if we're going to have these robust recommendations that
15 are on page 18, that we first should probably go through
16 some process whereby we validate those providers, and with
17 our interviewing of what we're going to do for physicians,
18 it might be an easy climb to do a pilot of, say, maybe 40
19 or 50 physicians to say, "Have you looked at the
20 website? Have you disputed what was found there? If not,
21 are you aware that you have the capacity" -- or some kind
22 of discovery where we actually look at reinforcement

1 because manufacturers are just reporting one-sided. I
2 think that if manufacturers were reporting to both the
3 physicians that they're reporting as well as to the public
4 reporting, so that there would be disputes on -- and I'm
5 sure -- this is not 100 percent -- there might be disputes
6 of what is actually seen there before we draw some of the
7 conclusions that we are.
8 And one of the issues is, for the research, do we
9 think that the research funds for patient recruitment,
10 patient participation, all of those things should be
11 attributed to physicians? And I think that's a problem for
12 me if we lump it all together, and then all of a sudden,
13 it's sitting in the house of physicians. So I don't know
14 if you've had a chance to kind of consider that in
15 particular.
16 MR. WINTER: It's not something that we have
17 thought about much in detail yet but something we can
18 certainly talk about.
19 The issue is that the statute requires reporting
20 of payments made to physicians but not other entities, and
21 in our original recommendation, it included other entities,
22 like academic medical centers, CME organizations. And if

1 you could report it in the name of other entities, then it
2 would not necessarily show up as the name of a physician.
3 It could show up in the name of an academic medical center
4 or the research institution or the specialty society, but I
5 think because the legislation is limited to physicians and
6 teaching hospitals that the files and the data are
7 structured around the individual physicians and individual
8 teaching hospitals. But under our original recommendation
9 and our original concept, it could have been reported under
10 the name of entities and not necessarily under the name of
11 physicians.
12 Does that help?
13 DR. COOMBS: Right. So should it be broken out
14 as to this dollar amount is attributed to physicians and
15 the rest of it is for the operation of the research
16 protocol?
17 MR. WINTER: Are you suggesting that you'd break
18 it down by the amount that is physician compensation for
19 their time managing the trial versus the amount that's
20 spent on patient care and the --
21 DR. COOMBS: Right. And patient --
22 MR. WINTER: -- cost of the drugs and devices?

1 Yeah. It's certainly something to think about.
2 DR. COOMBS: Yeah. And then lastly --
3 MR. WINTER: We can make that suggestion to CMS.
4 DR. COOMBS: And lastly, in terms of royalties,
5 there are other industries that we look at in terms of
6 other disciplines, that royalties are kind of assessed at,
7 okay, this is an appropriate amount for, say, engineering
8 discovery, something in biomedical engineering.
9 What we see here, is that comparable to those
10 other industries? I'm thinking about how in the GIPC, we
11 considered what's a cost of doing business for -- we talked
12 about this with MEI -- for a physician versus what does is
13 the cost of doing business for an accounting. Is there a
14 way to do comparable kind of comparison of this is an
15 appropriate amount? Or it might be over. It might be
16 under what you would have expected if you compared it to
17 other professions.
18 MR. WINTER: I'm not aware of a database that
19 would -- public database that has royalty payments to other
20 professions that we could use as a benchmark, but it's
21 something we can think about.
22 One thing that complicates this is that the

1 patent -- one patent may be much more valuable than another
2 patent, and if you're comparing -- even within the drug and
3 device world, patents have vastly different values. Then
4 if you're comparing between drug and device patents and
5 other kinds of patents, I'd be concerned about whether
6 those are really comparable worlds.
7 DR. COOMBS: Right.
8 And then lastly, for samples, I think if we do
9 samples, we definitely have to have some bidirectional kind
10 of commitment on -- the manufacturers, pharma is reporting
11 that these samples were given, that there should be some
12 kind of way of attesting that physicians actually receive
13 the samples, and it shouldn't be unilateral as the website
14 appears to be currently.
15 MR. WINTER: Just one point about the role of
16 physicians and teaching hospitals and validating the data,
17 they do have an opportunity to review and validate the data
18 and dispute it if they discover there's an error.
19 Physicians and the AMA have raised lots of
20 questions and concerns about how cumbersome this process is
21 and whether physicians are aware that this process exists,
22 and so CMS has taken some steps. They have said to

1 simplify the process, make it easier for physicians to
2 review and dispute the data, and also to educate physicians
3 that the data are out there and that they should be
4 reviewed. But, certainly, this is an important area.
5 DR. COOMBS: My only thing is that you can't
6 dispute it if you don't know that you're one of those
7 618,000.
8 DR. CROSSON: So just on that point, Alice,
9 you're saying the concern is that the company might report
10 providing samples to a physician and the physician never
11 received them.
12 Ariel, I think the proposal is that this database
13 would be available to researchers and not the general
14 public. So, if that were the case, how would the physician
15 -- in the event of concern that Alice has raised, how would
16 the physician know to dispute that?
17 MR. WINTER: I think you probably want to include
18 a process as exists for open payments that would allow
19 physicians to review the data that are being reported about
20 them in terms of samples and dispute any data that they
21 disagree with or that is inaccurate.
22 DR. CROSSON: I'm sorry. I interrupted you.

1 Sorry.

2 MR. WINTER: So you may want a process where

3 whoever is administering this database, whoever in HHS is

4 administering the database, reaches out to physicians who

5 are included in the database, to alert them to the fact

6 that they've been reported as having received samples, and

7 they should go in and review the information to confirm its

8 accuracy.

9 DR. COOMBS: But that doesn't exist right now.

10 MR. WINTER: Currently, CMS does not reach out to

11 the 618,000 physicians who have been reported in open

12 payments, not individually, but as a group, they try. They

13 have efforts reach out to physicians as a profession but

14 not individual physicians.

15 DR. CROSSON: Okay. Rita is up.

16 I'm sorry. On this point?

17 DR. BAICKER: Yeah, on that point. So I do

18 believe it's quite widespread practice for pharmaceutical

19 manufacturers to collect signature form physicians as

20 they're handing out samples. So I believe the data

21 absolutely exists. I don't know about 100 percent of

22 manufacturers, but I believe their internal kind of audit

1 that they track of those products, that they have all of
2 that information, so yeah.
3 DR. CROSSON: That's right. I remember that.
4 Yeah, yeah. Okay.
5 Okay, Rita.
6 DR. REDBERG: Thanks, Ariel and Amy. This was an
7 excellent chapter, and clearly you can see the work from --
8 that's progressed in open payments. I do support the
9 recommendations to extend advanced practice nurses and
10 physicians' assistants. There was a research letter
11 published in JAMA Internal Medicine last month called
12 "Guess Who's Also Coming to Dinner," that looked at that
13 data from medical files in Australia, where they do report
14 on nurses, and they had -- and I'll send you the article --
15 but almost 40 percent of attendees that do pharmaceutical
16 events were nurses, and they report -- 51 to 96 percent of
17 nurses report interaction with industry as part of their
18 work.
19 And I would just say, anecdotally, I've noticed
20 in the last two years, actually, before I realized about
21 this loophole for nurses, that more commonly, when I've
22 been leaving work I run into nurses that tell me they're

1 going downtown to some nice restaurant for a pharmaceutical
2 industry-sponsored dinner, and then I kind of put that
3 together with this exclusion thing.
4 And the same with patient advocacy organizations.
5 I mean, when I worked in the Senate back in 2004, and took
6 a lot of meetings as part of that work with patient
7 advocacy organizations, you know, I was on leave from
8 medical -- from my cardiology job. So, you know, and they
9 would say things that didn't sound really quite right to
10 me, certainly not at all with the evidence, so I started
11 always asking about the funding of these advocacy, and
12 every one of them was funded by a drug company that often
13 was making whatever it was.
14 And, you know, it just changes, to me -- it's not
15 a patient advocacy. It's industry-sponsored, you know,
16 voice, and that's very different than, I think -- and it's
17 not that we're talking about it but I think relevant to
18 PCORI too, because I'm not sure that we're really hearing
19 from patients in that patient center, when -- so I
20 certainly think the reporting of funding for a patient
21 advocacy is very important.
22 I wanted to also comment on the devices and the

1 drugs. You know, I think it's a good idea, for future
2 work, to link open payments to Part B and Part D, but as
3 you noted, a lot of the payments, even more than drugs, are
4 from device manufacturers which would not be covered by
5 Part B and Part D. I don't know if the unique device
6 identifier, which still has not been implemented, would
7 allow tracking of those payments, but I think it's
8 important to think about how to track device payments, and,
9 in particular, I think that's a lot of what I think is
10 going on in orthopedic surgery, and we saw the very
11 lucrative royalties and a lot of surgeons may develop their
12 own devices, develop their own companies, have royalty
13 agreements. And I think it's an important issue for
14 beneficiaries because I don't think there is consistent
15 disclosure when doctors are implanting a device that they
16 actually are profiting from, and I do think that should be
17 part of informed consent, which is sort of related.
18 And the last -- oh, and for drug samples, I also
19 think that's a good idea to track. I would say, at UCSF,
20 at least 5, maybe 10 years ago, we banned drug samples, and
21 it -- which, by that time, you know, I've been there 26
22 years -- when I started I didn't really question it. But

1 then I started noticing that the only drug samples we ever
2 had in cardiology were the very expensive new ones, you
3 know, the sort of ones that, of course, you start your
4 patient on these new, expensive ones and then they want to
5 keep refilling it, and they were never, you know, the low-
6 cost, you know, multiple drugs for every -- most cardiology
7 categories. And so I thought it was a good idea when UCSF
8 decided to ban them system-wide, because it wasn't really
9 increasing access to all medications. It was just the very
10 new and expensive ones.
11 And the last thing I was going to say, you know,
12 on the research -- because I've heard some discussion, at
13 least in medical meetings, about should research payments
14 be considered the same as general payments, and I do think,
15 you know, there's all kinds of industry-sponsored research.
16 But there certainly -- and you cited some of the data, is
17 data to suggest that industry-sponsored studies are more
18 likely to find a positive result. I mean, there's a lot of
19 ways to influence how you ask the question, how you choose
20 your inclusion and exclusion criteria. And then the other
21 problems with the failure to report negative results, which
22 we know is a big problem because then we don't learn when

1 things don't work, which are all more likely to happen with
2 a biased funding source.
3 So I think that was it. Thank you.
4 MR. WINTER: In terms of the device -- I'm sorry.
5 In terms of the device, linking devices to individual
6 physicians, device payments to individual physicians, one
7 thing you could do is look at surgeons who get payments,
8 high payments from device manufacturers that maybe make
9 implants, and look at whether there's a correlation between
10 the payments they -- those surgeons and their -- the rate
11 at which they do certain implant procedures. So even if
12 you -- you couldn't link the specific device company to a
13 specific device that was used, but you could look at it
14 more generally, in terms of physicians who received a lot
15 of device company payments.
16 DR. REDBERG: I think that would be a great area
17 for future work.
18 DR. CROSSON: Brian, on this point.
19 DR. DeBUSK: If you did -- if we did follow the
20 recommendation of including UDI information on the CMS
21 claims form, you would then be able, at the practitioner
22 level, to be able to tie individual devices and individual

1 cases. If I'm not mistaken, I believe the open payments
2 and GUI ID databases actually mesh, using the same Dun and
3 Bradstreet identifier for the manufacturer. I believe that
4 data would actually mesh right out of the box.
5 DR. CROSSON: Okay. Very helpful.
6 Okay. Can I see, roughly, hands for discussion
7 here? Okay. So we have -- let's start here with Bill Hall
8 and go this way and then come around here.
9 DR. HALL: I think this is very informative work,
10 and I just want to make sure that we have a little bit of
11 historical perspective on this. When I graduated from
12 medical school, every medical student got a fancy bag from
13 one of the companies that I think is out of existence now.
14 I don't even remember which it was.
15 DR. CROSSON: It was Lilly.
16 DR. HALL: Lilly. That's right. Thank you.
17 [Laughter.]
18 DR. HALL: You're dating yourself.
19 Also, it would have a reflex hammer which is a
20 sort of medieval device you use to test reflexes.
21 [Laughter.]
22 DR. HALL: Also good if you're mugged sometimes

1 in the street.

2 And it was assumed that you would be showered

3 with gifts at every medical meeting, including dinners,

4 silly tee-shirts, pens, pencils, candy. I mean, it was a

5 terrible situation, and study after study after study

6 showed that no matter how people denied it, it influenced

7 their patterns, sometimes for a lifetime. So the problem

8 was real.

9 That's -- it's a total difference now. It's a

10 completely different kind of system now, and I bet you that

11 if we wanted to have efficiency of inquiry it would be the

12 5 percent and 90 percent rule, and some of that data was in

13 your report, that it's probably 5 percent of the physician

14 workforce that are perhaps -- need to explain why these

15 payments are so high. So do you penalize everybody because

16 of this -- the -- what might be called the 5 percent? So I

17 think it might be helpful to do a little more analysis on

18 that and see if we pick some cutoff arbitrarily, say does

19 this kind of quote not sort of solve the problem.

20 At my own institution, which is no different than

21 many others, we have to have a declaration as part of our

22 faculty appointment. We have to list these things

1 separately. So the idea is you keep track of all of this.
2 As I'm sure Rita could speak to more informatively than I
3 can, an article -- a research article that is submitted to
4 a journal is almost automatically devalued if it looks like
5 pharmaceutical support was there. So at -- evidence-based
6 medicine says we don't know whether there was any problem
7 here but the study would not be considered quite as
8 worthwhile.
9 On the other hand, there are a lot of advances in
10 medicine, a lot of information that needs to be distributed
11 that might not otherwise be distributed. So I don't think
12 we should throw the baby out with the bath water, but we
13 took a serious look at this, was once a serious problem,
14 but -- because the implication is that if you're on that
15 list that you must be kind of crooked or something. I
16 think the vast majority of people probably -- as was
17 pointed out, probably had no clue that they were on that.
18 DR. CROSSON: Okay. Amy.
19 MS. BRICKER: So generally speaking a support the
20 recommendations for changes to the open payments that have
21 been outlined.
22 I wanted to take one of Rita's comments maybe a

1 step further, and I would be interested in further
2 discussion with my colleagues around the value of samples
3 with respect to the Medicare population. We know that
4 coupons, for example, are not permitted to be given to, you
5 know, Medicare beneficiaries, supplementing their out-of-
6 pockets associated with drug expense, and should we take
7 that a step further with samples for the very reason that,
8 Rita, you pointed out? Less about helping folks afford or
9 have access to very crucial therapies but more about
10 starting people on high-expense, new products, for them to
11 just be -- you know, need to continue or really not started
12 on what is, you know, in the best interest, potentially, of
13 the patient at the time.
14 So I'm interested in maybe looking at that in the
15 future. But, yes, support of tracking of that information
16 in the least. I don't know about the recipient's name and
17 address, and how far we have to necessarily go identifying
18 the patient, but if there's a way for us to track that back
19 to a Medicare patient, at a minimum I'm in support of that.
20 DR. CROSSON: You know, I'd just like to
21 emphasize support for what you said, because -- and Rita,
22 as well -- because it's been a while now but some number of

1 years ago, when I was working on the issue of drug use, and
2 we looked in a very large group practice, among all the
3 things that appeared -- this is not scientific, but based
4 on discussions -- that appeared to be influencing
5 prescribing patterns, you know, it was much less the free
6 pizzas -- and we didn't have very many of them, and they
7 couldn't have any pepperoni -- but it was the provision of
8 samples, and its impact both on the physician but
9 particularly on the patient who got used to taking a brand-
10 name drug when, in fact, in many cases, if not all, there
11 was a generic available.
12 It's a difficult issue because, to some degree, I
13 think it can speed up medical practice -- I mean if you can
14 just -- as a physician, if you can reach in the drawer
15 behind you and give the patient something very quickly and
16 easily, I can understand that, and I think from the
17 patient's perspective sometimes they view this as a net
18 gain. And yet I think, in the end, the Medicare program's
19 interest and the beneficiary's interest is not in this
20 direction. So I think it's -- anyway, my own experience
21 bears out what you said.
22 Going down, coming up. Jack.

1 DR. HOADLEY: So again, thank you for this paper.
2 It's really very helpful.
3 I mean, I think one of the things to keep in mind
4 as we think about this, and this goes a little bit to what
5 Alice and some others have said, is the purpose of this
6 exercise is about transparency. We're not taking any
7 action step in terms of saying, okay, based on the amount
8 of money you get, something else happens to your payments.
9 So, I mean, that's the advantage of, you know --
10 people can go in, like you're doing, and analyze and see
11 whether there are patterns that emerge, and if, in the
12 example of the research costs, it does seem like it would
13 be worth making sure we have the appropriate breakdowns of
14 the amounts that go directly to the physician in question
15 versus the expenses of actually running the trial, they
16 could all be there and simply labeled in appropriate ways,
17 or in the scenario you said, where the institutional
18 payments could be pulled out differently. You've already
19 got the issue where there's a PI but it's a whole team of
20 people, and who do you attribute it to.
21 So the more of those details that are there it
22 allows people like yourselves, who are going in and digging

1 into these data, to sort of understand. But again, the
2 point is transparency.
3 I'm supportive, I think, of the various things
4 you've identified on Slides 17 and 18, in terms of items
5 from our original recommendations. You know, we might want
6 to go back and think about payments from other entities.
7 PBMs was mentioned. I mean, you could think about health
8 plan payments. Some of those might get farther afield and
9 doesn't really belong in this box, but somewhere along the
10 line that might be worth thinking about.
11 I do think maybe there's -- worth thinking more
12 about, from the question I asked in the previous round,
13 about the delay and whether we should recommend going back
14 to just a two-year delay or a notion of reporting the
15 amounts but not the purpose of particular things. So yes,
16 it's a payment from this particular company but not what
17 it's for. I mean, I think those would be things to at
18 least consider for other refinements.
19 I think on the research area, I think, you know,
20 there's a lot of good ideas here, and I can imagine -- and
21 I'm happy to offer more thoughts offline -- but, I mean, I
22 can imagine targeted studies for certain drugs, or certain

1 drug classes, such as some of the studies that you've
2 referenced from the literature, where you're looking at
3 brands in a class that has a lot of generic availability,
4 or where there are several competing brands, and does it
5 influence choices on the Part B side.
6 You know, we've talked, in our other discussions
7 about classes, where there really are competing products,
8 maybe at different price points for treating a particular
9 thing, and by targeting into some of those particular
10 cases, and the previous discussion about devices, even
11 without the identifier you ought to be able to look at, as
12 Brian was suggesting, at things in that same light. And I
13 think trying to look at the high people -- the 5 percent or
14 whatever percent of people with the highest amounts, and
15 trying to figure out what's going on, it may turn out some
16 of those are because they're PIs from much larger studies
17 that go on, and it's not really money to them, that might
18 look different than somebody else who's just had a lot of
19 travel and a lot of straight-out gifts.
20 But trying to understand a little more of what's
21 going on, and in your case, in your example of one hospital
22 that had some enormous share of all the hospital payments,

1 again, there may be a perfectly legitimate story behind
2 that, or not. I think trying to understand that would be
3 useful as well.
4 And I do think -- I was going to add on the
5 question of samples and things -- I mean, there are
6 sampling -- sample kinds of programs that operate not at
7 the level of the sort of traditional way of giving samples
8 to individual docs, but there are organizations,
9 particularly working with clinics and things. Virginia has
10 a whole program where they collect samples from
11 manufacturers -- there's still some of that issue of bias
12 towards the brand products -- and then, in turn, those are
13 made available to clinics that are working with poor
14 patients, but without kind of that same, right, that same
15 sort of direct relationship. And obviously that could be
16 done in a way that encourages samples for generic products
17 as well, operating through that process, you know, that can
18 improve.
19 And then, you know, it would be also interesting
20 since copay coupons, as Amy said, are not allowed in
21 Medicare, but again, some of the aggregated programs or the
22 ones within the IG's rules -- again, I'm getting a little

1 farther afield from where we started here -- but sort of
2 looking what's going on and seeing if there's any issues in
3 those. I don't know that it's a high-priority item for us,
4 but something that we could consider looking further into.
5 MR. WINTER: Jack, can I just address two things
6 that you mentioned? I just wanted to clarify that the
7 analysis we did of the top 5 percent of physicians only
8 included the general payments. We were excluding research
9 payments. This is only things like consulting, promotional
10 speaking fees, royalties, that sort of thing. So we left
11 out research payments from that -- this analysis that's on
12 that slide.
13 And then the hospital that we referenced that
14 accounts for half of the payments to all teaching
15 hospitals, they hold patents related to three costly cancer
16 drugs, and so there's a manufacturer that's paying them for
17 the right to use that patent -- those patents.
18 DR. HOADLEY: That may be a legitimate -- but
19 again, that's where transparency --
20 MR. WINTER: Yeah.
21 DR. HOADLEY: -- if we say, okay, there's one but
22 there's a perfectly understandable reason for it.

1 MR. WINTER: Right.

2 DR. HOADLEY: People can judge -- you know,

3 people -- you can talk about that and people can judge if

4 that's something we should worry about or not.

5 DR. CROSSON: Kathy.

6 MS. BUTO: It just occurred to me, Ariel. I

7 don't know if you all have looked at the ACE demonstration,

8 the orthopedic demonstration. You're probably aware of

9 this. And the reason I ask is that I think underneath this

10 whole issue is the concern that physicians are obviously

11 going to be prescribing or using either devices or drugs

12 based on their relationships, and not based on an overall

13 management fee or ability to manage the care of the patient

14 over time, including how well did they do after surgery,

15 kind of thing.

16 And I guess I just wonder if one thing we can

17 think about in the next iteration of this is, you know,

18 what are -- aside from the reporting part, and getting

19 greater transparency, what are the approaches that we might

20 take as a commission to look at de-linking, or taking the

21 relationship part out of this to a greater extent, and

22 making it, whether it's a bundled payment or some kind of

1 other approach, that would give greater assurance that
2 choices are being looked at, that there isn't steering
3 going on based on personal investment or interest or
4 compensation. So let's get underneath that and figure out
5 sort of what are the kind of positive things that could be
6 done to promote that kind of behavior, as maybe our next
7 version or generation of this work.
8 Because I think, you know, the reporting always
9 feels to me like you're chasing something, and that -- will
10 you ever catch it? And my own instinct is it's really hard
11 to catch once it's gotten going, but if we could figure
12 out, to sort of get underneath that and move more toward
13 how do you break that underlying strong tie, that would be
14 useful. And I thought of the ACE demonstration because I
15 know that that was part of the underlying rationale.
16 MR. WINTER: Right. And one important element of
17 bundled payments, such as the ACE demonstration, is the
18 ability for physicians and hospitals to gain share, for
19 surgeons, other physicians to share in savings when they
20 reduce device and supply costs, as long as patient quality
21 is protected, and safety.
22 DR. CROSSON: Okay. Coming down this way. Did I

1 hear something?

2 MS. BUTO: Brian.

3 DR. DeBUSK: Regarding Kathy's comment, too,

4 something like ACE or BPCI or CJR, when there is a gain-

5 sharing component in place with that, you actually open

6 yourself up to both ends of that, which is now not only do

7 you have the potentially improper relationship but now you

8 have potential stinting of the device, for example, going

9 only to a low-demand hip across the board, where before

10 maybe I used 50-50. And to the point that Rita made

11 earlier, I think that's where having some of that UDI

12 information available on a CMS claims form allows us to

13 track patterns of use in both directions.

14 MS. BUTO: I wasn't -- I mean, I think you're

15 right, there can be issues on both sides of it, but I do

16 think, ultimately, what we want to do is inject more sort

17 of, I guess, objective choice based on the patient need,

18 and that's why reporting on outcomes is so important to

19 that, I think.

20 DR. DeBUSK: Well, I couldn't agree with you

21 more. Absolutely.

22 DR. CROSSON: David.

1 DR. NERENZ: Just one friendly amendment point
2 with regard to everything on 17, 18, 19. I would think
3 that maybe in terms of sequencing we might focus first on
4 Slide 19, about the analysis, in order, then, to prioritize
5 the actions on 17 and 18. All the reporting things have
6 some level of cost and burden associated with them that's
7 going to be incurred by somebody, somewhere, and I think
8 that we'd want to be thoughtful about where we ask that
9 burden to be taken up, and just make sure they're aligned
10 with the greatest priorities.
11 And by priority I mean how much evil is there in
12 any of these areas? I presume it's not all the same, that
13 there's some more evil some ways and some less evil other
14 ways, and whatever burden of reporting we recommend to take
15 on is just organized in that way. I suspect there's a
16 little more we can learn through some additional analysis
17 about the relationship between any kind of payment and some
18 subsequent behavior change. So just a thought about that.
19 And then the last one is just, you know, we have
20 to be careful what we wish for, if we play this chess game
21 all the way out. And so all this reporting occurs and then
22 less payments occur, or some change in payment occurs, and

1 then less bad behavior occurs. One of the consequences
2 maybe just more direct-to-consumer advertising, and that
3 has its own downside, and none of us can watch TV anymore
4 because there's nothing but ads on there that we don't want
5 to see.

6 DR. CROSSON: Is it possible for there to be more
7 drug ads?

8 DR. NERENZ: Well, maybe not, although, I don't
9 know, for those of us that watch sports, the timeouts are
10 just going to be made longer and they're going to slip more
11 ads in there, and that's where the money's going to go. So
12 that could be a really bad effect.

13 DR. CROSSON: To your first point -- yeah?

14 DR. MILLER: No, no, you go first.

15 DR. CROSSON: No, I was just going to say to the
16 first point, this is sort of a temporal issue, right? I
17 mean, because it seems to me that reiterating previous
18 recommendations is pretty easy. We can do that in short
19 order. If we wanted to -- you're saying not do that until
20 we have done the --

21 DR. NERENZ: No, or actually make it part of the
22 reiterated recommendation, say whatever agency is going to

1 take this up, to actually mandate the reporting, might want
2 to do that in priority order based on some things learned
3 in addition --
4 DR. CROSSON: I see. I thought you meant --
5 okay.
6 DR. MILLER: That was one of my questions. And
7 the other was -- and I think everybody gets this, but I
8 just want to say it out loud. So the burden falls on the
9 actor who's providing the money. So in a sense, the drug
10 company and the device company have to decide that it's
11 worth giving a meal or worth giving, you know, travel or
12 something because they know they have to support it.
13 Now, that's not to say it's zero burden on the
14 physician, because the physician does have to look in and
15 say, okay, do I want to dispute this? But the large
16 burden, you know, tends to fall on the actor who has
17 decided to distribute the dollar here. I think, if I'm
18 following your point.
19 DR. NERENZ: Oh, and I don't claim to know the
20 ins and outs of corporate accounting. But then if those
21 become tax-deductible business expenses, then somebody else
22 picks it up. So it falls on us all somewhere somehow.

1 MR. THOMAS: Just on this page 17, it doesn't
2 mention -- we mention PAs and MPs, but we don't mention
3 pharmacists. I know in the chapter it was indicating that
4 pharmacists are not part of the disclosure at this point.
5 Is that something that -- is it a change that's being
6 considered or would they still be excluded under your
7 recommendations?
8 MR. WINTER: So our original recommendation
9 included pharmacists. I think there's a full list
10 somewhere in the paper. So here we were trying to
11 highlight entities or people that were excluded that we
12 thought were high priorities to include in open payments.
13 So we're not saying we're backing -- I don't think we're
14 saying we're backing away from saying that payments to
15 pharmacists should not be reported. I don't think we're
16 saying that. But I think we're trying to highlight which
17 categories that were excluded are high priorities to be
18 included, and this is really for your discussion. So we're
19 not --
20 MR. THOMAS: Just getting back to Rita's point
21 around nurses and pharmacists, I mean, I think it's
22 important to understand if there's funding being done there

1 that we understand what that looks like, just like we would
2 a physician, because they're all involved in the care
3 decisions. And so I think it's important to organizations
4 that are involved with this and also for patients. I would
5 encourage us to make sure it's a broad enough list or put
6 some materiality factor on it or whatnot. But if it's
7 above a certain materiality threshold, then I think it
8 ought to be recorded.
9 DR. CROSSON: And, Amy, on this?
10 MS. BRICKER: Just I would support that, Warner.
11 I think what we're finding is likely nurse practitioners
12 and PAs, you know, the prevalence of them was more limited
13 when this was a requirement, and while pharmacists today
14 don't have broad prescribing authority, they are advocating
15 and hoping to, you know, have that ability at some point.
16 So I think it's wise of us to, you know, require that
17 pharmacists also be included or any other practitioner, for
18 that matter, even if today it's quite limited, just so that
19 we're not back here having this discussion in five years.
20 MR. THOMAS: I think more like PharmDs or folks
21 that are involved in, you know, really helping to think
22 through what drug regimens will be, especially in the

1 inpatient world. I mean, they play a much, much bigger
2 role now of kind of what the drug regimens are going to be
3 in treatment.
4 DR. CROSSON: Okay. Thanks, Ariel. Thank you
5 very much, and Amy as well. Thank you for a good
6 discussion to the Commissioners, and we'll move ahead with
7 the next presentation.
8 [Pause.]
9 DR. CROSSON: Okay. We are going to come back to
10 a continuing discussion that we've had about what at the
11 moment we're using the term "premium support" for, and our
12 directive here, our goal, is to try to determine what
13 design elements we might recommend if and when the Congress
14 decided to pursue this rather substantial change in the
15 Medicare program for the future.
16 Eric is going to take us through this discussion.
17 MR. ROLLINS: Good afternoon. Today I'm going to
18 discuss how benchmarks and beneficiary premiums could be
19 determined if Medicare used a premium support model for
20 Part A and B services. This presentation is part of a
21 broader exploration of premium support that we are
22 undertaking during this meeting cycle.

1 We first discussed premium support at last
2 month's meeting, where Ledia and Carlos examined the issue
3 of rewarding high-quality care, and we anticipate
4 presenting additional topics related to premium support in
5 the spring. The Commission plans to include a chapter on
6 premium support in its June 2017 report to the Congress,
7 but this chapter will not make any recommendations. Your
8 discussion on today's presentation will be reflected in the
9 chapter.
10 I'd like to start by giving you a quick overview
11 of the presentation. I'll first provide some background on
12 the concept of premium support and then move on to discuss
13 three key issues that would need to be addressed if premium
14 support were going to be used in Medicare: the role of the
15 fee-for-service program, the use of competitive bidding to
16 determine benchmarks, and options for mitigating large
17 increases in beneficiary premiums. I'll then raise some
18 possible topics for discussion.
19 Moving now to Slide 3, the Commission has been
20 examining premium support for a number of years as a way to
21 encourage beneficiaries to use care in a more efficient
22 manner. Under premium support, beneficiaries would choose

1 to enroll in the fee-for-service program or a managed care
2 plan, much as they do now. However, Medicare would make a
3 fixed payment for each beneficiary's coverage, and this
4 payment would remain the same no matter which coverage
5 option the beneficiary chose. The beneficiary premium for
6 each coverage option would then equal the difference
7 between its total cost and the Medicare contribution. This
8 means that higher-cost plans would have higher premiums,
9 while lower-cost plans would have lower premiums. As a
10 result, beneficiaries would have an incentive to use a
11 lower-cost plan.
12 If policymakers decided to use premium support in
13 Medicare, the role of the fee-for-service program is a key
14 issue that would need to be addressed. Premium support
15 proposals have taken a variety of approaches on this topic.
16 Some proposals would only use premium support to change how
17 Medicare pays managed care plans and would leave the fee-
18 for-service program untouched. Other proposals would treat
19 fee-for-service as a competing plan under premium support,
20 and some proposals would phase out the fee-for-service
21 program and rely entirely on managed care plans to provide
22 Medicare benefits.

1 There are strong arguments for treating the fee-
2 for-service program as a competing plan in a premium
3 support environment. Under this approach, fee-for-service
4 would operate much as it does now, except that CMS would
5 prepare a bid that reflects the cost of providing coverage
6 through the fee-for-service program, and this bid would be
7 compared to bids submitted by managed care plans to
8 determine beneficiary premiums.
9 Treating the fee-for-service program as a
10 competing plan would ensure that beneficiary premiums
11 accurately reflect the difference between the cost of fee-
12 for-service and managed care in an area. The fee-for-
13 service program would also help limit Medicare spending
14 because it would be the low-cost option in some areas of
15 the country, and its presence would help keep the rates
16 that managed care plans use to pay providers close to fee-
17 for-service levels. Fee-for-service would also provide
18 coverage in areas where no managed care plans are
19 available. Finally, some beneficiaries will continue to
20 prefer fee-for-service coverage, even if they might have to
21 pay a higher premium for it in some areas.
22 Moving on now to Slide 5, in a premium support

1 system, Medicare would establish a benchmark that would
2 serve as a reference point for the cost of providing Part A
3 and B benefits. The method used to calculate the benchmark
4 would be very important because the benchmark would be used
5 to determine how much Medicare pays for coverage and how
6 much beneficiaries pay in premiums. Higher benchmarks
7 would lead to higher Medicare spending, as well as lower
8 beneficiary premiums, since the difference between a plan's
9 bid and the Medicare contribution would be smaller.
10 Conversely, a lower benchmark would mean lower Medicare
11 spending and higher beneficiary premiums.
12 The benchmark could be established through
13 competitive bidding, as in the Part D program, or through
14 some form of administered pricing, as in the MA program.
15 The use of competitive bidding would likely give
16 policymakers more accurate information about the relative
17 price of fee-for-service and managed care plans, and thus
18 result in beneficiary premiums that better identify the
19 lower-cost plans in an area, particularly if the fee-for-
20 service program is treated as a competing plan. One way to
21 use competitive bidding would be to compare the fee-for-
22 service bid to a representative measure of the managed care

1 bids in a market area, such as the median or average bid,
2 and use the lower of the two as the benchmark. This method
3 would reduce Medicare spending by basing the amount it pays
4 for coverage on the lower-cost delivery system in each
5 area.
6 As I noted a minute ago, the benchmark in a
7 premium support system would be used to determine how much
8 Medicare pays for coverage and how much beneficiaries pay
9 in premiums. This would be done by splitting the benchmark
10 into two pieces: a base premium and the Medicare
11 contribution. Once the Medicare contribution had been
12 established, it would be the same for every plan in an
13 area, including the fee-for-service program. The premium
14 for a plan would then equal the base premium, plus any
15 difference between the plan's bid and the benchmark. Plans
16 that bid below the benchmark would have premiums that are
17 lower than the base premium, while plans that bid above the
18 benchmark would have premiums that are higher than the base
19 premium.
20 Policymakers could set the base premium using one
21 of two basic approaches. They could have the base premium
22 equal a standard dollar amount that would apply throughout

1 the country, like the Part B premium. Alternatively, the
2 base premium could equal a standard percentage of the
3 benchmark. For example, in Part D, the base premium equals
4 25.5 percent of the national average bid.
5 One area of controversy in the debate over
6 premium support has been the issue of limiting the annual
7 growth of the Medicare contribution as a way to reduce
8 program spending. Some premium support proposals would
9 limit the annual growth based on a formula that is usually
10 linked in some fashion to the overall growth of the U.S.
11 economy, which historically has grown more slowly than
12 Medicare spending. If this trend continued under premium
13 support, the Medicare contribution would grow more slowly
14 than the benchmark, and the difference would be made up by
15 higher base premiums.
16 I'm now going to walk through two examples that
17 illustrate how the bidding process under premium support
18 could work. But before I do, I'd like to briefly review
19 the key steps in the bidding process.
20 Step 1 is determining the benchmark. In the
21 following examples, we assume that the benchmark would be
22 set at the lower of the fee-for-service bid or the median

1 bid from a managed care plan, but this is a policy choice.
2 Under this approach, the benchmark in some areas would
3 equal the fee-for-service bid, and in other areas would
4 equal the median plan bid.
5 Step 2 is determining the base premium. In these
6 examples, we assume that there would be a standard base
7 premium of $125 in every area, similar to the current Part
8 B premium, but this is also a policy choice.
9 Then in Step 3, you would subtract the base
10 premium from the benchmark to determine the Medicare
11 contribution. As I mentioned earlier, the Medicare
12 contribution would be the same for every plan in an area.
13 Finally, in Step 4, you add the base premium and
14 the difference between the plan's bid and the benchmark to
15 determine the premium for each plan.
16 In the first example on Slide 8, there are a
17 total of six bids in an area: the fee-for-service bid,
18 which is the column on the left, and five bids from managed
19 care plans, which are the columns on the right. The bids
20 from the managed care plans are sorted from the low bid,
21 which is Plan A at $680, to the high bid, which is Plan E
22 at $800. Each bid shows the cost of providing a standard

1 package of Medicare benefits to a beneficiary of average
2 health, which allows bids to be compared on an apples-to-
3 apples basis.
4 This example shows how premiums would be
5 determined in an area where the fee-for-service bid is
6 $700, which is a relatively low amount. CMS would
7 determine the benchmark by comparing the fee-for-service
8 bid to the median plan bid of $740 from Plan C. Since the
9 fee-for-service bid is lower, the benchmark in this area
10 would be $700. The standard base premium of $125 would
11 then be subtracted from the benchmark, resulting in a
12 Medicare contribution of $575 for every plan in the area.
13 This is the gray portion of each column.
14 The beneficiary premiums for each plan are shown
15 in green. Since the fee-for-service bid equals the
16 benchmark, the premium for fee-for-service coverage in this
17 area equals the base premium of $125. The bid for Plan A
18 is $20 lower than the benchmark, so its premium would be
19 $20 lower than the base premium. Since the bids for Plans
20 B through E are higher than the benchmark, their premiums
21 would be higher than the base premium and would range from
22 $135 to $225 per month. So beneficiaries in Plan E would

1 face a premium that is $100 higher than the premium for the
2 benchmark plan in the area. They could choose to either
3 stay in the plan and pay the higher premium or switch to a
4 lower-cost plan.
5 The second example shows how premiums would be
6 determined in an area where the managed care bids are the
7 same as in the first example, but the fee-for-service bid
8 is $800 per month instead of $700. Since the fee-for-
9 service bid is higher than the median plan bid of $740 from
10 Plan C, the benchmark in this area would equal the median
11 plan bid of $740. The base premium would still be the
12 standard amount of $125, but it would now buy coverage from
13 Plan C instead of fee-for-service. The Medicare
14 contribution for every plan in this area would be $615,
15 which is the difference between the benchmark of $740 and
16 the base premium. The bids from Plan A and Plan B are
17 lower than the benchmark, so their premiums would be lower
18 than the base premium. The bids for the fee-for-service
19 program, Plan D, and Plan E are all higher than the
20 benchmark, so their premiums would be higher than the base
21 premium. In this area, beneficiaries in fee-for-service
22 and Plan E would face premiums that are $60 higher than the

1 benchmark plan in their area. As in the first example,
2 they could choose to either stay in the plan and pay the
3 higher premium or switch to a lower-cost plan.
4 Turning now to Slide 10, it is well known that
5 Medicare spending varies significantly across the country
6 due to regional differences in payment rates,
7 beneficiaries' health status, and service use. The
8 Commission has found that variation in service use accounts
9 for about half of the overall variation in spending. Some
10 variation in spending remains even after spending has been
11 risk-adjusted to account for geographic differences in
12 beneficiaries' health, and much of this remaining variation
13 appears to reflect regional differences in physician
14 practice patterns. In a premium support environment,
15 policymakers would need to decide who should pay for this
16 remaining variation. When this issue has been raised in
17 previous presentations, the discussion among the
18 Commissioners suggested that beneficiaries living in high-
19 cost areas should not be expected to pay for this remaining
20 variation because there is little that they can do to
21 control it. Two components of the bidding process would be
22 particularly important in this regard: the bidding areas

1 that would be used and the method for calculating the base
2 premium.
3 This slide uses three simplified examples to
4 illustrate why the bidding areas and the method used to set
5 the base premium would be important. In these examples,
6 Area 1 has average per capita spending of $850 per month,
7 and Area 2 has average spending of $1,000 per month. The
8 same number of beneficiaries live in each area, so average
9 spending for the entire country just equals the average of
10 the two regional figures, or $925.
11 These three examples show base premiums and
12 Medicare payments under three different bidding processes.
13 Note that the sum of the premiums and the sum of the
14 Medicare payments are the same in each example. The only
15 thing that changes is how premiums and Medicare payments
16 are allocated between the two areas.
17 The first and second examples show the impact of
18 using local bidding areas. In the first example, the
19 benchmark is set nationally at $925. The Medicare
20 contribution equals 86.5 percent of that, or $800, and is
21 the same in both areas.
22 The base premium equals the difference between

1 the average cost in each area and the Medicare payment. As
2 a result, beneficiaries in Area 1 pay $50, and those in
3 Area 2 pay $200. Under this approach, much of the cost of
4 the additional spending in the high-cost area is borne by
5 the beneficiaries who live there, in the form of higher
6 base premiums.
7 In the second example, the Medicare contribution
8 still equals 86.5 percent of the benchmark, but there are
9 now separate benchmarks for each area. Compared to the
10 first example, the Medicare contribution in the high-cost
11 area is higher and the base premium is lower. For the low-
12 cost area, the reverse is true. The use of local bidding
13 areas, thus, shifts more of the Medicare spending to high-
14 cost areas.
15 The second and third examples show the impact of
16 setting the base premium as a standard percentage versus a
17 standard dollar amount.
18 In the second example, the base premium equals
19 13.5 percent of the area's benchmark, while in the third
20 example, it equals $125 in both areas. If the base premium
21 equals a standard dollar amount, premiums in the high-cost
22 area are lower than they would be if the base premium

1 equals a standard percentage of the benchmark. The reverse
2 is true in the low-cost area. The use of a standard base
3 premium, thus, also shifts more of the Medicare spending to
4 high-cost areas.
5 Moving now to Slide 12, the illustrative examples
6 that I discussed earlier would give beneficiaries an
7 incentive to enroll in the lower-cost delivery model. That
8 incentive would be provided through beneficiary premiums
9 that vary based on the relative costs of fee-for-service
10 and the median plan bid in each market, although I would
11 like to reiterate that those are policy choices. As a
12 result, the extent to which those two figures differ would
13 be a key factor in determining how much premiums might
14 increase or decrease.
15 This slide shows the distribution of the
16 difference between fee-for-service spending and the median
17 MA bid for 2016. The values on the horizontal axis show
18 local average fee-for-service spending minus the median MA
19 bid in each market. As you can see, there are areas where
20 MA is more expensive and areas where fee-for-service is
21 more expensive.
22 The two biggest columns in the slide indicate

1 that about 45 percent of beneficiaries live in areas where
2 local average fee-for-service spending and the median MA
3 plan bid are within $50 of each other. Under our
4 illustrative examples, the change in premiums for these
5 beneficiaries would be relatively small.
6 On the other hand, about a third of beneficiaries
7 live in areas where local average fee-for-service spending
8 and the median MA plan bid differ by $100 or more. Most of
9 these beneficiaries live in areas where fee-for-service is
10 much more expensive than MA. That's the right-hand tail of
11 the distribution. But there are also some beneficiaries
12 who live in areas where MA is much more expensive than fee-
13 for-service. That's the left-hand tail of the
14 distribution.
15 Tables 4 and 5 in the mailing materials list the
16 biggest markets where MA and fee-for-service premiums would
17 see significant increases, if benchmarks were set at the
18 lower of fee-for-service costs or the median plan bid.
19 Given the magnitude of the potential increase in
20 premiums in some areas, many of you have expressed interest
21 in exploring how policymakers could mitigate the impact of
22 large increases on beneficiaries. We will turn to that

1 now.

2 There are a number of ways that policymakers
3 could mitigate the impact of higher premiums, and this
4 slide lays out just some of the options. As we go through
5 these, keep in mind that premium support is meant to give
6 beneficiaries a financial incentive to use a more efficient
7 delivery model for receiving their Medicare benefits, and
8 that beneficiaries could avoid paying higher premiums by
9 switching to a lower-cost plan. Mitigating the impact of
10 higher premiums would reduce the effectiveness of that
11 incentive.

12 First, the higher premiums under the new system
13 could be phased in over time, which would give
14 beneficiaries and plans time to adjust. During the
15 transition period, premiums could be a weighted average of
16 the amount calculated under the old system and the amount
17 calculated under the new system, with the weight for the
18 new system rising over time.

19 Second, policymakers could limit how much
20 premiums increase from year to year, using either a dollar
21 or percentage limit. Under this approach, the transition
22 to the new system would take longer in areas where the

1 difference between fee-for-service and the median plan bid
2 is larger.
3 Third, in areas where fee-for-service premiums
4 rose significantly, new Medicare beneficiaries who are now
5 enrolled automatically in fee-for-service could be enrolled
6 instead in lower-cost managed care plans.
7 Fourth, policymakers could provide subsidies that
8 would pay some or all of the premium for low-income
9 beneficiaries. As part of this, policymakers would need to
10 decide which beneficiaries would be eligible for a subsidy,
11 what kind of subsidy they would receive, and how the
12 subsidies would be financed by the federal government and
13 the States.
14 This next slide demonstrates how different
15 approaches could be used to mitigate premium increases.
16 The figures here are based on an analysis of MA plan bids
17 and projected fee-for-service spending for 2016.
18 Like the illustrative examples that we discussed
19 earlier, we assumed that there would be a standard base
20 premium and that the benchmark would equal the lower of the
21 fee-for-service bid or the median plan bid.
22 This time, we used the Chicago area as an example

1 because it is one of the largest markets where the cost of
2 fee-for-service exceeds the median MA plan bid by $100 or
3 more. Given the data that we used for this analysis, the
4 base premium for 2016 would be $106. Here, we roughly
5 project premiums for 2016 through 2021, using growth rates
6 from the latest Medicare Trustees' Report, and assume that
7 the transition to the new system starts in 2017.
8 The green line at the bottom of the graph, marked
9 D, shows fee-for-service premiums under current law. The
10 yellow line at the top, marked A, shows how fee-for-service
11 premiums would increase if Medicare switched immediately in
12 2017 to the new system for calculating premiums.
13 The two lines in between, marked B and C,
14 illustrate two options for mitigating the increase in
15 premiums. Under Option B, the higher premiums are phased
16 in over a five-year period and take full effect in 2021.
17 Under Option C, fee-for-service premiums could not increase
18 by more than $20 annually during the transition to the new
19 system. Given the size of the difference between local
20 average fee-for-service spending and the median MA bid, the
21 transition to the new system would still be under way in
22 2021 and would likely take more than a decade to fully

1 implement.

2 Again, these options are for illustration only,

3 but they demonstrate how policymakers could substantially

4 mitigate the impact of higher premiums under a premium

5 support-type model. Obviously, though, mitigating premium

6 increases would also weaken the impact of using premium

7 support.

8 Moving now to the last slide, I'd like to close

9 with some potential topics for discussion. From our

10 earlier presentations on premium support, the discussion

11 among Commissioners has suggested that there are arguments

12 for setting benchmarks and beneficiary premiums using a

13 method that has five key elements: one, treat the fee-for-

14 service program as a competing plan; two, use competitive

15 bidding to set benchmarks; three, use local health care

16 markets as bidding areas; four, set the benchmark in each

17 area at the lower of fee-for-service or managed care; and

18 five, use a standard dollar amount as the base premium.

19 We would like to hear your views on these

20 elements, keeping in mind that the chapter on premium

21 support that we are planning to include in the June 2017

22 report will not contain any recommendations.

1 In addition, we would also like to hear your
2 views on whether, how, and to what extent policymakers
3 should mitigate the higher premiums that some beneficiaries
4 would face under premium support, given that it is designed
5 to encourage beneficiaries to use lower-cost ways of
6 receiving their Medicare benefits.
7 That concludes my presentation. I will now be
8 happy to take your questions.
9 DR. CROSSON: Thank you, Eric. Nice, clear
10 presentation of a very complicated area.
11 So we're going to do clarifying questions. I see
12 Kathy, Paul, Bruce, Jack -- Kathy, Paul, Jack, Amy, Bruce.
13 Kathy?
14 MS. BUTO: Thanks, Eric. This was very clear on
15 a very complex issue.
16 My question is about those areas where we found
17 fee-for-service spending is high and the MA -- I guess the
18 median MA plan cost is relatively low in comparison. Did
19 you take into account in thinking about the out-years the
20 issue of managed care penetration? In other words, fee-
21 for-service spending might be high, but let's say 80
22 percent or 95 percent of the population is in fee-for-

1 service. So, if you then use the median cost plan, MA
2 plan, as kind of your benchmark, you're really basing it on
3 a fairly small number of beneficiaries compared to the
4 total. I didn't know if you took any of that into account.
5 MR. ROLLINS: For the purpose of this example,
6 no. It was just here's what the premium would look like.
7 MS. BUTO: So is that something we should look
8 at? Because it strikes me that we base the benchmark on
9 the lowest cost or the median low-cost plan or whether it's
10 fee-for-service or MA, but most beneficiaries in the area
11 or in the other were really then going to create some real
12 dislocation. And you can mitigate that, but I'm just
13 wondering if it's something we ought to look at.
14 MR. ROLLINS: I think that's collectively your
15 decision and something you're going to have to grapple
16 with. You can make the argument that to the extent that
17 you want to encourage or provide an incentive for people to
18 go to managed care plans, do you want to have some -- are
19 there some hurdles that need to be cleared before you can
20 say the managed care plans in this area are well
21 established and they have the capacity to serve a much
22 larger number of beneficiaries?

1 There have been proposals from other
2 organizations where premium support would only sort of kick
3 in once managed care penetration in a particular area had
4 hit a certain threshold. That's an option you could
5 consider.
6 DR. MILLER: I hate to do these kinds of
7 conversations on the fly, but the other way, does some of
8 that get mitigated if you go to more of a straight average
9 of the premiums between fee-for-service and MA instead of
10 taking a lower of? Is that another way?
11 MR. ROLLINS: You could do that because, if you
12 did an overall weighted average across fee-for-service and
13 managed care, those benchmarks would generally be higher
14 than the example I was walking through in this
15 presentation, so that the impact on premiums would be
16 smaller.
17 DR. MILLER: [Speaking off microphone.]
18 DR. CROSSON: Okay. I have Pat, Paul, Jack, and
19 Bruce.
20 MS. WANG: You may have had this -- I have a for
21 example questions. Is it okay if I just rattle them out?
22 MR. ROLLINS: Can I take them one at a time?

1 MS. WANG: One at a time. Okay.
2 [Laughter.]
3 MS. WANG: It's probably in the paper, but can
4 you remind -- there are a lot of beneficiaries who only
5 purchase Part A and who don't pay any Part B premium today.
6 Does the premium support analysis assume that everybody
7 will have A and B? Because for somebody, obviously, who is
8 only A today and is paying no premium, this would be a big
9 change, much less like what the premium would be.
10 MR. ROLLINS: The analyses that are in the paper
11 are sort of agnostic on that question. That's definitely
12 an issue that policymakers would need to grapple with is
13 are we still going to allow people to be Part A only or to
14 be Part B only, or would this be sort of a new model where
15 sort of if you're in Medicare, you're getting A and B.
16 MS. WANG: Yeah. Okay. That's something to --
17 DR. MILLER: That's a really good question
18 because it really does force that issue.
19 MS. WANG: Yeah, yeah.
20 MR. ROLLINS: And with the baby boomers now, the
21 number of people who are Part A only is going up pretty
22 rapidly.

1 MS. WANG: Right. Partly because the premium for
2 Part B is becoming unaffordable, so some big implications
3 here.
4 When you looked at identifying a median MA bid,
5 is there a consideration around narrow network plans that
6 really do not look comparable to fee-for-service? So, if
7 you're going to make fee-for-service compete against MA
8 plans, should there be consideration about creating a bit
9 of a level playing field about the benefit that somebody is
10 getting? I mean, narrow network products are definitely
11 cheaper, but I think consumers have to be quite educated
12 about what they're buying before they do. And if you set
13 the benchmark premium or Medicare contribution based on the
14 low-cost option, which is driven by something that is a
15 much skinnier network than fee-for-service, is that an
16 unfair competition?
17 MR. ROLLINS: I'm not going to characterize it as
18 fair or unfair.
19 Certainly, I think you would want to have some
20 sort of minimum standards, like they have now in the
21 Medicare Advantage program about network adequacy. That
22 being said, I think an environment like premium support,

1 you're not going to get away from this notion of one way
2 you can deliver the Medicare benefit package in a lower-
3 cost fashion is to use a narrower network or restrictions
4 on which providers beneficiaries can use.
5 MS. WANG: I suppose you could also -- assuming
6 there were enough MA bids, you could drop the lowest and
7 the highest or something like that to maybe try to adjust
8 for something like that?
9 MR. ROLLINS: You could do that, and that's one
10 reason the examples that are in the paper sort of focus on
11 the median bid or the average bid and sort of not putting
12 too much weight on the bid from sort of one end of the
13 distribution of the managed care sector, sort of taking the
14 middle of the distribution.
15 MS. WANG: Now, this also --
16 DR. GINSBURG: Can I ask a follow-up on that
17 question?
18 DR. CROSSON: Okay. Pat, Paul would like to make
19 a point on that point; is that all right?
20 MS. WANG: Of course. Sure.
21 DR. CROSSON: Go ahead.
22 DR. MILLER: That's the one that Warner is

1 supposed to have.

2 [Laughter.]

3 MS. WANG: Turn your mic off, Jay.

4 DR. GINSBURG: Okay. Just on the narrow network

5 plans, I don't think that we will see in Medicare Advantage

6 anything to the degree that we're seeing narrow network

7 plans and marketplace plans because of the fact that, for

8 various reasons that we don't have to go through now, what

9 Medicare Advantage plans pay hospitals and physicians are

10 very similar to Medicare rates. So, in a sense, there's

11 not the usual, let's say, privately insured reason for

12 having a narrow network to keep your enrollees away from

13 some very high-priced providers and to be able to get --

14 restrict the networks to get lower prices.

15 So I think that to the degree that we're going to

16 see narrower networks in Medicare Advantage, it's probably

17 going to be driven by plan assessments as to which

18 providers are more efficient using some of the tools, like

19 looking at bundled payments -- not using a bundled payment,

20 but assessing cost per episode of care or this physician's

21 rate of -- to what degree do this physician's patients use

22 the emergency room. I think that's what we are more likely

1 to see in Medicare Advantage than we're seeing in the
2 marketplace.
3 DR. CROSSON: Go ahead.
4 MS. WANG: Okay. Can you explain a little bit
5 more about -- so the bids are based on the average, which
6 sort of suggest like a risk score-neutral beneficiary. Is
7 there a risk adjustment in the program after a beneficiary
8 joins and has eight chronic conditions and is polypharmacy
9 and has got all of these needs? How does that run through
10 this kind of model, and what happens to the beneficiary
11 premium in particular?
12 MR. ROLLINS: So risk adjustment would be used in
13 sort of two stages of the process and would very much be a
14 key part of it. The first would be when you are comparing
15 the bids from different plans in a particular area. You
16 would need the average risk score for each plan to then
17 adjust their scores -- use the scores to adjust their bids
18 to reflect a beneficiary of comparable health across all
19 the different options.
20 The examples that are in this presentation sort
21 of assume that the bids have already been risk-adjusted, so
22 that it's, as in the MA program, the risk score is 1.0, and

1 so they can kind of be compared sort of apples to apples.
2 So that's sort of the first part.
3 The second part would be, as we do now in the MA
4 program, if you have beneficiaries who said, "I want to
5 enroll in a managed care plan," you would need to risk-
6 adjust the payments that go to the plan to reflect the
7 additional costs that are due to the differences in their
8 health status, so something at least at the outset of the
9 premium support that would be fairly similar to the HCC
10 risk adjustment methodology that we now have.
11 MS. WANG: So the policy decisions around whether
12 the beneficiary contribution is a fixed-dollar amount or
13 some percentage of premium could affect the beneficiary
14 portion if it were a percentage, for example, of a higher
15 per cost?
16 MR. ROLLINS: Under these examples, the premium
17 would not vary based on the differences in your health
18 status.
19 MS. WANG: Okay.
20 MR. ROLLINS: The amount that Medicare pays to
21 your plan would vary based on your health status.
22 MS. WANG: Okay. I got it. Thank you.

1 Inside the study, there was a -- in the
2 description of local areas and local markets, there was a
3 statement based on your analysis that -- I mean, I think
4 you took plans that served at least half of beneficiaries
5 in a local market area, and a lot made the cut. Can you
6 say how many fell off? I mean, the question is about local
7 plans and what the definition of local market areas might
8 do. I think, as we talk about SNP plans and so forth,
9 which would tend to be much smaller -- the bigger the
10 market area, the more we are pushing towards plans of a
11 different model with maybe regional plans, national plans,
12 as opposed to local plans. So I was curious about that.
13 MR. ROLLINS: So a couple of things. The first
14 is you were talking specifically about special needs plans.
15 For the table in the mailing materials that talked about
16 plan availability in each area, we set aside the special
17 needs plans and the employer-sponsored plans because
18 they're not sort of broadly available to the Medicare
19 beneficiaries who live in a particular area. And that's
20 another set of issues that would need to be addressed under
21 premium support as sort of what's the role of those plans
22 under a premium support model.

1 In terms of, I think, the first part of your
2 question, how many plans did we exclude because they only
3 served a portion of the service area, I don't have that
4 sort of at my fingertips. It's knowable. My recollection
5 is it didn't make a huge impact. But as I said, we can
6 look into that.
7 MS. WANG: Thank you.
8 DR. CROSSON: Okay. Just to clarify, I've got
9 Paul, Jack, Bruce, and Bill Gradison just for clarifying
10 questions.
11 DR. GINSBURG: Yes, I wanted to clarify the role
12 of policy recommendations in the chapter in June. I mean,
13 it's clear that we are not going to recommend for or
14 against premium supports, but as we go through these
15 issues, are we going to take the stance, well, if Congress
16 decides to do premium support, it would be better if they
17 treated the fee-for-service program like a competing plan,
18 et cetera?
19 So are we just going to run through -- analyze
20 these issues, not come to a conclusion, but just have
21 Congress benefit from our analysis?
22 DR. CROSSON: Sometimes we throw the term

1 "recommendations" around loosely, but for the most part,
2 when we make a recommendation, we vote up or down, and it's
3 in bold type and it's delivered specifically to someone,
4 usually the Secretary or Congress. We are not doing that.
5 DR. MILLER: That's right, and so the way I think
6 about is what we've tried to do in these conversations is
7 capture the drift where people tended to think about
8 things. And something that Jay said at the outset or
9 earlier, if I'm remembering right, is the Commissioners
10 tended to be concerned about, you know -- think of the
11 consolidation conversation we had this morning -- runaway
12 prices, and so that kind of drove them into the fee-for-
13 service should be part of the mix argument. And then a lot
14 of the other design issues were about how much risk does
15 the beneficiary bear relative to the program, and that
16 drove a lot of the other decisions.
17 So what I was thinking -- and, you know, this is
18 to be worked out -- is there's no recommendation, but the
19 writing in the chapter would be you could do this different
20 ways, but there are strong sets of arguments for doing it
21 this way. And so that, you know, the astute reader, and
22 perhaps even the less astute reader, should be able --

1 [Laughter.]

2 DR. MILLER: -- to track through and go, "I think
3 these people would go over here first." And my thinking on
4 this is we really recognize, I swear to God, that this is
5 really complex, and that we've talked about quality last --
6 you know, whenever we did a couple meetings ago, and now
7 we're talking benchmarks. We're going to talk about
8 standardized benefits. And we know this is complex. And
9 to ask for a set of votes on things that really are like
10 this, I'm thinking the writing is really this drift kind of
11 feel to it. And that's not a very good word, but that's
12 how I was thinking about it.

13 DR. GINSBURG: That sounds like a very good
14 approach to me. I just wanted us to be clear that we will
15 be sharing opinions about, you know, there are a lot of
16 reasons for going this particular way, and we won't vote on
17 it.

18 DR. MILLER: That's my view at the moment, unless
19 somebody goes in a different direction.

20 DR. CROSSON: On this point, Alice? Go ahead.

21 DR. COOMBS: I had a question about that, and I
22 don't know if I'm getting into Round 2. I don't think so.

1 But would there be -- as I read the chapter, a constant
2 theme was is there a role for us to be issuing some kind of
3 element of prognostication in terms of how well it would
4 work and which setting we would be concerned about certain
5 barriers for this to be a successful plan.
6 That kind of information for Congress would be
7 valuable in terms of how this thing would grow legs and
8 walk out the door and work. And so that kept being a
9 recurring theme for me, is how likely is this to work in
10 all sectors of Medicare with all of the contingencies that
11 we're dealing with today. And maybe the next round we can
12 kind of talk about that.
13 DR. CROSSON: So I might say in part, yes, to the
14 extent that these design discussions are focused in on, you
15 know, if you do it this way, you get a better competitive
16 dynamic than if you do it some other way. Now, that
17 presumably leads to long-term success as opposed to
18 failure, but it's certainly not the only other -- not the
19 only element.
20 The second element is to what degree does this
21 take into consideration and serve to protect beneficiaries,
22 you know, and I guess to line that up with long-term

1 success, we'd have to be something, you know, approaching a
2 political public policy issue as opposed to a financial or
3 operational set of parameters.
4 But I don't think -- and please correct me -- I
5 don't think we have the intention to have a discussion with
6 takes the whole range of issues, financial and, you know,
7 delivery system organization and payment methodology and
8 all the things that would potentially lead to this model
9 working. Some of these we've discussed in other papers and
10 other chapters and at different times. But this work is
11 not meant to be comprehensive in that way. Is that fair?
12 Okay. So we go to Jack.
13 DR. HOADLEY: So one comment that sort of picks
14 up on a couple of the previous questions talking about the
15 use of medians and averages, I mean, I think we should
16 think a lot about where it should be a weighted average
17 versus an unweighted average. In Part D, there was the
18 experience that some of the parameters were initially
19 implemented -- obviously, in the first year they had to be
20 unweighted because there was no enrollment weight. But
21 even after the first year, there was some use of unweighted
22 average that ended up having some unintended consequences.

1 And at least in the Part D bidding, you know, the
2 unweighted average can be a quarter to a third higher than
3 a weighted average. So I think that is one other variant
4 on parameters we should keep in mind.
5 My question is a little different. I think I've
6 asked a version of this question before, but it was sort of
7 triggered again by Slide 12 and the distribution of sort of
8 where current day bids. And, obviously, all of this is
9 using current situations to illustrate what might happen.
10 But the question really is: Have we thought about how the
11 bidding dynamics really change under a different set of
12 rules? So these are bids that come in under a system that
13 has fixed benchmarks that plans bid to, and they know --
14 you know, they're higher in some low fee-for-service areas,
15 they're low or they're intended to sort of bring -- you
16 know, have a certain effect. And if you change the bid to
17 this kind of a more open bidding system, I don't know if
18 there's a bidding literature or something we can go to to
19 say, you know, what would -- how different might we expect
20 so we're not sort of setting up this expectation that this
21 really does reflect what the world might look like, even
22 though we write lots of caveats and say this is only what

1 we -- it's obviously the right starting place, but it does
2 seem like some discussion of sort of where the bidding
3 dynamics could operate differently would be helpful to sort
4 of think this through.

5 MR. ROLLINS: In terms of the literature, the one
6 thing I can think of is -- I think it was about three years
7 ago, CBO put out a study on premium support and sort of how
8 they thought it might work. And they looked at two
9 scenarios. One used a weighted average of all -- of fee-
10 for-service and all the plan bids, and the other used, I
11 think, the lower of fee-for-service or the second lowest
12 bid. And their assessment for both of those was that, you
13 know, given that you're creating a system where there's
14 more competition on price than you have now, the plans
15 would tend to change their behavior and would bid slightly
16 lower than they do now.

17 That being said, the magnitude of the change in
18 the bid was, I think, 3 or 4 percent, so they didn't -- you
19 know, they thought directionally they would probably go
20 down, but they weren't willing to say that the bids would
21 necessarily change a lot. But that is, as you note, one of
22 the great sort of unanswered questions about how this would

1 work.

2 DR. HOADLEY: My gut -- I don't know any -- you

3 know, I'm not an economist, and I'm not an expert on

4 bidding, but my gut says that if you go from the benchmarks

5 that are, you know, 95 percent of fee-for-service or 110

6 percent or whatever and you've got something that says,

7 well, fee-for-service is just going to be in the mix, that

8 you could potentially see quite different bidding, and it

9 wouldn't always be lower. It could be higher in areas. It

10 just seems like it mixes things up a lot. And if there's

11 any way to get somebody who really knows this area to, you

12 know, help inform us on sort of what changes you might

13 expect under some of the scenarios we're envisioning, it

14 seems like that would be helpful.

15 MR. PYENSON: Just to pick up on Jack's point, I

16 think an analogy, a historical analogy might be to see

17 what's happened in Part D bids where the dynamics there are

18 heavily driven by organizations going for the low-income

19 subsidy market. But I believe some of the studies probably

20 from CMS have identified the role of the risk corridors in

21 letting plans bid lower than they otherwise would have.

22 And that might be a feature of risk corridors that -- I

1 don't know if you've examined that as a transitional
2 element or permanent element for stability?
3 MR. ROLLINS: It's not something that we've
4 looked at in great detail given that the Medicare Advantage
5 program seems to have operated fairly well for many years
6 now without using them. But as you note, that would be one
7 option that could, in theory, give plans a little more
8 leeway to bid more aggressively. How much, I do not know.
9 MR. PYENSON: Just a couple of other questions.
10 I believe the paper identified advantages of looking at
11 regional -- bids on a regional basis compared to a county
12 basis.
13 MR. ROLLINS: So based on some work we did a few
14 years ago looking at the Medicare Advantage program, we did
15 make a recommendation to use areas that are larger than the
16 county-based areas that we now have in Medicare Advantage.
17 That being said, these would be regions that are
18 still very much regions and not getting up to the level of
19 state or something like that, which you have in Part D. In
20 urban areas, this would be sort of within the same MSA and
21 within the same state. That would be a region sort of as
22 you used the term. I think in the paper we used "market

1 area." And then for rural parts of a state that are not
2 part of an MSA, they'd be part of a -- I'm forgetting the
3 term. "Health service area," I think.
4 DR. MILLER: Yeah, it's basically the commuting
5 pattern [off microphone].
6 MR. PYENSON: HRR kind of concept.
7 DR. MILLER: [off microphone].
8 [Laughter.]
9 MR. PYENSON: I thought it was a MedPAC area,
10 MedPAC unit. But just a consideration on there. Provider-
11 sponsored organizations are often more local than that, so
12 finding a way to think about the impact on provider-
13 sponsored organizations, I wonder if you could do that.
14 Another question gets at Jack's question,
15 perhaps, and, you know, we've seen, as you know, in the
16 history of insurance, there always seems to be insurance
17 companies that forget and decide they're going to buy
18 market and make it up in the next year. And it never works
19 out well for them or for their competitors.
20 Now, there's a limited ability to do that under
21 the current bids for established plans, but I think that
22 gets at perhaps a nuance in is it the bid or some bid

1 adjusted for a standardized profitability or standard --
2 you know, that is if a plan is bidding at a loss and they
3 have a low bid because of that, that might not be an
4 appropriate contributor to the benchmark. So I'm wondering
5 if you've got -- if that's worth getting into that kind of
6 detail.
7 MR. ROLLINS: Obviously, that's something that we
8 can discuss. My off-the-top-of-my head reaction is that
9 might be a little sort of down in the weeds and sort of
10 more kind of a CMS area. I don't know, you know, to what
11 extent that's part of their existing bid review process.
12 We did sort of have that possibility in the back
13 of our minds, again, when we were setting the benchmarks
14 that we wanted to use maybe the median bid, which more
15 technically in our example was a weighted median bid,
16 weighted by the actual enrollment or enrollment-weighted
17 average, to give more credence to the plans that are
18 actually operating in the area and actually have enrollment
19 and guard against, you know, sort of a new plan sort of
20 coming into the area and pricing really aggressively
21 without any real proof that they can make it work.
22 MR. GRADISON: Currently, about two-thirds of

1 Medicare beneficiaries are using fee-for-service. Do you
2 have any idea what percentage of those at the current
3 moment in the framework that we're discussing would be
4 required to pay more than the median MA benchmark? Or
5 could you compute that? What I'm driving at, I might as
6 well just wrap it up because I don't know if it's a Round 1
7 or Round 2. I'm trying to think through, if this is going
8 to save money overall, how much subsidy may be required to
9 make this package attractive if there are really
10 significant increases, maybe any increases at all, for
11 people who say that they want to retain the fee-for-service
12 option. And so I'm just trying to figure out how to get to
13 some numbers that would permit me to get a proportion, a
14 sense of that -- it'll change over time, but working with
15 the numbers that we have now with regard to beneficiaries
16 and they actually have the fee-for-service numbers, and you
17 have the -- presumably could get -- I'm not saying it's
18 easy, but could get an MA benchmark figure based upon what
19 we know today. So that's really my question, whether you
20 could do some work on that that we might circle back to it
21 another time.
22 I don't know. I don't mean to be pouring cold

1 water on this, but politically, I just don't see how you
2 get -- how are you going to get somebody from Miami,
3 Florida, to vote for this thing if it's any increase at
4 all? I mean, that's a rhetorical question, but it's worth
5 thinking about.
6 DR. MILLER: Well, there's a couple things. The
7 last thing is a rhetorical question, and, you know, we'll
8 go through the plan and the design issues and, you know,
9 this is something that you know Congress periodically comes
10 back and actively discusses, and the mechanics of them
11 getting the votes are their problem. So, you know, I just
12 want to make sure -- and I know you said it was a
13 rhetorical question for all those reasons. I just want to
14 reinforce it with them -- with everybody else.
15 But some of his answer is right here, isn't it?
16 The distribution of who potentially pays and who --
17 MR. ROLLINS: Yes, and then I was also going to
18 point out there's a table in the paper that sort of says if
19 the benchmark was based on -- if you compared fee-for-
20 service to either the low bid, the median bid, or the
21 average bid, sort of which is lower in your particular
22 area? And under all three of those options, at least two-

1 thirds of beneficiaries were living in an area where the
2 managed care, the median bid is lower than fee-for-service.
3 MR. GRADISON: It's two-thirds of two-thirds [off
4 microphone].
5 MR. ROLLINS: Roughly --
6 MR. GRADISON: Total population under Medicare
7 [off microphone].
8 MR. ROLLINS: Very roughly although -- very
9 roughly. But, again, the magnitude of how much your fee-
10 for-service premium would go up would depend on that, sort
11 of what's the gap between fee-for-service costs in your
12 area and the median bid. And as that shows, there's a lot
13 of variation.
14 DR. MILLER: And, Bill, the other point I wanted
15 to make off of your point is it's not just a fee-for-
16 service consideration, because your point -- and mine often
17 starts here, too -- goes right to Miami and you sort of go,
18 well, wait a minute, how is that going to work? But,
19 remember, there's markets in other parts of the country
20 where you're going to have to pay to stay in MA.
21 So, you know, your dynamic of, like, well, who is
22 going to support this actually cuts in both of those

1 directions. You know, like I don't want my fee-for-service
2 constituents to pay more, but in some markets it's going to
3 be, but wait a second, my MA constituents are going to pay
4 more.
5 So there are some real serious dynamics, and I
6 think what this chapter, among other things, is trying to
7 do is lay this out so that people understand what they're
8 actually constructing.
9 DR. CROSSON: Warner.
10 MR. THOMAS: Have we done this similar analysis
11 over a period of time, and do we have any idea what this
12 may look like as we kind of trend the escalation of
13 traditional Medicare costs versus MA?
14 MR. ROLLINS: We have not looked at it over time.
15 I suspect at least over, you know, comparing one year to a
16 year or so and not looking over a long period of time, I
17 suspect this distribution looks roughly similar.
18 MR. THOMAS: So you don't really think that
19 there's a -- any difference in cost control between fee-
20 for-service Medicare and MA?
21 MR. ROLLINS: I will welcome input from any of my
22 colleagues. I'm not under the impression that over the

1 long term, per capita cost growth would be different in
2 Medicare Advantage than it would be in fee-for-service.
3 The shift in Medicare Advantage, you might get some
4 transitional changes in utilization and things like that
5 through better management and things like that. It's very
6 unclear, over the long term, that sort of the long run cost
7 growth is different in a managed care setting than in fee-
8 for-service.
9 There are some who argue, under premium support,
10 that if enough people were in managed care they might
11 collectively insert more control over that, but that is
12 obviously somewhat speculative.
13 DR. MILLER: Yeah, and I was also going to draw
14 the distinction between, you know, what you can do with
15 static data and say, well, if you could try and straight-
16 line project -- you know, do some straight-line projection
17 stuff, and I think his point stands. Your point could also
18 be, but wait a minute. Doesn't the dynamic change
19 significantly under a bidding structure like that -- which
20 is Jack's point -- and that is very hard for us to estimate
21 because there's not a lot of experience with this.
22 But the other thing I think I would say is Eric,

1 the CBO report that you referred to a few minutes back,
2 they did make some assumption about how much they thought
3 they would get out of this, and my recollection, which is
4 very consistent with your answer, is they got a few points
5 but they didn't necessarily get a different trajectory of
6 time, was sort of what I took away from it, which is a
7 relatively aggressive group of folks who took a look at
8 this and know things like this.
9 MR. ROLLINS: [Inaudible.]
10 DR. CROSSON: Okay. I think we are ready for the
11 general discussion. Let's see if we can throw up Slide 15.
12 It's going to be the basis for the discussion.
13 So, you know, I think comments can go where they
14 go, but I particularly want to know if we have
15 Commissioners who disagree with one of those five bullets,
16 because otherwise the assumption is since this direction or
17 these design elements have been kind of accrued over a
18 period of time, that there's a general belief that these
19 are the right ones, for the purposes that we're engaged in.
20 So we've got Paul and Jack who are going to
21 start. Paul, we'll start with you.
22 DR. GINSBURG: Oh, great. I think the materials,

1 the presentation, Eric, were really excellent, not only
2 clear but very sophisticated in their understanding of
3 these issues.
4 I'm very interested in premium support. I've
5 worked on it in the past. My sense is that the issue
6 stopped being debated in Congress after the 2012
7 presidential campaign. In the jargon, it became toxic. I
8 think premium support will be an important issue in the
9 future, and I think it's really terrific that the
10 Commission is having these discussions so that Congress
11 will be much better prepared when the political winds shift
12 and premium support is no longer toxic and something
13 they're eager to support -- to consider.
14 I'm comfortable with all five of the points, the
15 elements. I have comments on a couple of and I want to
16 propose a sixth element. One is as far as using
17 competitive bidding to set benchmarks. I think it's really
18 important to think along the lines of weighted means in MA,
19 rather than points in the distribution, like the second-
20 lowest, or even the median. And the concern is about areas
21 that have a fairly small number of MA plans, and just the
22 potential for gaming, if we're, you know, really targeting

1 it on one particular point in the distribution.

2 I agree with using local markets as bidding

3 areas, and the materials that were sent ahead I think

4 suggested that it should be an entire local market that's

5 the bidding area. And I just want to point out that

6 particularly as we're making the local areas larger than

7 counties, that there probably will be many considerations

8 where provider-sponsored plans, or plans that are

9 partnerships between a provider organization and an

10 insurer, may have difficulty really covering the entire

11 area.

12 I also could see reading it, how much more

13 complicated it gets when you have entities bidding for only

14 part of the local market area. So it may be that it's just

15 too complicated to do that. That's just something to

16 target.

17 And the additional elements I want to bring up is

18 that, you know, I think one thing that was an unwise

19 addition to many of the premium support proposals we saw a

20 few years ago was another element, which was -- let's call

21 it a cap, you know, that the benchmark can increase more

22 than the CPI or GDP+1 or some other index. I believe in

1 having -- you know, certainly there is a mechanism in
2 premium support that's really harnessing beneficiary
3 choice, it's harnessing plans behaving differently as their
4 MA market becomes more competitive, and I think that's
5 where the savings should come from.
6 I think if you put in artificial limits you
7 enormously increase the uncertainty of what this means to
8 the public. In a sense, does this mean that Medicare will
9 no longer -- Medicare support will no longer rise in
10 proportion to health spending? You know, is there this
11 possibility that it will rise less than health spending and
12 I will be responsible for an increasing proportion of
13 health spending over time?
14 You could set up a premium support without that.
15 If the savings were disappointing, Congress could always
16 come back to a cap. But I think building premium support
17 with a cap, which is usually motivated to get a bigger
18 score from CBO, is really a mistake. And, you know, we're
19 racking up increasing examples that when Congress puts in
20 unrealistic targets like SGR, and, you know, has a hell of
21 a time undoing the mess it's gotten itself into.
22 DR. CROSSON: Thank you. Jack.

1 DR. HOADLEY: So I want to go back to sort of the
2 fundamental question here of whether we think that
3 beneficiary choice can drive efficiency, which is sort of
4 what's really framed this discussion. And to the extent
5 that I answer the question no, I think -- you know, I come
6 back to the question of why risk some of the disruptions
7 that this create. And I continue to be very concerned that
8 some of the reasons we think beneficiary choice leads to
9 efficiency just don't hold up. There are challenges for
10 beneficiaries in making decisions about plans, ranging from
11 the inadequate information available.
12 There's an issue this year on Plan Finder, where
13 you can't directly look up the additional benefits that
14 Medicare Advantage plan provides, so there are problems all
15 along with Plan Finder in terms of comparing traditional
16 Medicare to fee-for-service, to looking up network -- you
17 know, whether your providers are on networks. And so
18 that's one part of it, the confusion of trying to sort out
19 choices in a very complex environment.
20 Lack of standardization, I know, we'll come back
21 to that issue in the future. We know, in the Part D world,
22 that beneficiaries do not shop regularly for plans and

1 don't switch enough to influence premiums, and one of the
2 results of that is a lot of gaming of the system from the
3 plan side, and we see companies that, you know, have
4 developed strategies of letting their older plans age and
5 the premiums go up because people don't leave the plans,
6 and then they bring in a new product to attract new
7 enrollment, at a lower premium, and, you know, this works
8 to the detriment of those who are in the old plan.
9 Obviously you can say people ought to switch, but, you
10 know, we make it hard for people to do that by some of the
11 things I just mentioned.
12 So, you know, these are the kinds of things that
13 really concern me, that, you know, that the system, as it's
14 designed, to try to let beneficiary choice drive efficiency
15 will ultimately not work and we'll get the kinds of
16 disruptions that Bill was point to, without the benefits.
17 You know, I think you go on to talk about issues
18 of sort of -- one of the arguments we made for keeping
19 traditional Medicare in as a competitor, and in a lot of
20 ways I think that's the right thing, but how are we really
21 going to do that in a high-cost area if an area like Miami
22 is going to cost people so much? And if we figure out how

1 to communicate that to people, they'll either end up paying
2 a lot or they'll switch out of it, and if enough people
3 switch out do we lose the anchoring of traditional Medicare
4 that we think is important to sort of maintain the provider
5 rates? And at some point, that notion that MA plans are
6 getting something close to Medicare rates for hospitals and
7 other providers, you know, will go away if there's not
8 enough of a piece in the market.
9 You know, the reverse is true in the low-cost
10 areas. We've gone through, over years, of trying to figure
11 out Congress trying different methods, not all of which,
12 you know, worked out very well. But it tried to figure out
13 how to keep plans in the low-cost areas. Are we
14 comfortable with the idea that if we widen the gap based on
15 current prices and current bidding, whether the MA plans in
16 those low-cost areas will simply go away because it will
17 now cost too much -- the premiums will go up substantially
18 and it will cost too much to do that.
19 So, I mean, those are some of my real concerns
20 about this path we're going down. Some of the more
21 specific things that have come up, in terms of the topics
22 here, you know, I think -- and we've kind of -- maybe we've

1 already talked this one through, but the reliance on the
2 low-cost plans, I think, could be quite risky, and I think
3 the notion of going to some kind, as Paul was saying, an
4 enrollment-weighted average or enrollment-weighted median,
5 you know, is critical, because I think there is the
6 potential to have low-quality plans that bid low.
7 Yeah, I think narrow networks under this new kind
8 of environment could be more of a possibility. I think
9 there are lot of -- I mean, Paul's right, that under the
10 current environment that's unlikely, but I think that
11 potentially changes under these kind of incentives. And so
12 we could see a lot of sort of really not very good plans
13 entering in, and so we need to make sure that they don't
14 get to drive the price.
15 Geographic variation, I think is a big issue. I
16 know in Part D, where you don't have a geographic
17 adjustment, we're seeing people in New Jersey pay double
18 the average premium that they pay in New Mexico, and that's
19 in a world where you don't even expect the kind of
20 geographic variation that you do in other parts of health
21 care. Right now it's a two-to-one difference between New
22 Jersey and New Mexico in the kind of premiums, without that

1 kind of adjustment. Now people are living with that,
2 obviously, but it's kind of a -- it's a real question
3 whether that's the fair thing to do to our beneficiaries.
4 I think on some of the, what you call the
5 mitigation measures, I think, you know, a lot of them are
6 important. But I do think it's important to distinguish
7 between what are -- the way I would use the word
8 mitigation, which is to sort of reduce the effect on
9 somebody, sort of on a permanent basis, as opposed to
10 transitions or things that would delay the impact. And I
11 think we really should be careful to distinguish between
12 things that are transitioning. Transitions are -- we've
13 always said are important with new systems, versus things
14 that -- and some of the examples you have there would be
15 more what I would call mitigation, which is, you know, not
16 having a full effect go in for certain kinds of things.
17 And then picking up on one of the points Paul
18 made, I do think it's very important that we don't end up
19 basing premiums in the Medicare contribution on some kind
20 of an external measure or a cap. I think that is very
21 risky, and Paul said that point well.
22

1 And the last one I'll make -- oh, one more on
2 that, related to the transition, was you mentioned auto-
3 enrollment as an option, and I have real serious concerns
4 about that. I think that, you know, we've seen issues
5 right now with the seamless conversion that exists for
6 people who are new to Medicare, and that CMS has put a
7 temporary stop to that program because of some of the
8 concerns that have been raised.
9 Anyway, my other last point was on whether
10 average fee-for-service spending is really the right way to
11 set a traditional Medicare premium. I look at a lot -- you
12 know, we think about Miami as, again, the poster child for
13 what's out of line, and the question is, what does that
14 higher spending really mean? We've never done a good job
15 of figuring that out.
16 To the extent that it's abuse or fraud or just
17 overuse by certain providers and the patients that see
18 certain providers, you're essentially going to attribute
19 that to everybody who lives in that area, and because, you
20 know, I live in Miami but I'm not going to those providers
21 that have driven the average up, you know, why should I end
22 up paying as a result of what's going on there? And since

1 we don't really see the path to which this changes that
2 behavior on the part of providers, I think we should think
3 hard about sort of whether there are issues in using that
4 as a measure to attribute a fee-for-service premium.
5 So I know that's a long list of things, but
6 they're ones that I wanted to put on the table.
7 DR. CROSSON: So, Jack, I just want to see if you
8 could help me square the circle on your first two comments,
9 because what I thought I heard was, the first comment was
10 beneficiaries are not going to switch. Right? Then the
11 second comment was, but if they do switch, then we have a
12 whole series of potentially untoward --
13 So what I'm thinking you're saying is something
14 like this. Tell me if it's right. Where the price --
15 where the premium -- beneficiary premium differentials are
16 not large, it's not likely to be enough impetus for
17 beneficiaries to switch. On the other hand, where they are
18 large -- Chicago, Miami, for example, are on the other
19 side, on the MA side -- then, perhaps, they would shift but
20 they would shift to such a great degree that we could have
21 some of the problems that you've mentioned.
22 Is that sort of what you're saying?

1 DR. HOADLEY: I mean, in some ways what I'm doing
2 is playing out different potential scenarios. I actually
3 think that the degree of switching would be insufficiently
4 great to sort of have some of the effects that even I'm
5 making in my second point, but, you know, our switching
6 study in Part D said that as the premium differential that
7 you faced from Year 1 to Year 2, you know, as a result of a
8 new open enrollment period, got larger, yeah, eventually
9 people did start to shift.
10 Even then, we looked at -- I can't remember
11 exactly numbers, but like where there was a $20-a-month
12 shift for their Part D benefit, we still saw less than half
13 the people make that kind of shift. But if eventually,
14 over time, you know, if we did some of the things to make
15 it easier for people to make choices -- which is part of
16 the remedy I would give to my first point -- is if we
17 really do want this to work -- and I'm not sure how much I
18 do -- but if we want this to work, if we're going to do it
19 and, therefore, I'm trying to mitigate it, one of the
20 things you would need to do is make it easier for people to
21 make choices. And then, at some point, you'll do that well
22 enough that people will move, and then I'm worried that you

1 get into a different problem.

2

3 DR. CROSSON: As always, please feel free to say

4 what you think.

5 [Laughter.]

6 DR. CHRISTIANSON: [Off microphone.]

7 Paul and Jack both said it. This is a very

8 narrow thing, and it's nothing to take on any of the things

9 that you said. So they have both criticized this indexing

10 approach, you know, tying the federal contribution.

11 Everybody is clear that's not what this direction that

12 we're talking about is going in. You guys are just

13 reinforcing that. Right. Okay.

14 DR. CROSSON: Okay. We are going to have a

15 general discussion. I see a lot of hands.

16 DR. GINSBURG: Can I just say one thing about

17 Miami?

18 DR. CROSSON: Go ahead.

19 DR. GINSBURG: It's -- you know, when Jack

20 brought up Miami, I think the way to characterize Miami,

21 which is such an outlier, is phenomenally expensive fee-

22 for-service, perhaps much of it a result of fraud and

1 abuse, and we have a situation where a lot of the
2 beneficiaries who live in Miami have been able to pursue a
3 bonanza of basically enrolling in a Medicare Advantage
4 plan. These plans seem to be able to avoid some of the
5 forces that make fee-for-service so expensive in Medicare.
6 And it's a bonanza to them because their benchmark is based
7 on the fee-for-service experience. So, you know, we're
8 spending -- that, actually, I don't know if it compounds
9 it, but, you know, Medicare program isn't saving a thing,
10 because Medicare Advantage being important, competitive in
11 Miami, and reducing costs, is really all going to the
12 beneficiaries and the plans.
13 DR. CROSSON: Okay. So we've got a lot of
14 discussion. I'm going to start with Jon, and this time
15 we're going to go this way.
16 DR. CHRISTIANSON: Okay. With respect to the
17 topics for discussion, I think treat the fee-for-service
18 program like a competing plan I think for sure. I don't
19 think the Medicaid program or the taxpayers could stand a
20 15 percent increase in Medicare costs, which is our current
21 estimate of what it would be.
22 Using competitive bidding to set benchmarks,

1 Eric's argument for that is that will kind of reveal what
2 the costs of delivering care are. And I'm in favor of
3 using some sort of competitive bidding if we go down this
4 route, but just based on my own work here in this area,
5 there's four things that have to be in place for you to
6 really come close to figuring out whether the bids, you
7 know, relate to actual costs.
8 One is the design in terms of what's a winning
9 bid, and Paul and Jack have already argued against the
10 design that's used in the treasury bill auction and other
11 places, which is the second lowest bid being the winning
12 bid. That has the strongest incentives to try people to
13 reveal their true costs, and it doesn't sound like we're
14 interested in that.
15 Second, you have to have a lot of bidders, not
16 only actual bidders but potential bidders, for this to
17 happen.
18 Third, you have to be willing to -- or it
19 increases the incentives if you're willing to throw some
20 bids out, they're just too high. Well, we don't see a lot
21 of interest in that. I don't think we're likely to see a
22 lot of interest in, you know, throwing bids out.

1 Then the fourth thing is contract length. We
2 haven't talked about contract length. But is it a one-year
3 contract, or do we really want to have a bidding process
4 like every single year? That's different than the
5 enrollment process. So the length of the bidding process
6 really makes a big effect on how seriously people take the
7 bidding, not wanting to be out of the game for three years,
8 for instance, versus one year.
9 So all of these things play into whether or not
10 you actually get numbers that actually reveal something
11 like the cost of providing care. So the justification is
12 if you're using the bidding process to do that, then I
13 still think it's probably a good idea to some degree. I
14 don't think we want to go into it assume we're going to get
15 too much more than we're actually going to get, given the
16 way we're going to have to end up designing this bidding
17 process. A lot of these things are not going to be part of
18 it.
19 Using local areas as bidding areas, sure, I think
20 we should. Setting the benchmark at the lower of fee-for-
21 service or managed care, yes, some version of that.
22 I'm not sure what I think about the fifth point

1 yet, base premium should be a standard dollar amount.
2 And the last one, you know, this would be the
3 most fundamental change in the Medicare program since it
4 started, basically changing the program from a fixed set of
5 benefits to a dollar amount. That's philosophically a big
6 change. It's fundamentally a big change for the
7 beneficiaries. So we're going to say, yes, we should try
8 to mitigate things, and we should phase it in and all that.
9 The problem is that to make such a big change
10 philosophically, we're probably going to have to be in a
11 period of financial crisis for the Medicare program. And
12 given we're in a period of financial crisis, people want
13 savings right away, and so the notion that you're going to
14 mitigate things by phasing it in over ten years is probably
15 not going to fly in that kind of environment. So I think
16 we should suggest mitigating it, but I think we should be
17 realistic in terms of what we think actually would happen
18 if you implemented a program like this in the real world.
19 So those are just a few thoughts.
20 MS. WANG: Overall, I think this was, you know,
21 great and sort of like very precise and very crisp. I hope
22 that when the final chapter gets written, you know, all of

1 the strands around the quality discussion, et cetera, can
2 be woven together in some way to lay out policy options to
3 design a program like this around value as opposed to --
4 you know, because this was very precise about this is just
5 focused on cost. The other presentation was focused on
6 quality, but value has other aspects to it.
7 As far as the bullet points, treating fee-for-
8 service like a competing plan, yes. Competitive bidding to
9 set benchmarks, fine, but I would be careful because I
10 think that, you know, to Jon's point, you do need multiple
11 bids, and even in some markets now, that you might have a
12 lot of sort of competing MA products. They're actually --
13 because of consolidation on the plan side, the insurance
14 company side, they're all offered by the same carrier.
15 And, you know, it might introduce some skewing in the way a
16 bidding process would operate.
17 To that point, I am very concerned about using
18 like the local market areas that are much bigger than the
19 current county-based system for MA for a couple of reasons.
20 I think that, you know, local plans, provider-sponsored
21 plans probably have a lot of overlap. I think that there
22 are a lot of provider-sponsored plans that are doing the

1 sort of work around integration of the delivery system and
2 insurance mechanisms, value-based payment, population
3 health that are initiatives that are valued and that we
4 want to see promoted.
5 I am worried that if the local market area is
6 defined too broadly, that those plans will not be able to
7 expand and that you then further the difficulty of -- or
8 the first problem about compounding that there's more
9 consolidation and, therefore, less competition, real
10 competition in market areas. So I'd be careful about that.
11 To that point also in terms of setting benchmark
12 at lower fee-for-service or managed care, you know, from a
13 pure cost perspective, I get it. But here, again, in areas
14 where fee-for-service is lower than managed care and fee-
15 for-service is the winning bid, what does that actually
16 leave in the system? Are there ACOs in those environments
17 because the fee-for-service benchmark is so, so low
18 already? And are we sort of locking that in forever? Does
19 that have some sort of ripple effect in terms of some of
20 the other population health initiatives that, you know, we
21 want to see introduced?
22 I just think these are -- I don't know the

1 answers, but I think that these are considerations that
2 need to be highlighted within the context of a premium
3 support model that focuses on value.
4 DR. MILLER: Just a couple of things to say in
5 reaction to that. At least in some of the conversations in
6 the past, the other concern on the side of going to a
7 larger market was a county-based market created too many
8 opportunities to pick and choose who you could avoid, if
9 you will, and that there were certain populations you
10 didn't want to go to, you didn't go to this county. So
11 some people, at least Commissioners in conversations like
12 that, were saying, no, I want you to go and you have to
13 offer in this entire market, which is Part 1 of the reasons
14 that kind of drove us into that direction.
15 And then the other thing on your -- you know, is
16 the ACO in there? I think in this conversation, when we're
17 using the words "fee-for-service," we're assuming the ACO
18 is also in the fee-for-service environment. ACOs would be
19 able to do what they do. It would just be that would be
20 part of the calculation of the fee-for-service bid.
21 MS. WANG: My only point there is that I do think
22 that in some low fee-for-service areas, given the way that

1 ACOs are now constructed, it's hard for them because fee-
2 for-service spending is already so low, and when they get
3 measured against their own performance and their own
4 baseline, it's like, what are they cutting, you know, if
5 they have to continually -- and so in those areas, MA plans
6 can introduce more innovation in terms of care coordination
7 in a different type of delivery system. So, you know, and
8 I realize that there's a cost consideration there, but I
9 just would be concerned about that.
10 As far as the first point, maybe it would be
11 useful to do some research around identifying local plans
12 or identifying provider-sponsored plans and understanding
13 how large their service areas are in defining what would be
14 an ideal market area, because I get your point there. But
15 if they are generally, you know, covering X number of
16 contiguous counties, maybe that can inform the definition
17 of a local market area if we think that it's valuable to
18 keep them in the game.
19 DR. MILLER: Right. I think Bruce was making the
20 same point a couple iterations back.
21 DR. NERENZ: I've just been trying to think
22 through how this plays out over multiple cycles. You know,

1 our examples are essentially what happens in the first
2 year, and I'm just trying to think about how does it play
3 out over and over again, particularly in the situation we
4 have on Slide 9. And I'm wondering if I can just run
5 through that a little bit, if there's a problem either I'm
6 seeing that's not real or if it's real.
7 I'm thinking mainly about a premium spiral sort
8 of effect, mainly on the fee-for-service side. I am making
9 an assumption that the people likely to stay in fee-for-
10 service, when this kind of thing is in place, are probably
11 a little sicker on average because they want to preserve
12 their ability to go to MD Anderson or they want to go to
13 the local academic medical center that's not in the network
14 of Plan C or something like that. So it starts with that.
15 But basically it says in Year 2, Year 3, Year 4,
16 the healthy people are gradually gravitating more than they
17 were at the beginning into the MA plans. The sicker people
18 are staying in fee-for-service. Now, the bids on the MA
19 side are not necessarily going down because, again, these
20 are pegged to the health needs of an average person. But
21 the actual mix of people is getting healthier. But the key
22 -- and that's not necessarily a problem, but on the fee-

1 for-service side, each year that is going up, meaning the
2 premium that we're going to charge people to be there keeps
3 going up, which then keeps multiplying the effect, because
4 eventually only the most desperate people who must, must go
5 to MD Anderson are willing to pay that higher premium. And
6 I just don't know where it ends.
7 So I know this hasn't been part of the
8 discussion, and there's probably a similar kind of multi-
9 cycle dynamic over on the size where fee-for-service is
10 low. I suspect what -- and that it's even harder to figure
11 out, because one scenario I can imagine is eventually the
12 MA plans just go away and there aren't any. And then the
13 fee-for-service bid, so to speak, is just set on the
14 historical experience there.
15 So is there any way to actually model through how
16 this plays out over time and if there's a train crash
17 somewhere down the road?
18 DR. MILLER: I mean, I think what we could bring
19 -- I mean, just to try and always be as direct as possible,
20 on the modeling exercise, no.
21 [Laughter.]
22 DR. MILLER: And I'm being facetious to some

1 extent. This is extremely difficult to do the behavioral
2 stuff because, in addition to what you just said, what does
3 the beneficiary do for economic reasons, what does the
4 beneficiary do for clinical reasons, what's the benefit
5 package that's offered, there's a whole other set of
6 dynamics of does the plan play, does the plan leave, which
7 plans -- that type of stuff. It's extremely complex.
8 But there have been studies and analysis where
9 other people have tried to talk about some of those
10 dynamics, and we can try and capture some of that and bring
11 it into it. But I really can't commit to do the analysis
12 directly because I just don't think there's the
13 wherewithal.
14 The other thing I want to say is the same -- I
15 think, you know, what you're expressing is a real-life
16 concern. In theory, you could be seeing some of that right
17 now in the current environment, right?
18 DR. NERENZ: Yes.
19 DR. MILLER: Because we have an MA plan and all
20 the rest of it. And so, you know, how much of that have we
21 seen? But then, of course, there's what's happening in the
22 exchanges, which -- right. And so, yes, this is decidedly

1 one of the risks when you go into a direction like this.
2 Hopefully risk adjustment tries to capture that, but it's
3 imperfect, and you might have to have mitigation effects on
4 top of that if you wanted to try and control the spiral.
5 But it is decidedly a risk.
6 DR. NERENZ: And if we just say, look, it's just
7 too complicated to model out, that's probably a fair thing.
8 DR. MILLER: [off microphone] bring into this.
9 Maybe there are things we can get from other people's
10 analysis to at least inform your point.
11 DR. NERENZ: But even if we thought that some
12 general trend like the one I described could happen, aside
13 from any real formal modeling, you know, risk adjustment
14 has certain protective effects in the MA side, but there
15 isn't anything like that on the fee-for-service side, and
16 the question is: Well, could any such thing be created and
17 what would it look like? Or is maybe there some kind of a
18 cap phenomenon over on that side?
19 And, again, I don't know what the answer is. My
20 first thought is: Am I just imagining ghosts that don't
21 exist? But maybe the ghosts do exist.
22 MR. ROLLINS: Well, I think in the bidding

1 process we sketched out here, again, reiterating Mark's
2 point that risk adjustment is imperfect, but to the extent
3 that you had a sicker group of beneficiaries who were
4 sticking around in the fee-for-service program, their risk
5 scores would go up over time, and you would be making a
6 bigger adjustment to the fee-for-service bid to try and
7 capture that.
8 Now, again, that may not be perfect, but there
9 would be at least some mechanism there to help do that.
10 DR. NERENZ: Well, but then let me just clarify
11 on that, because that might help. But I thought the bid
12 here was pegged to the services of an average-risk
13 beneficiary, so that's not really --
14 DR. MILLER: It is [off microphone].
15 DR. NERENZ: The bid is, but you just -- okay.
16 So the bid wouldn't change, actually.
17 MS. WANG: But then the contribution [off
18 microphone] --
19 MR. ROLLINS: So if fee-for-service --
20 DR. NERENZ: Okay. That's what I wanted to
21 clarify.
22 DR. GINSBURG: Yeah, I just want to say that I

1 think David's scenario is a risk for the current system. I
2 think that, you know, where we just a fee-for-service
3 benchmark without risk-adjusting it. So in the premium
4 support that Eric sketched out, we would risk-adjust the
5 fee-for-service number as well as each of the MA bids.
6 DR. NERENZ: But then -- and I'll give up on this
7 because it's a long enough time. But, yes, the fee-for-
8 service system, so to speak, would be protected, but I
9 think the beneficiary part of the premium would not be
10 protected if the bid doesn't move. So that's just --
11 MR. ROLLINS: The premiums would be based for a
12 beneficiary of average health. So, again, to the extent
13 risk adjustment works, your premium in a fee-for-service
14 sector would take into account the fact that the people who
15 are still in fee-for-service are on average sicker. Now,
16 as multiple people have said, that's a real area of
17 concern.
18 DR. CROSSON: Okay. So we're going down here,
19 and I think we're arriving at Kathy.
20 MS. BUTO: Okay. My thoughts have gotten more
21 complicated as time has gone on. But so one of my
22 underlying concerns is that the structure of premium

1 support could actually accelerate the opting out of
2 Medicare Part B by those who might have other options,
3 because depending on how it's structured, you were
4 mentioning, Eric, that we're already seeing for some baby
5 boomers the not taking up of Part B and staying on employer
6 retiree insurance or whatever else.
7 My concern is if the costs go up and there are
8 subsidies for low income, then there are people who can't
9 afford or might have other options who will actually opt
10 out of the Medicare benefit. I'm really worried about the
11 social insurance nature of the program, fundamentally that
12 we don't kind of accelerate that movement. So I just put
13 that out there.
14 The issue of the limit that both Paul and jack
15 mentioned I know is not our preferred option, but we do
16 mention it on page 22 and talk about an alternative kind of
17 limit tied to the benchmark. Any limit we put on there I
18 think is by necessity going to shift more cost to
19 beneficiaries or to the beneficiary's share. So I'm
20 concerned about that.
21 Back to the point that David was just making, I
22 think we maybe ought to think about an escape valve. So

1 what happens if for whatever reason Congress decides to
2 adopt this approach and we start to see some kind of a
3 spiral, whether it's more and more people leaving Medicare,
4 whether it's we're in a conundrum of fee-for-service gets
5 more and more expensive and we can't figure out how to deal
6 with that, risk adjustment isn't doing it?
7 So one concern is when you do a major change like
8 this, that if you make a mistake, there ought to be a way
9 to either adjust or to back out of it. With the SGR, we
10 couldn't figure out how to back out of it. It took us
11 forever. And so just something to think about. It might
12 be that if we think Congress is going to do this, they
13 ought to try it first, either regionally or they ought to
14 try it for a certain number of years, phase it in,
15 something. But there ought to be design issues that say
16 after so many years the authority might even expire and
17 would have to be renewed, which would give you another
18 opportunity to take the savings from anything that's done
19 and redesign parts of it.
20 So I don't know what that is. I'm just thinking
21 ahead to the fact that any dramatic change like this really
22 needs to have some ability to make adjustments, because

1 this is not anything that really exists in Medicare now.
2 DR. CROSSON: Jack.
3 DR. HOADLEY: One quick follow-up to the question
4 that Dave started raising. I mean, obviously, as I think
5 somebody said, you know, if risk adjustment really, really
6 worked, you really just shouldn't have as much of that
7 particular kind of problem, but what we're seeing is -- I
8 think we're just putting more reliance on the risk
9 adjustment where the consequences of its failure or its
10 inadequacy gets accentuated in some of this. And again,
11 the example I used in Part D, where we see these two-to-one
12 ratios, you know, it's unlikely that a lot of that is due
13 to simple prescribing differences in a couple of different
14 states around the country.
15 It seems more likely -- although, you know, I
16 can't show it, empirically, that a lot of that has to do
17 with unmeasured risk adjustment. We do risk adjustment in
18 Part D. Differences between, you know, plans out there
19 that charge $70 for the identical benefit that somebody
20 else charges $20 for in the same part of the country,
21 almost has to be risk-driven.
22 So, I mean, that's just a way to kind of see how

1 far away you can get when risk adjustment doesn't work as
2 well as it should.
3 DR. CROSSON: Okay. Warner.
4 MR. THOMAS: So a couple of comments I had, and I
5 think going back to Jack's comment, one of my concerns on
6 this -- I don't disagree with the key elements up there,
7 really. I think -- the big concern I have is whether a
8 beneficiary can really -- or will really make the choice
9 between, you know, the best option or a cost-effective
10 option. I think we see this in fee-for-service versus MA
11 today, where we have MA program which are more cost-
12 effective. They actually have, in some cases, better
13 benefits and yet people select fee-for-service
14 consistently.
15 So I just get worried that we think that the
16 market and the selection of the plans is going to play out
17 in the right fashion. So that's a concern I have.
18 I think the second piece -- and this is, I
19 believe, related, although on a slightly different topic,
20 is that on the auto-assignment, I think one of the things
21 that ought to be considered if we're going to write this
22 chapter is just the whole idea of how we auto-assign today,

1 because essentially, everybody automatically assigns in
2 fee-for-service. So we're auto-assigning people into the
3 option that in many markets is more expensive.
4 And I guess part of the question is, should
5 people be auto-assigned into the most cost-effective
6 option, with clarity around what's being done, and they
7 could opt into a different option but, in many markets,
8 especially the more expensive markets, we auto-assign
9 people into the most expensive option, and I think that's
10 something that ought to be thought about and considered.
11 The last comment I would make is around the ACOs,
12 and if folks are going to go into the fee-for-service
13 option perhaps we ought to think about how they get
14 assigned into an ACO model. And I think this is a benefit
15 to the ACOs, in areas where fee-for-service is the cheapest
16 option. You know, this would be a benefit to be in an ACO,
17 that you would potentially be able to gain more members,
18 you know, kind of selecting into your model, which I think
19 may encourage more organizations to embrace the ACO model.
20 And if ACOs work the way we would hope, which is better
21 coordination, obviously we would like folks to select into
22 models that have the ACOs.

1 So, you know, I know that we're not making a
2 recommendation around premium support, but if we -- if we
3 went in that direction I think these are key elements that
4 would make sense.
5 I think the other comments are just important,
6 regardless of premium support. I think they're items that
7 ought to be highlighted or brought up in the chapter, I
8 think, aside from the premium support model.
9 DR. CROSSON: Brian.
10 DR. DeBUSK: First of all, I wanted to mention
11 that the chapter is laid out as a really exciting path for
12 premium support, and I think the models and the analytics
13 that were done were very well-done. Mark, I think the word
14 we were looking for was it's a "gist" that we're going to -
15 -
16 DR. MILLER: Oh, not the drift.
17 DR. DeBUSK: Not the drift. It's the gist of
18 what we're trying to convey.
19 But I loved the gist of where it took us,
20 because, you know, this concept of area-specific benchmarks
21 obviously I support. As far as the competitive, or the
22 bidding model, really any competent method that does price

1 discovery, I'm somewhat indifferent to. I mean, I
2 understand the merits of second-lowest bids and medians and
3 weighted medians. I think, really, anything that helps us
4 discover that price, I think, is going to get us there.
5 The one thing I wanted to comment on, or two
6 things in particular, though, the base contribution for
7 Medicare. I think that should be set at a fixed
8 percentage, not necessary a fixed amount. And the thinking
9 there was that that would allow -- there would be some
10 geographic variation -- well, there is going to be
11 geographic variation -- but some of that, presumably, would
12 be tied, or at least hopefully would be tied to the cost of
13 living anyway. So the thought was that some of the
14 variation you would see in premium -- because, again,
15 you're setting -- it's a percentage contribution -- would
16 be on the -- reflect the cost of living.
17 And then the final thing I wanted to mention, how
18 much should be done to mitigate those -- the potentially
19 large premium increases. Is this an opportunity to
20 introduce some type of means testing into how we do that?
21 I mean, is that the third rail? Jack is shaking his head
22 at me already. You know, I mean --

1 DR. HOADLEY: It destroys Medicare, basically.
2 It's a social insurance program, and if we go to a full
3 means-tested Medicare it will become Medicaid.
4 DR. DeBUSK: I didn't use the word full.
5 DR. HOADLEY: We're already there, with the
6 income-related premiums and we're starting to see the
7 effects of people dropping out.
8 DR. DeBUSK: Well, I did notice -- in the --
9 there are now some Part B -- I figure up to $200 or $300
10 premiums, once you hit certain income levels. So we have
11 means testing now. The question is, is this a chance to
12 refine or introduce it? And I'm seeing enough heads --
13 well, I'm seeing enough heads shaking to know that it may
14 be a dead-on-arrival idea.
15 That's all.
16 DR. CROSSON: Okay. Bill.
17 MR. GRADISON: I think there's a connection
18 between this general package we're discussing and the idea
19 of benefit design, which we've been over before. I think
20 this kind of a program, if adopted, would work a lot better
21 if there were a change in premium design first, which is to
22 combine A and B and have a catastrophic benefit -- I mean,

1 not that that's a new idea. But in terms of -- I at least
2 want to suggest that perhaps we should be referring to that
3 in some manner, in whatever we present.
4 Most of my thinking about this is how to package
5 it. At one point I -- and I'm not sure this wouldn't work
6 -- at one point I thought of it as an actual decision tree,
7 because there are a lot of things you're going to have to
8 work through that lead to other branches. And I'm not
9 trying to be formalistic or look too far ahead. But
10 fundamentally, I think the main contribution we can make to
11 intelligent discussion of this issue, from people who like
12 it or don't like it, is to pinpoint the key decisions. I
13 may be way off on this but I think there are probably about
14 -- I can't number them all, but about a dozen, maybe. I
15 mean, it isn't that -- you can put it on one page.
16 I mean, I would think that would be an objective
17 to have a one-page. What are they decisions you've got to
18 make? And then there are subsidiary decisions, of course,
19 that are very important, because I think this could
20 contribute to -- the presentation, I think, would
21 contribute to trying to keep this on a basis that you never
22 can say it -- objective is -- nothing about this is

1 objective. It's all subjective. But at least maybe some
2 degree of facts-based thinking.
3 DR. CROSSON: Craig.
4 DR. SAMITT: I have a macro comment and then a
5 couple of micro comments here. The macro comment really
6 stems from a comment that Pat made, that I would hope that
7 as we derive the chapter for June that we not think about
8 the pieces of premium support in isolation, that I think,
9 Pat put it, is we need to weave this together into a common
10 fabric. I think it's dangerous to talk about each part in
11 isolation without continuing to tie it back.
12 So, for example, these topics for discussion, we
13 really need to talk about the fact that the bidding and the
14 benchmarks would need to be tied to a quality metric, so
15 that this isn't about cost; it's about value. And so I
16 know that the reason we've done it this way is it's a
17 complex discussion, and so we've broken it into parts, but
18 I think at some point soon we're going to want to pull the
19 pieces back together, so it's not viewed as an either-or;
20 it's always viewed as an "and."
21 I am in support of the elements here. I'm a
22 little bit uncomfortable given some of the conversation

1 about competitive bidding versus benchmarks and how to set
2 the benchmarks, and really would love to learn more about
3 the enrollment-weighted bidding, and whether enrollment-
4 weighted bidding actually can serve as a mitigation
5 strategy in and of itself, because it would blend or smooth
6 the transition and the curve so that it wouldn't be as
7 striking if it's kind of an either-or or second-lowest or
8 what have you, that it's more of a blended approach to
9 benchmark development, which could smooth the potential
10 disruption here.
11 I also, to Warner's comment, I don't want to lose
12 sight of the -- sort of the default enrollment issues here
13 as well, that if we believe that this program will work,
14 and we work through the mechanics to align the incentives
15 to choose the highest-value options, that default should
16 also default to highest-value options as opposed to the way
17 things work today.
18 And then, finally, and you mentioned doing some
19 work on this, I would be interested in knowing and
20 understanding how duals and special needs plans kind of fit
21 into all of this, and how that will work. And I know that
22 adds another layer of complexity but it would be important

1 to understand that too.

2 DR. CROSSON: Sue.

3 MS. THOMPSON: At a very macro level, I can't

4 help but reflect on conversations and previous lives where,

5 in organizations, we have been faced with problems of

6 funding pension, and the whole question of defined

7 contribution versus a defined benefit. And I'm worried

8 about the employee and whether or not they could manage

9 their own retirement planning. And in that context, I just

10 think it's important that we have an opportunity here to

11 pull the beneficiary into this discussion and make them a

12 part of the decision-making here, in terms of their

13 managing not only their health but their health plan.

14 So I think there's an opportunity here we

15 shouldn't miss.

16 DR. CROSSON: Sue, I just want to be sure. When

17 you said "in previous lives," I think you mean in previous

18 aspects in your own life program.

19 [Laughter.]

20 DR. CROSSON: We generally don't deal in the

21 supernatural here, although it might seem that way

22 sometimes.

1 [Overlapping speakers.]

2 [Laughter.]

3 DR. CROSSON: Bruce.

4 MR. PYENSON: Yeah. Thanks. First, my
5 compliments to Eric. The -- you know, the material
6 actually turned me from a skeptic saying, what is all this
7 stuff about, you know, this idea of premium support, to a
8 point where I am actually viewing this as a guide to
9 incremental change to the current Medicare Advantage
10 program. And this is not huge changes, anything worse than
11 what we've seen, you know, in terms of big change, to what
12 Medicare Advantage has gone through a few times, you know,
13 in Part D, or even if you think about what ACA has -- how
14 that's fundamentally changed the way insurance is sold.
15 Right? Not just individual insurance on the Exchange.

16 So what we have -- what we're going through, I
17 think, is a series of issues to fix the problem that Warner
18 addressed, to fix a series of other problems that we have
19 with, you know, the one-third, two-thirds issue -- Medicare
20 Advantage and fee-for-service -- and to do that in a
21 reasonable way, tackling a series of problems and
22 identifying ways to do that.

1 So I don't see this as, you know, hugely dramatic
2 or, you know, might be fundamental change, but I see it as
3 a series of steps that can be taken in a reasoned way. And
4 certainly none of it is going to be perfect. You know,
5 risk adjustment is not perfect. That's -- it's not called
6 risk elimination. There's still risk. Right? And a
7 series of other kinds of issues of how the bids are
8 constructed.
9 But one element I would urge that we put into
10 this is to make the system simpler. The burden of annual
11 bids on Medicare Advantage, the other structures,
12 everything from the star system, the risk adjustment
13 system, and so forth and so on, to the extent we can, in
14 the course of our gist, identify elements that can be
15 simplified in the whole process, I think would be very
16 helpful. And in that context, what we're creating, I
17 think, is a guidebook for fixing the system, whether it's
18 called premium support or something else.
19 So that's my overall view. So I support the
20 issues, the five issues there.
21 On the last one, the sixth -- how much should be done to
22 mitigate large premium increases -- I think it's important

1 to consider beneficiary spending on Medigap as a real
2 spending. It's not inexpensive. A lot of people buy it,
3 and often that spending is offset by the kinds of extra
4 benefits that Medicare Advantage provides. So if we're
5 concerned about the actual out-of-pocket, how much an
6 individual has to pay, it's not just the premium for Part
7 B. And I think that gets to some of Bill's comments
8 about, well, you know, in fact if we create a catastrophic
9 and some other changes like that, then maybe we would
10 address that issue.
11 So from an overall, you know, technical
12 standpoint of let's go ahead, let's figure this out, then I
13 think there will be a lot of valuable things that come out
14 of it.
15 DR. CROSSON: Thank you. Bill.
16 DR. HALL: So going around the room, I'm
17 impressed with the complexity of this issue, even if we're
18 -- some people in the room here who have tremendous life
19 experience with this, and also a little reflected by the
20 annual Medicare enrollment period, where a lot of patients
21 come in, and I don't know the right answer to some of the
22 questions.

1 I'm wondering about timing. This will be for the
2 June report -- is that right? So what about a scenario
3 where we find out, in a week or two, that there might be
4 some substantial changes in priorities in Washington and in
5 the states, or not?
6 [Laughter.]
7 DR. HALL: On every list that I've seen --
8 DR. CROSSON: I said we don't deal in the
9 supernatural.
10 [Laughter.]
11 DR. HALL: All the lists that I've seen is that
12 the Affordable Care Act has to be eliminated, day one. I
13 think change to Medicare through the House might be
14 something that comes up.
15 So I'm wondering, do we need to do even more work
16 and emphasis on this, in some sort of very rapid fashion?
17 Where are people going to get -- the responsible people who
18 are making decisions, going to get the information? Are
19 there lots of different ways, or is this -- is the
20 Commission the major vehicle where people would look for
21 reliable information? Does that speed up or change our
22 timeline?

1 DR. MILLER: Well, my first reaction is, you
2 know, in all honesty, I don't know how it can deliver it
3 faster than June. You know, we'll have to go through all
4 our update process stuff. All that gets into the March
5 report, by law, and, you know, and that's what's going to
6 be in the March report. Meanwhile, we'll be working with
7 this kind of information, gathering the other non-update
8 stuff into the June report. So I don't know how it can
9 move much faster than that.
10 However, the other thing I would say is as it
11 turns out we have been talking about this for a couple of
12 years, and it's kind of in bits and pieces all over the
13 place. And what we're trying to do in June is saying, this
14 is really what everyone thinks, you know, and write it
15 down. And so there is information out there and obviously,
16 if we were to get urgent calls, we can take people through
17 it in bits and pieces.
18 The thing, I think -- and I've said this a couple
19 of times but I'm just going to say it again -- is I think
20 the point of this is to have a reasonably thought-out, at
21 least at a principled and general policy direction, guide
22 to what you have to think through if you're going to take

1 on a policy like this. But the other objective is, I think
2 a lot of people come to this and think there is -- it's
3 simple. It's much more straightforward. And as you can
4 see, it does involve some serious issues that can cut in
5 one direction or another, and I think part of having it
6 available at the time that, you know, we have March and
7 June, is that if people want to have a serious
8 conversation, they have to be able to answer these
9 questions in how they design it.
10 So I don't think we can deliver it much faster
11 than June, but the whole intention is, is if there was a
12 shift and people were to talk about this seriously, have
13 some place where they could go for at least a first-level
14 take on what -- you know, you have to be able to answer
15 these five questions if you're going to start having this
16 conversation.
17 DR. CROSSON: Okay. Alice and John.
18 DR. COOMBS: Thank you very much. This has been
19 a learning session for me, and I think I've learned a lot.
20 One of the things I think impressed me most in
21 listening around the table was the whole notion that if we
22 provide this, we are actually functioning as choice

1 architects for beneficiaries. And in that, I think Jack
2 pointed out some issues with beneficiary choosing for the
3 Part D plan. I think Craig something about the quality
4 piece. If you are a choice architect, you're supposed to
5 provide the patient with the ability to choose as they see
6 fit and also give them a tool set or create an environment
7 whereby they choose the right thing. And so the right
8 thing is judged by whom?
9 And so one of my issues is this whole notion of
10 setting the premium in the absence of the quality, and so
11 that you might have a patient who chooses solely based on
12 the premium, and the risk adjustment is not perfect, no
13 matter how much we say it is. There's one renal failure
14 patient that is much more advanced than another, and I
15 think that systems can kind of triage patients the way they
16 see fit, panels will fill up. There might be capacity
17 issues with different plans.
18 I would like for us to be able to say somewhere
19 along the line that the challenges in this area have to do
20 with patients' capacity to choose, and on the opposite side
21 of the spectrum is our ability to be the best choice
22 architect because we are functioning in that manner because

1 we provide the patient with some tool sets that say this is
2 going to help you to make the right decision. Even if you
3 don't have exposure to it, there's something out there for
4 you.
5 And so the quality piece is something that's
6 going to be a harder thing to really kind of tease out, but
7 it needs to be ever present within the decisionmaking
8 environment for the patients.
9 DR. CHRISTIANSON: Having the last word is -- a
10 quick comment on what you just said. I think one way in
11 competitive bidding and other kinds of programs you deal in
12 a very crude way with quality is you have to meet some
13 quality benchmark to bid. It's either a historical
14 benchmark to bid, or your bid is thrown out if your quality
15 rating isn't, you know, satisfactory. So there's a crude
16 way of dealing with that, not perfect.
17 I was struck with the conversation here, going
18 back to what Warner said this morning, and I was often --
19 things that we talk about feed into each other,
20 interlinked, and he was saying, well, maybe we should look
21 at consolidation that's more things than just provider.
22 Maybe we should look at health plan consolidation. Then

1 Pat brings up, oh, are there really enough organizations
2 here? Got a lot of plans, but how many organizations? So
3 we know that work that Kaiser Family Foundation has done
4 that's very interesting, it shows a relatively small number
5 of organizations in the MA program enroll a relatively
6 large number of bidders. So that would maybe discourage us
7 from, you know, the notion of competitive bidding and how
8 that's going to work. But we do this work over with ACOs,
9 right?

10 And so it's really not number of actual
11 organizations that play now. It's that plus potential
12 number of organizations that really affect the bidding
13 process. And I know in my community already the ACOs are
14 now being offered as risk-bearing options for -- you know,
15 in private sector employer-based plans.

16 So we've been pushing ACOs, not with the thought
17 that it would help the competitive bidding process and
18 premium support, but it all kind of feeds into each other,
19 and it's interesting to sort of think about that. And I
20 was glad that Pat brought that up, and we go back and think
21 about yet another reason why we might want to do something
22 that seems a bit afield, which is look at consolidation

1 that's going on in the health care industry.

2 DR. CROSSON: Okay. Eric, thank you so much for

3 taking on so ably such a complicated topic for us.

4 Now we turn to the last presentation and

5 discussion today, the Medicare outlier payments to

6 hospitals, and Craig and Jeff are going to -- it looks

7 like, Craig, you're starting.

8 MR. LISK: Yes, I am. All right. Good

9 afternoon. Today we are going to go to review some

10 research we have done on the relationship between Medicare

11 outlier payments and hospital charging practices.

12 I want to first discuss our motivation for this

13 analysis.

14 Going back more than a decade, well over a decade

15 ago, some hospitals were gaming the outlier payment system

16 by inflating their charges to take advantage of some

17 loopholes that were in the outlier -- with how outlier

18 payments were being -- costs were being determined for the

19 outlier payment system. But CMS, in I think 2003, made

20 some modifications to the outlier policy to close those

21 loopholes.

22 In 2013, the Office of Inspector General

1 conducted a study of Medicare outlier payments in which
2 they examined hospitals with a high share of outlier
3 payments and found that these hospitals charged
4 substantially more for services in the same MS-DRG, even
5 though the patients had similar lengths of stay, raising
6 concerns about why charges for similar cases vary
7 substantially across hospitals.
8 In addition. three recent articles in Health
9 Affairs by Ge Bai and Gerry Anderson have looked at the
10 relationship between hospitals' financial performance and
11 hospitals' charge markups, finding that hospitals appear to
12 be using the charge-master to maximize revenues, raising
13 questions as to whether hospital markup practices might
14 also be affecting Medicare outlier payments.
15 So in our presentation today, we are going to
16 review the policy rationale for outlier payments and review
17 how Medicare pays for outlier cases and examine the type of
18 cases and hospitals that receive these outliers. We'll
19 then focus on two issues in Medicare outlier policies: the
20 influence of charge markups on outlier payments and the
21 calculation of outlier costs. We'll finish with a
22 discussion of potential changes that could be made to

1 Medicare outlier policy.
2 So, first, why have an outlier policy?
3 Well, under Medicare in the PPS, hospitals
4 receive a fixed payment for a case, giving hospitals a
5 strong incentives to provide care efficiently, as they keep
6 any gains when their costs are less than payments, but must
7 absorb losses when costs are greater than payments.
8 Some patients, however, are very high cost,
9 either because of adverse outcomes or patients are
10 extremely sick with multiple conditions; the basic DRG
11 payment was not intended to offset the losses on this set
12 of cases, particularly since outlier cases are not randomly
13 distributed across hospitals.
14 The outlier policy, therefore, acts as a stop
15 loss insurance for these high-cost cases, with a deductible
16 and coinsurance. Hospitals have to first cover a fixed
17 loss on a case before outlier payments kick in and then
18 share in the cost of the case for covered costs above that
19 amount. Thus, outlier cases are not meant to be
20 profitable. The policy is intend to limit the losses
21 hospitals incur on extraordinarily high cost cases.
22 The program sets aside a fixed amount of funds to

1 support the outlier program by reducing all the DRG weights
2 uniformly. It's a fixed pool of dollars, so any changes in
3 the outlier program are basically done budget neutral.
4 This next slide shows the outlier payment
5 formula.
6 Hospitals can receive outlier payments once total
7 costs of a case are greater than the DRG payment plus the
8 fixed loss cost threshold of $23,573 in 2017. Then
9 Medicare pays 80 percent of covered costs above this
10 amount.
11 To calculate costs, Medicare takes total
12 Medicare-covered charges for the case and multiplies this
13 amount by the hospital's Medicare inpatient cost-to-charge
14 ratio.
15 So please note, Medicare is using total covered
16 charges for the case and multiplying it by a single cost-
17 to-charge ratio to come up with an estimate of costs.
18 So we know that outlier cases need to be high
19 cost, but how do they compare to the typical case in a
20 hospital? So we can see here in this chart they have much
21 longer inpatient stays, they have a higher average DRG
22 weight, they have higher average costs per day, and that is

1 generally from greater use of special care units, and
2 higher daily expenses for pharmaceuticals, supplies, lab
3 services, and therapy, reflecting the more complexity of
4 those cases.   Altogether this leads to an average
5 case cost of over $64,500 in 2014, more than five times the
6 average of a regular case.
7   Payments per case are also higher, but because
8 hospitals need to cover the fixed-loss cost threshold
9 before they start receiving outlier payments, payments for
10 outlier cases are generally much lower than their costs.
11   So how does the incidence of outlier cases fall
12 across MS-DRGs given that we see that outlier cases
13 generally have a higher DRG weight?
14   Well, we find that there is wide variance in the
15 distribution of outlier cases across MS-DRGs. But we do
16 find a higher incidence of outlier cases in MS-DRGs with
17 high weights, long lengths -- longer lengths of average
18 stays, and with major complication and comorbidities. So
19 the more complex higher-weighted DRGs tend to have much
20 more outlier cases. These include transplants, major
21 cardiac procedures, and major spinal procedures that are
22 some that have incidence of outliers of over 20 percent.

1 Conversely, the low-incidence outlier DRGs are
2 the opposite -- generally in lower-weighted DRGs, with
3 relatively short lengths of stay, and no major
4 complications or comorbidities. These cases will include
5 COPD, heart failure, simple pneumonia, and major joint
6 replacements.
7 So the implication is really the mix of cases a
8 hospital has can affect its incidence of outlier cases.
9 So in the next chart we see how the incidence of
10 outlier cases varies across hospitals, and as you can see
11 here, the distribution is uneven across hospitals.
12 For over half of all hospitals, less than 2
13 percent of their cases become outliers, and 7 percent have
14 no outlier cases at all. But 13 percent have outlier
15 shares of over 5 percent. And we found that at the very
16 top distribution here, 50 hospitals were over 15 percent of
17 their cases became outliers, and this very high outlier
18 group is different from the typical hospital.
19 What we find is that a majority of these 50
20 hospitals with the highest outlier shares are small
21 surgical subspecialty hospitals. The outlier cases for
22 this group do not look like the slide I showed you just

1 back on Slide 5. The average length of stay for these
2 cases was much shorter than average for the typical outlier
3 cases, just 5.2 days.
4 The high incidence of outlier cases in the
5 surgical specialty hospitals appears to come from three
6 sources: high charge markups in the operating room, very
7 high charge markups in the operating room; high device
8 costs; and high per diem costs, in part probably because of
9 their small size.
10 A case becomes an outlier because of high
11 relative costs. In determining costs, Medicare uses a
12 simplified method to determine costs by multiplying total
13 covered charges for a case by the hospital's overall
14 Medicare inpatient hospital cost-to-charge ratio.
15 One of our concerns is how markups potentially
16 affect outlier payments here, and one way is through the
17 mix of services used. More service use from departments
18 with higher markups will result in higher outlier cost
19 estimates and vice versa.
20 Second is the difference in markups within a
21 department or cost center. Thus, a higher than average
22 markup for a particular service or device in a cost center

1 will also increase outlier cost estimates.

2 So, remember, in determining costs for outlier

3 cases, current policy is to use Medicare's inpatient

4 overall cost-to-charge ratio to calculate cost. But as you

5 can see here in this slide, markups vary substantially

6 across hospital departments or cost centers, with routine

7 and special care services having lower than average

8 markups, but drugs, operating room, lab, and radiology

9 services having much higher markups. Please note what I'm

10 showing you here is the ratio -- when I'm talking about

11 markups, I'm talking about the ratio of charges to costs.

12 It is this difference in the mix of services used

13 for a case that potentially could affect the hospitals'

14 overall cost estimate for outlier cases.

15 If we look across hospitals, we see wide

16 variation in the overall average markups. In this chart

17 the level of the markup is shown across the bottom of the

18 chart (as the ratio of charges to costs) with the share of

19 hospitals with those markups on the left.

20 As you can see here, most hospitals' charges are

21 two to four times the cost of care, with the median being

22 3.2. But many hospitals, over 17 percent, have charge

1 markups over five times the cost of care, and a few even
2 have markups over ten times the cost of care.
3 So do we see any relationship between these
4 markups and the incidence of outliers?
5 Well, in this slide we do see potentially a
6 slight weak relationship if we look at the heart of the
7 distribution where outlier cases lie in terms of those
8 share from two to five -- markups of two to five times the
9 cost of care.
10 But then when we have the very high markups, the
11 incidence of outliers drops down. So we kind of have this
12 weak relationship. It's hard to say what is going on, and
13 it's a relatively small difference. There's some
14 relationship there, but it appears to be relatively weak.
15 So how well does the total CCR work in estimating
16 costs for outlier cases?
17 To examine this, we compare outlier case costs
18 using the total cost-to-charge region and departmental CCRs
19 at the individual hospital. Departmental CCRs should
20 provide a more accurate picture of hospitals' claim costs
21 as it will reflect better the mix of services used and the
22 differential markups across departments.

1 Neither method, though, will capture differential
2 markups within a department, such as a higher markup for a
3 particular high-cost device. But in aggregate, we find
4 both the total CCR and departmental CCRs give similar
5 estimates of total outlier costs. But at the case level,
6 the mix of services used will affect the estimated cost,
7 and here we have a simplified example of how cost estimates
8 can vary between the departmental CCR and total CCR.
9 In this example we have a case that uses services
10 from three departments with different cost-to-charge ratios
11 or different markups: CCR 0.5 for routine, 0.1 for
12 operating room, and 0.3 for supplies and devices.
13 In the next line we show the total charges for
14 services in each of these three departments. We then show
15 estimated costs using the two approaches for calculating
16 outlier costs -- departmental CCR and total CCR. The total
17 CCR for this hospital is 0.32. And what we find between
18 these two calculations is a very different estimate of
19 costs?
20 If we look at the total -- and you can see the
21 differences between what happens with routine and operating
22 room for each of these services. But the total comes out

1 to be $37,000 with the departmental CCR, and the total CCR
2 produces a cost estimate of $48,000 when a single CCR is
3 used like in the current outlier policy.
4 Thus, if the service mix is weighted to services
5 with higher markups, the total CCR will give a higher
6 estimate of costs. But if service mix is weighted to more
7 routine services -- such as for long stay patients -- the
8 total CCR potentially will underestimate costs.
9 And if we look across MS-DRGs, we see large
10 differences in the average outlier cost estimates between
11 the two approaches, reflecting the fact that the mix of
12 services used varies by DRG.
13 We find, for example, that the total CCR tends to
14 underestimate costs of outlier cases in MS-DRGs with a high
15 incidence of outlier cases and overestimate outlier costs
16 in MS-DRGs with a lower incidence of outlier cases.
17 So our findings from this analysis lead us to two
18 potential policy changes for you to discuss. These policy
19 options are not mutually exclusive.
20 As we just showed, the total CCR at the case
21 level does not provide an accurate estimate of outlier case
22 costs, tending to overstate costs for cases with more high

1 charge markup services and understating costs for cases
2 with more routine costs that might be the result of long
3 inpatient stays.
4 So one option would be to use hospital-specific
5 CCRs to calculate cases costs for determining outlier
6 payments. This option would potentially increase the
7 complexity of calculating outlier payments since instead of
8 using a single CCR, multiple departmental CCRs would need
9 to be used to calculate costs. This potential increasing
10 complexity would need to be weighed against the improvement
11 that would be made in payment accuracy at the case and
12 hospital level to determine whether this option is worth
13 pursuing.
14 The second change would address the phenomenon of
15 the large share of outlier cases in surgical subspecialty
16 hospitals. We find that the length of stay for outlier
17 cases in these hospitals was much shorter than the typical
18 outlier case, 5 days compared to 19. so it is puzzling why
19 these hospitals should have so many outlier cases with such
20 short stays, unless they are taking advantage of the way
21 costs are determined or they are extremely inefficient or
22 it's somehow in their markup practices.

1 In this policy, CMS would establish a two-part
2 test to qualify for outlier payments. First, the case must
3 stay a set number of days over the average for the DRG,
4 such as 5 days; and, second, the case must exceed a fixed
5 loss cost threshold, such as is the case with current
6 policy. If a patient died, there might be an exception to
7 the length of stay rule.
8 This option would reduce the number of cases
9 identified as outliers in many of the small surgical
10 subspecialty hospitals and other hospitals that tend to
11 have much shorter than average stays for outlier cases. It
12 will not affect the traditional longer-stay outlier cases
13 and, in fact, may result in some redistribution of outlier
14 payments as the fixed loss cost threshold potentially might
15 be reduced. This policy also should be relatively
16 straightforward to implement. Both of these policies would
17 be budget neutral. We're just redistributing outlier
18 payments to cases that have truly higher costs -- or that
19 we suspect have truly hard costs.
20 And so with that I'll be happy to answer any
21 questions you might have about our analysis or Medicare
22 outlier payment policy, and discuss the policy options we

1 presented.

2 DR. CROSSON: Okay. Thank you, Craig.

3 Clarifying questions. [Inaudible.]

4 DR. CHRISTIANSON: Yeah. So I guess I have one.

5 On the top of page 5 in your paper.

6 MR. LISK: In the paper?

7 DR. CHRISTIANSON: I just want to make sure I

8 understand. So, basically, there's a policy decision that

9 Medicare should spend about 5 percent of payments to

10 hospitals on outliers, or is it no more than 5 or is it

11 about 5?

12 MR. LISK: It's between 5 and 6 percent.

13 DR. CHRISTIANSON: Yeah, but that -- okay.

14 [Overlapping speakers.]

15 DR. CHRISTIANSON: So then what drives reaching

16 that is the setting of the threshold.

17 MR. LISK: Correct.

18 DR. CHRISTIANSON: So that's the manipulated

19 policy. It turns out that's the variable that makes sure

20 that --

21 MR. LISK: [Inaudible.]

22 DR. CHRISTIANSON: So it's a zero sum game.

1 MR. LISK: Yes. So CMS is estimating each year
2 what that cost threshold would be to get them to that
3 amount of money, and 5.1 percent is what CMS is --
4 DR. CHRISTIANSON: And you give us two years for
5 the threshold values, this year's and last year's.
6 MR. LISK: Yes.
7 DR. CHRISTIANSON: Has there been any trend in
8 that, that is motivating our discussion of this topic, or -
9 -
10 MR. LISK: No. That's not really part of our
11 topic of discussion here. It has -- it increased between -
12 - it increased this past year but it's fluctuated somewhere
13 in the -- generally in the 20s -- lower to mid 20s.
14 DR. CHRISTIANSON: So that's not driving the fact
15 that we have this session.
16 MR. LISK: No.
17 DR. CHRISTIANSON: So what is driving is you guys
18 have taken a look at this and you think there's a better
19 way to do this. Is that right?
20 MR. LISK: We think there could be some
21 improvements.
22 DR. CHRISTIANSON: Yeah. Sure.

1 MR. LISK: I mean, that's what we're offering you
2 to think about.
3 DR. CHRISTIANSON: Yeah. Okay.
4 DR. MILLER: There were a couple of things
5 written in the last year that were pointing to raising
6 questions about this, and we had look at outliers several
7 years back, and we hadn't looked at it recently. So we
8 thought --
9 DR. CHRISTIANSON: So the point is this isn't
10 something that's just generating lots of new expenditures
11 by Medicare.
12 MR. LISK: No. This is -- that's why we're
13 saying -- we actually mentioned budget-neutral a couple of
14 times here, so we're not at that part. I mean, the charge
15 markups have these other -- there's the -- you know,
16 there's the other issue of the charge markups and what they
17 might be doing on the private sector and stuff, but --
18 DR. CROSSON: Can I see hands again? I'm sorry.
19 So Pat, Alice, Jack, Bruce, and Bill. Sorry. Did I miss
20 Rita? Sorry. Pat?
21 MS. WANG: But Craig, on that last point -- so
22 the outlier withhold, if you will, is set by law as being

1 between 5 and 6?

2 MR. LISK: Yes.

3 MS. WANG: It is? Okay. But it's theoretically

4 possible, to Jon's question about why the focus here, it's

5 possible, isn't it, that if there were more accurate

6 identification of true outlier cases, that the total

7 outlier payments would come down and perhaps it could

8 influence the amount that all hospitals are nicked in their

9 DRG payments to fund the outlier?

10 MR. LISK: No, it wouldn't. It still would be 5

11 to 6 percent.

12 MS. WANG: Okay.

13 MR. LISK: It just would be --

14 MS. WANG: The threshold might be --

15 MR. LISK: -- the payments themselves would be

16 more accurate. It might change the threshold some because

17 some hospitals that were getting outlier payments wouldn't

18 get them --

19 MS. WANG: Okay.

20 MR. LISK: -- or they would get less. But it

21 probably would be a relatively small change --

22 MS. WANG: Okay.

1 MR. LISK: -- on that side.
2 MS. WANG: So my question is on page 15, with the
3 recommendations. Are these -- if you did number one and
4 had a more accurate estimate of case costs, would you need
5 number two?
6 MR. LISK: Well, number two -- you still might,
7 yes, but it might be less so because you'd be getting more
8 accurately at their cost, but you would never get at what
9 might be happening in some of those hospitals, because I
10 saw -- what we see in some of those hospitals is very high
11 markups on devices -- charges on devices, but not higher
12 markups on devices. So there might actually be
13 manipulation within the -- that specific device category
14 that they're marking up particular devices, taking
15 advantage of the system. We're never getting at that part
16 of it with current system.
17 DR. MILLER: [Off microphone.]
18 It won't -- I thought Warner had his kill switch
19 on.
20 [Laughter.]
21 Well played, my friend. You're going to let me
22 get going. Fair enough.

1 I think about it two ways, in my head. So a
2 couple of articles were written over the last few years,
3 and we hadn't looked back at the outlier policy in a while,
4 and every once in a while you open it up. We found, in the
5 past, some strange things. This year we're not finding a
6 lot of odd things but there are two things that came to a
7 head. One is, we found a set of hospitals which just, in a
8 face validity kind of way, didn't make a lot of sense --
9 for-profit, small surgical hospital, don't have a long
10 length of stay, but have gigantic costs. And it's sort of
11 like the outlier pool isn't for being inefficient. It's
12 for getting a patient who's, you know, really crashed.
13 The length of stay probably boots those hospitals
14 out of the outlier pool. Then the first one, the CCR, and
15 whether you use the average or all the revenue centers,
16 that probably just increases that equity among the
17 hospitals who are probably rightfully in the outlier pool.
18 That's the way I think about these two things.
19 DR. CROSSON: Okay. Alice.
20 DR. COOMBS: So Craig, what was the $500,000
21 loss? Is that something that the hospital has to qualify
22 first before you get to the next step?

1 MR. LISK: So that is -- so one part I didn't go
2 over in the discussion here is the reconciliation. So what
3 happens is that -- because we're using older cost-to-charge
4 ratios in terms of on the claims, to determine what cost
5 estimates are, and then what happens is there's a
6 reconciliation process that goes on, and there's a two-part
7 test for that reconciliation process, to use actually the
8 cost-to-charge ratios -- the cost-to-charge ratio reflects
9 that -- the claim -- the claim year costs. But it's a two-
10 part test. And first you have to have outlier payments of
11 over $500,000 and your total CCR has to change by more than
12 0.1. So it has to change from 0.3 to 0.2 or less before
13 you have reconciliation kick in.
14 DR. COOMBS: Okay.
15 MR. LISK: And we have not seen, at least on the
16 claims, seen much reconciliation go on. So I'm not sure
17 whether CMS isn't doing it -- there was no OIG study about
18 CMS was behind on doing reconciliations. But the other
19 thing is I'm not sure that this criteria that CMS has put
20 in place -- and this wasn't part of our discussion --
21 DR. COOMBS: Right.
22 MR. LISK: -- in our paper, really -- whether

1 that's actually taking -- whether it's not taking place or
2 hospitals aren't meeting that criteria because they're
3 keeping their charge growth down enough that it won't kick
4 in.
5 DR. COOMBS: So they're holding just below that.
6 MR. LISK: They could be holding just below that.
7 I did not do a longitudinal analysis to be able to take a
8 look at that, to see if that's what's happening, but that's
9 something that could be there, or another area that could
10 be discussed too, if you wanted. But we didn't bring that
11 to you.
12 DR. COOMBS: Okay.
13 MR. LISK: It's not --
14 DR. COOMBS: Appreciate it. So in the reading
15 material and the chart with the procedures -- the table --
16 I'm sorry, Table 4 --
17 MR. LISK: Right.
18 DR. COOMBS: -- MS-DRGs with highest share of
19 outlier cases, 2014 --
20 MR. LISK: Mm-hmm.
21 DR. COOMBS: -- and I'm looking at the diagnosis,
22 pretty labor-intensive cases that come to fractions of

1 millions of dollars for most of these cases. So it's not
2 unusual that it would be -- these would be the outliers.
3 MR. LISK: No it's not -- no, it's not surprising
4 --
5 DR. COOMBS: Okay.
6 MR. LISK: -- that these cases are, and there's a
7 lot of variance in terms of what ends up happening in those
8 cases, and that's why you have probably a lot more outlier
9 cases in those.
10 DR. COOMBS: So one question I would have is that
11 when we talk about centers of excellence we look at what's
12 called low-volume hospitals and high-volume hospitals for
13 some of these procedures, in that low-volume hospitals are
14 said to have a greater complication rate, have providers
15 who have less volume per year, and so that there's all
16 these criteria for reaching proficiency. You won't want --
17 I wouldn't want someone to do a CABG on me if he only does
18 five a year.
19 And so that, in and of itself, may be a piece of
20 this, in terms of the volume of the institution. Within an
21 institution you can have high-volume providers and low-
22 volume providers. But the question really is how does

1 volume relate to this, and then I have another question for
2 Round 2.
3 DR. CROSSON: Sorry. Alice, was your question
4 how does volume relate to it, or how does the proportion of
5 outlier cases that are due to complications relate to that?
6 DR. COOMBS: Right. So how does an institution
7 who has low-volume cases relate to the number of outlier --
8 the number of times they fall into the outlier status.
9 DR. CROSSON: Right. But the middle point, the
10 implication of that is the lower volume, higher
11 complication, higher outlier.
12 DR. COOMBS: Right.
13 MR. LISK: That very well could be. We did not
14 take a specific look at that. That is getting more
15 complicated than we were trying to do initially here.
16 DR. COOMBS: So there's a lot of literature,
17 especially when you talk about transplants and CABG
18 surgery. Looking at those would be something that would be
19 of interest, because just the complications -- when you
20 have complications in those procedures, you are going to
21 meet your benchmark quite easy.
22 DR. NERENZ: But also you're going to a higher-

1 paid DRG.

2 DR. COOMBS: Well, no. These are already high-

3 paid DRGs. I mean, this set of DRGs are complicated cases

4 to begin with. It just is -- basically they're all losing

5 -- generally losing money on them anyway. It's just that

6 everyone has the same loss. Just remember, every DRG, to

7 get outliers, is actually -- has the same loss. So loss

8 doesn't vary.

9 DR. CROSSON: So maybe this is too simplistic,

10 but do we know to what degree -- what proportion of outlier

11 payments are due to potentially preventable complications?

12 DR. COOMBS: No, we don't.

13 DR. COOMBS: That's a really important piece of

14 this whole process, because when you take these highly --

15 you know, just what's required for these procedures, at any

16 event -- at any point you can have a complication, and it

17 has a lot to do with the patient's biology and the makeup,

18 in terms of their advanced disease process.

19 DR. CROSSON: Jack.

20 DR. HOADLEY: So I was wondering if you look at

21 all at the potential impact, particularly on the first of

22 these. It's obviously budget neutral so it's a question of

1 redistribution across the hospitals that are collecting
2 outlier payments. And I assume, from what you've
3 described, it's got to be pretty small.
4 MR. LISK: So what happens is that the hospitals
5 are tending to get more outlier payments. Their outlier
6 payments would go down. So the top group is actually
7 getting overpaid by about $2,800, on average, between -- if
8 you changed the method of calculating. And the bottom half
9 of hospitals, when they have an outlier case, they're
10 getting underpaid probably, on average, about $1,000. Or
11 some -- I mean, that's a broad -- those are just broad
12 numbers, but that's kind of how it comes, in terms of cost
13 estimate.
14 DR. HOADLEY: Have you looked at all at the sense
15 of what's the percentage, up or down, for hospitals in --
16 MR. LISK: No.
17 DR. HOADLEY: Okay. At some point, that's
18 something we should do that, if we get any further.
19 DR. CROSSON: Rita.
20 DR. REDBERG: Thanks. I was trying to understand
21 better what was going on with these outliers, and I'm
22 wondering if we have any outcomes data on how these

1 patients do.

2 MR. LISK: A lot of outlier patients end up not

3 doing well in the end --

4 DR. REDBERG: Like dying.

5 MR. LISK: -- because they were very sick and

6 many die. And we did not take a look at that as part of

7 this. But because a lot of these patients are very sick,

8 many -- but many recover too, so it's a mix -- it's a

9 mixture, and it may be difficult to really tease out. It

10 may even be difficult to tease out who has really

11 complications or due to the source of care and stuff too,

12 in terms of just -- or were more biologically based issues

13 that happened with the patients on some cases too. So --

14 DR. REDBERG: Like, for example, do these

15 represent any duals, or are they all just Medicare over 65

16 patients in the outlier group?

17 MR. LISK: They're all Medicare patients, so

18 there's going to be both under 65 and over 65, duals, non-

19 duals. It's a mixture of patients.

20 DR. REDBERG: It looks like heart transplant is a

21 big source of outlier payments, and I'm assuming they were

22 not at the surgical -- for-profit surgical --

1 MR. LISK: No.
2 DR. REDBERG: -- special hospital.
3 MR. LISK: No, those were not --
4 DR. REDBERG: Those are orthopedic cases.
5 MR. LISK: -- no, no.
6 DR. REDBERG: Because, you know, obviously a
7 heart transplant is a very limited resource and it's very
8 important to choose -- you know, many more people are going
9 to die on the -- you know, waiting for a donor, and having
10 all these high proportion of outliers just makes me think
11 that perhaps -- that we could be choosing recipients
12 better. What's going on here?
13 MR. LISK: Or maybe -- I mean, there's another
14 issue that could come up, is actually is a fixed payment
15 per case for some of the transplants, because -- with such
16 high variance. Because the other thing that happens is
17 that there are huge profits for the inlier cases on some of
18 these cases, and again, I didn't go over this. On the
19 caseload there's huge profits made by some of these cases,
20 for some of these cases.
21 DR. REDBERG: Is that the outlier cases?
22 MR. LISK: Huge profits. Yes -- no, the inlier

1 cases.

2 DR. REDBERG: Oh, the inlier. Uh-huh.

3 MR. LISK: So the losses are -- you know, losses

4 and profits are supposed to even out, but for some of these

5 places there are very big profits on the cases that do not

6 become outliers. So that kind of raised the question of --

7 it could raise a question of maybe this set of cases, does

8 the DRG system work for them because there's such high

9 variance in the cases.

10 But I agree with you in terms of what you're

11 talking about, in terms of saying are the -- in terms of

12 what places are doing these things.

13 DR. REDBERG: I'm just thinking, you know, the

14 point of the outlier I understand, but you don't want to

15 give people incentives to do surgeries or transplants on

16 patients that would have been better of -- that you could

17 have predicted would become outliers because they should

18 probably -- were -- you know, and you wouldn't want to

19 reward that behavior with the stop loss insurance. We need

20 more data.

21 DR. HOADLEY: I think we usually don't, because

22 these cases are generally unprofitable, because they have

1 to reach that fixed loss amount before they start getting
2 outlier cases. So if you look at -- generally, outlier
3 cases are not going to be making you money, so you don't
4 have an incentive to do it. That's why there is that fixed
5 loss amount, because we don't want people to have incentive
6 to do it.
7 DR. CROSSON: Okay. So Bruce, you have the last
8 question, and -- I'm sorry. Did I miss something? No.
9 You have the last question and you're also opening the
10 discussion, so you've got a twofer opportunity.
11 MR. PYENSON: Oh man. I don't [inaudible] my mic
12 for a while.
13 [Laughter.]
14 DR. CROSSON: There is a kill switch.
15 [Laughter.]
16 MR. PYENSON: That explains a lot of things.
17 A question on page 7. Whether it would be
18 possible to look at the stability in this from year to
19 year. That's kind of getting at the issue of whether these
20 are random from one organization to the next, that is, do
21 the organizations that have a high percentage, they
22 persistently have that?

1 MR. LISK: They tend to persistently have -- yes,
2 in terms of share of outlier cases they get, it's pretty
3 persistent in terms of the general areas that they are.
4 Hospitals that don't get many outliers tend to -- year by
5 year don't get many outliers, and cases tend to have above
6 average number of outliers tend to be the same hospitals.
7 So that is pretty -- relatively stable.
8 MR. PYENSON: Another question is when you look
9 down the listing, what's the biggest payment in a year
10 you've seen?
11 MR. LISK: Oh, in terms of a per-case payment? I
12 mean, it's over -- there are a couple that are over a
13 million.
14 MR. PYENSON: It's -- and I wonder if, for
15 comparison, you could look at the probabilities and sizes
16 distribution of other kinds of risks, like med mal or
17 workers' comp. And where I'm getting at is that the
18 purpose of -- from my eyes, the purpose of an outlier
19 program is a financial backstop for risks that you can't
20 sell funds, and for sure there's self -- lots of self-
21 funding or an insurance market for med mal, workers' comp,
22 all sort of other liabilities. So I think those are -- the

1 frequency and size distribution of those are pretty well
2 known.
3 MR. LISK: Yeah. I'm not sure exactly how to
4 respond.
5 MR. PYENSON: Well, yeah. I guess to turn that
6 into a question is, can you put that together?
7 DR. MILLER: Well then, one thing I would ask
8 here is how far down this road, in hospital outlook -- is
9 that where you guys were going? I'm representing my
10 clients. How far down this road do we want to go? I mean,
11 you know, Jon asked a good question at the beginning, which
12 is why are we talking about this? We felt like other
13 people were sort of raising questions. We hadn't looked in
14 a while. We looked.
15 I wouldn't characterize what we found here as oh,
16 my God, there's a huge problem. We found a couple of nits
17 that, like, you know, these hospitals are showing up in
18 this distribution where standards civilian would go "I
19 don't think they should be here," that type of thing. So
20 you could clean this. If you want to really unpack it, I'd
21 want some more sense from, you know, the crew that this is
22 a direction that we want to go in. That's the only thing I

1 would say there.

2 MR. PYENSON: Yeah, well, since I have the floor

3 --

4 [Laughter.]

5 MR. PYENSON: -- I think moving to the second

6 portion of the discussion, I think the outlier issue points

7 strongly to the weakness of the cost accounting -- the lack

8 of cost accounting in the hospital industry, and that as a

9 part of recommendations, that we consider encouragement of

10 a -- move towards cost accounting. As you pointed out,

11 even within departments there could easily be manipulation

12 within the department on the particular device, I think was

13 the example you used, Craig. And, you know, cost

14 accounting is not perfect but it would have a lot of

15 advantage, I think, in this and other areas.

16 And the question I was getting at before is

17 whether it actually makes sense to let some organizations

18 self-fund this risk, and lots of hospitals have offshore

19 captives self-fund their med mal, so fund workers' comp and

20 other risks. And that involves, you know, lots of

21 discussion. But I think that could result in a net savings

22 rather than a budget-neutral that we've been discussing.

1 MR. LISK: Just to explain -- sorry.
2 DR. MILLER: I'm finally starting to see --
3 MR. LISK: Just to say one thing in terms of the
4 variance and risk. It's one thing that I did some stuff on
5 a couple of years ago, in looking at outliers, is a
6 hospital receives a transfer case. They are more than 2-
7 1/2 times likely to become outliers, for instance. So the
8 risk is not uniform, and that distribution you see, I
9 think, is reflective of the different risks of the cases
10 and mix of cases hospitals have. So the risk is not
11 uniform across hospitals. It varies by the type of cases
12 they receive and such too.
13 DR. MILLER: No. I mean, I think I've started to
14 connect the dots now, on what you were saying, an dos tell
15 me if these two sentences are so, are what you're saying.
16 So you were asking us whether there was some
17 rethinking of the cost accounting structure that underlies,
18 you know, a lot of this -- the cost report -- and I think
19 we should talk about that. I know there are feelings about
20 this around the table. But I think what you were saying is
21 if you were to convert to more of a cost accounting type of
22 approach, the program wouldn't have -- would be -- would

1 not necessarily have to continue to provide the -- reinsure
2 the outlier, and that this would be something that
3 organizations would be better able to predict and self-
4 fund. Possibly.
5 MR. PYENSON: Yeah. I'm happy to be your client.
6 In part, I mean, but even without a cost
7 accounting system, I think some organizations could look at
8 this and say, "We're getting dinged 5 percent and we're
9 maybe playing these games to collect on it, and if we just
10 self-funded this in some way we could do fine."
11 And I think, you know, there's implications,
12 redesign, and selection issues. I think Craig pointed out
13 certain hospitals are much more likely to get -- to need
14 this than others. But in the scope of things, it sounds
15 like if the biggest case in a year, across all the
16 hospitals in the U.S., is $1 million, that doesn't strike
17 me as, you know, real dramatic compared to other kinds of
18 risks hospitals are dealing with all the time, you know,
19 med mal and things like that.
20 MS. WANG: Can I -- but Bruce, this is a self-
21 insurance for a very large pool of hospitals. It's 5
22 percent of, you know, the DRG payment. And the reason that

1 it seems appropriate to spread it across that large a pool
2 is that there's a concentration of the cost in, you know,
3 teaching, academic, whatever hospitals. If everybody was
4 left on its own and said you got 100 percent back, the
5 folks who never had an outlier payment would say, "We don't
6 need to self-fund anything." But then the guys who
7 actually need the help -- I mean, they might need to self-
8 fund at a huge level.
9 I mean, I feel like the way that it's set up now,
10 it is a kind of a self-funding mechanism, but the pool is
11 appropriately large enough.
12 MR. PYENSON: It's a form of redistribution, and
13 the question is we don't do that for what might be bigger
14 risks that hospitals are managing without redistribution.
15 So -- and perhaps this is off topic, but, I mean, that's
16 the question.
17 DR. GINSBURG: I really need to answer this.
18 Jon, can I?
19 Yeah, I mean, there are two perspectives,
20 reaction to the self-insurance. One is the fact that I
21 don't think outlier payment, historically, has been pursued
22 as an insurance mechanism. I know that Craig described it

1 as stop loss insurance. I think it was really always
2 envisioned as making the payment, the DRG payments as to
3 more accurate, and that was a goal in itself.
4 The other comment is that, you know, I think it
5 is extremely dangerous to have any type of voluntary opting
6 out into a self-insurance. I just don't think we could do
7 it right. I don't think it's worth the thought resources
8 to try to figure it out and monitor it, because we're not
9 talking about a system that's working particularly badly.
10 I think they're two good ideas for tweaks, but to, you
11 know, revamp it, I think there's very little return and big
12 risk.
13 DR. CROSSON: So just to be clear, were you
14 talking about essentially scrapping this program and
15 replacing it completely, or having opt-out, as Paul is
16 suggesting?
17 MR. PYENSON: Well, perhaps I was actually asking
18 that we look at the -- almost from an insurance basis, what
19 -- how this program compares with other stop loss type
20 programs, other risks that hospitals face. It's -- you
21 know, it strikes me in the scope of things this is a nice -
22 - not -- it is a relatively stable and small program within

1 the DRG structure, and certainly, you know, I'm not opposed
2 to tweaking it along the lines that are proposed here. But
3 I'd feel better if I understood these risks in the context
4 of other risks that hospitals seem to manage on their own.
5 DR. CROSSON: Warner did you have a point on
6 this?
7 MR. THOMAS: I was just going to make a comment.
8 I think -- I agree with Paul. I mean, to me, this --
9 what's been identified in the chapter is that you've got
10 some organizations that have been able to adjust their
11 charge structure to benefit from this program, where it
12 appears, you know, probably inappropriately, or
13 disproportionately to others. And I think the specific
14 department CCRs, I think, probably helps to adjust that and
15 so does the length of stay.
16 So I think that to reconfigure the whole program
17 is -- it's a lot of work for -- and I think to have people
18 opt out of it, you know, it's -- to me that's just not
19 going to work. It's going to hurt the organizations that
20 actually need it, if you actually have folks that opt out,
21 because the only people who are going to opt out of it are
22 the people that don't need it. So I think it's really

1 designed to deal with those patients that have a -- you
2 know, a significant additional issue that a typical DRG
3 payment doesn't capture. So I would agree with Paul and I
4 think the recommendations that are outlined make a lot of
5 sense.
6 DR. CROSSON: Oh, did you have --
7 DR. CHRISTIANSON: I may be following on -- Mark
8 said something. It's late in the day so this may -- but he
9 said something recently that actually made sense to me.
10 [Laughter.]
11 [Overlapping speakers.]
12 DR. CHRISTIANSON: So he said, you know, the
13 system is designed to compensate hospitals that have bad
14 luck and not to reinforce the decisions of hospitals that
15 have decided to have a certain kind of cost structure, and
16 I think that's exactly right and I think that if these
17 things can deal with that problem, then I think that's
18 great. I'm in favor of them. But given the other things
19 that are on the plate of the staff and things that have to
20 be accomplished, I wouldn't spend another few minutes on
21 this topic, I don't think.
22 [Laughter.]

1 DR. CROSSON: Yeah. Feel free to say what you
2 want.
3 Jack and then Kathy, and then I also am getting
4 ready to call it quits.
5 [Laughter.]
6 DR. HOADLEY: My question was simply -- and I
7 don't think you said this -- is this something -- are these
8 two items things that can be done administratively by the
9 secretary, or do they require statutory?
10 MR. LISK: I was trying to figure that out.
11 [Laughter.]
12 MR. LISK: I'm not quite sure, because I was
13 trying to look at what flexibility the secretary has. I'm
14 not specifically sure there yet.
15 DR. HOADLEY: Because I'm thinking in the context
16 of the way we're talking about it, if this is something
17 that's going to require a change in law, like, you know,
18 we've got a long list of those things and this isn't going
19 to get very high on that. If it's something the secretary
20 could do, then to put it out there, I mean, there's no
21 harm, obviously, if we can just say this, even if it
22 requires law. But if it's something the secretary can do,

1 then I think that makes it more useful to make the
2 recommendation.
3 MR. LISK: I think that the secretary has a fair
4 bit of discretion in some things, but this kind of was the
5 -- the outlier policy was phased out so I'm not sure about
6 the day requirement. I think the CCR may -- there may be
7 some flexibility there but I really need to check back or
8 have legal advice on what is or not on that one.
9 DR. CROSSON: Kathy.
10 MS. BUTO: Meanwhile, having -- I tend to agree
11 with the idea that this isn't work a lot of -- a huge
12 amount of work, but I don't think it's that difficult to
13 find out what Medicare does on malpractice. And it did
14 something, and while I was there there were a whole bunch
15 of lawsuits, and we changed what we did. So if somebody
16 could just look that up, what is it that Medicare does with
17 respect to malpractice, in terms of a policy with
18 hospitals, I think that would shed a little light to
19 Bruce's question. And I think it ended up being more
20 complicated than simple. But a change was made, and I
21 think it was actually made as a result of lawsuits, not
22 legislation.

1 DR. CROSSON: So that's something, Bruce, we
2 could bring back to you. But, I mean, here's what I'm sort
3 of thinking here. I haven't heard a lot of objections to
4 these two ideas. Now, there is the question of how
5 difficult they would be to accomplish, and we can
6 potentially get more information about that. But on the
7 other hand, I'm not sure that bringing this topic back for
8 another discussion is worth the squeeze, as somebody has
9 like to say.
10 So I'm going to say something here. Is there
11 anybody who disagrees with either of these two approaches?
12 Alice.
13 DR. COOMBS: Just briefly, the second one.
14 Although it may reduce gaining the -- because you look at
15 the components of that table, it may or may not be able to
16 address, because of the disease processes that are
17 occurring the procedures, I personally don't think the
18 length of stay is going to be helpful with the priority of
19 that chart that we're dealing with, in terms of transplants
20 and things of that nature.
21 And part of it has to do with the nature of
22 transplants. They are prioritized based on how sick they

1 are. So the New England Organ Bank will put someone on the
2 list and they move up the list the more sick they are. So
3 I don't know if length of stay makes a difference because
4 the mortality is very high and they may still have, you
5 know, major interventions for greater intensity, for a
6 shorter period of time, which may still result in them
7 reaching their outlier benchmark to qualify.
8 So the second part, I have a problem with. It
9 decreases gaining but because of that chart -- the chart
10 says that those diseases that are in that chart, and the
11 procedures that are being performed, are not going to lend
12 itself to length-of-stay issues because of the severity of
13 the illnesses.
14 DR. CROSSON: So I think what I hear you saying
15 is -- yeah, and I'm going to ask you in a second, Craig --
16 is that some of this lower length of stay in the higher
17 charge ratio hospitals may be a function of the severity of
18 the DRGs and patients are dying and so they're at a higher
19 rate, so their length of stay is less. Is that what you're
20 saying?
21 So can you speak to that, Craig?
22 MR. LISK: Well, what I was going to say is what

1 I said in my presentation but not in the paper was that you
2 could actually have an exception for people who died, so
3 that you would not end up -- that if the people died, the
4 length of stay criteria would not apply. Because we're
5 talking about these places that are taking simple cases --
6 and I think, in general, in terms of -- and you could -- I
7 mean, there could be a second type of length of stay
8 criteria too. There could just be -- set relative to the
9 DRG, or it could be a set length. But it would tend to be
10 still cases that are going to be -- just five days is, you
11 know, one quarter of the way to what a typical length of
12 stay is for an outlier case. So --
13 DR. COOMBS: I don't think we need to bring it
14 back, but the other issue regarding transfers -- because
15 some large institutions will do that CABG surgery and then
16 do a shuttle to that rehab, and they don't go back to the
17 primary hospital where they had the high-intensity
18 procedure. They wind up at a community hospital. And
19 right now there's no one really tracking that right now.
20 MR. LISK: So what I was going to say is another
21 thing I brought up in the paper, and did not discuss
22 extensively, and the length of stay takes care of this, is

1 there is a different criteria for outliers for transfer
2 cases. And transfer to post-acute care even. So they have
3 a -- they get a shorter stay and the length of stay
4 criteria would take care of that. But the transfer issue
5 is another one. Those short-stay hospitals had a lot more
6 -- a fairly higher proportion of their cases is transfers.
7 About 5 percent overall have a lower outlier criteria --
8 outlier cost threshold criteria because they are
9 transferred to either post-acute care or to another
10 hospital.
11 DR. CROSSON: So that said, if the mortality were
12 extracted, would that go a long way to resolving --
13 DR. MILLER: I think that would largely -- I
14 mean, I think it would largely address the issue you're
15 raising.
16 DR. COOMBS: The first part, yes, and then the
17 second part, transfers, and we have had this discussion
18 before regarding the transfers, so that would be --
19 DR. CROSSON: Okay. So I'm not seeing any other
20 hands so I'm thinking that what we have is, as we've often
21 said, a bobble-head consensus --
22 [Laughter.]

1 DR. CROSSON: -- to support these two
2 recommendations. And, you know, maybe at some point in the
3 ES in the next couple of meetings we can just do a quick
4 follow-up in terms of, you know, what would be required to
5 get this to happen. How does that sound. Okay?
6 DR. CHRISTIANSON: Sounds good.
7 DR. CROSSON: Okay. So we have come to the end
8 of this discussion. Thanks to Craig and Jeff. And we are
9 now at a point where we're ready for our public discussion
10 period, public comments.
11 If there are any members still remaining in the
12 audience who would like to make a comment, please come to
13 the microphone.
14 [No response.]
15 DR. CROSSON: Not seeing anyone, we are adjourned
16 until 8:30 tomorrow.
17 [Whereupon, at 5:15 p.m., the meeting was
18 recessed, to reconvene at 8:30 a.m. on Friday, November, 4,
19 2016.]
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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, November 4, 2016
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
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AGENDA PAGE

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1 P R O C E E D I N G S

2 [8:30 a.m.]

3 DR. CROSSON: Okay. Good morning. We have a
4 couple of Commissioners who I think have been delayed a
5 bit. Dr. Redberg has an unavoidable conflict for a portion
6 of the meeting, so she may be here a little later.

7 Our first presentation and discussion today is
8 about Medicare Advantage, and we've got Andrew and Scott.
9 Andrew, are you beginning?

10 DR. JOHNSON: Yes.

11 DR. CROSSON: Well, take it from the top.
12 Thanks.

13 DR. JOHNSON: All right. Good morning. Next
14 month the staff will present the bulk of our annual
15 analysis of the Medicare Advantage enrollment, bids, and
16 quality for the coming year.

17 Today Scott and I will give you a head start on
18 two issues that we discussed last year. I will begin with
19 an overview of how risk adjustment affects payments to MA
20 plans and will then present our updated analysis of the
21 impact of coding differences on MA risk scores. Next,
22 Scott will present analysis on how CMS calculates the fee-

1 for-service spending measure that is the basis for MA
2 benchmarks.
3 Now to begin with risk adjustment, Medicare pays
4 MA plans a monthly amount that is unique to each enrollee.
5 These payments are the product of two factors: a base rate
6 that is based on a local benchmark and a plan's bid, and a
7 beneficiary-specific risk score. The base rate represents
8 the average spending for the fee-for-service Medicare
9 beneficiaries in a given geographic area. The risk score
10 is a standardized measure of expected spending and adjusts
11 the base rate, by increasing payment for beneficiaries who
12 are sicker and more costly than average, and decreasing
13 payment for beneficiaries who are less sick and less
14 costly.
15 A risk score is calculated based on a
16 beneficiary's demographic characteristics and whether he or
17 she has certain medical conditions. In the risk adjustment
18 model, medical conditions are identified by diagnosis codes
19 and are grouped into hierarchical condition categories, or
20 HCCs. Each demographic characteristic and HCC is
21 associated with a relative expected spending amount. A
22 risk score is the sum of those relative spending amounts.

1 The more HCCs that are indicated for a particular enrollee,
2 the larger the risk score and the larger the associated
3 Medicare payment will be for that enrollee.
4 The relative spending amounts in the risk
5 adjustment model are estimated using Medicare fee-for-
6 service diagnostic and spending information and, therefore,
7 reflect the relationship between diagnostic coding and
8 spending that exists in fee-for-service. The vast majority
9 of HCCs are identified through physician and outpatient
10 claims, which in fee-for-service are paid based on
11 procedure codes and do not depend on diagnoses. Hence,
12 there is little incentive to document all diagnoses or
13 identify all HCCs for fee-for-service beneficiaries.
14 In MA, however, payment is tied directly to
15 identifying HCCs, so there is a significant financial
16 incentive to documenting all diagnoses. These differing
17 incentives have led to diverging rates of diagnostic coding
18 between MA and fee-for-service Medicare, such that
19 enrollees of equivalent health status have higher risk
20 scores and, therefore, generate higher payments when
21 enrolled in MA.
22 This result is shown in a prior Commission

1 analysis which looked at beneficiaries who spent at least
2 one year in fee-for-service and then switched to MA.
3 Compared to the beneficiaries who remained in fee-for-
4 service, those who switched to MA had risk scores that
5 increased at least 6 percent faster in the first year. For
6 each subsequent year of MA enrollment, MA risk scores
7 increased by an additional 2 percent faster than fee-for-
8 service.
9 For the past few years, we have also conducted an
10 analysis to estimate the overall impact of differences in
11 coding. For MA enrollees in each year, we calculated the
12 cumulative increase in their risk scores over a period of
13 past continuous MA enrollment, and then we compared these
14 estimates of growth to similar cohorts of fee-for-service
15 enrollees.
16 For 2015, we estimated that MA risk scores were
17 10 percent higher than fee-for-service. This estimate
18 includes the effect of phasing in a new risk adjustment
19 model, which excludes certain diagnosis codes that have had
20 particularly divergent coding rates between MA and fee-for-
21 service. Although the new model produces a lower overall
22 impact of coding, both the old and new models exhibit a

1 steady divergence in MA and fee-for-service risk scores of
2 about 1 percent per year, shown in the first two rows of
3 the table.
4 By law, starting in 2010, CMS has reduced all MA
5 payments by a single factor to adjust for differences in
6 diagnostic coding. Starting in 2014, the law specified a
7 minimum adjustment amount, and in each year since then CMS
8 has applied the statutory minimum adjustment. For 2015,
9 the statutory minimum was 5.16 percent. After factoring in
10 all adjustments for coding, we found that 2015 MA risk
11 scores were 4 percent higher than fee-for-service due to
12 coding differences.
13 Given the impact of unadjusted coding differences
14 and evidence of variation in coding intensity across plans,
15 last year the Commission recommended adjusting for the full
16 effect of coding differences and emphasized equity in the
17 adjustment across MA plans. First, the Commission
18 recommended using two years of diagnostic data for risk
19 adjustment. This would reduce coding differences between
20 MA and fee-for-service and would naturally target HCCs
21 where coding is inconsistent across years. This policy
22 would reduce the impact of coding differences by about 1 to

1 2 percent.

2 Second, the Commission recommended excluding

3 diagnoses that are only identified through a health risk

4 assessment from risk adjustment. This policy would affect

5 MA plans in proportion to the number of assessment-based

6 diagnoses that have no follow-up care and would reduce the

7 overall impact of coding differences by about 2 to 3

8 percent.

9 Finally, after implementing these two policies,

10 the Commission recommended that the Secretary apply an

11 adjustment to account for the remaining impact of coding

12 differences, which we estimate to be about 5 to 7 percent.

13 The Commission discussed options for implementing this

14 adjustment in an equitable manner across plans.

15 This graph shows coding intensity estimates for

16 individual MA contracts and highlights the variation across

17 contracts. On the left-hand side, some contracts have

18 coding practices similar or below fee-for-service Medicare,

19 and on the right-hand side, some contracts have average

20 risk scores that have grown in excess of 30 percent over

21 fee-for-service growth. Although the graph does not

22 account for the effect of implementing the Commission's

1 first two recommended policies, I'll use it here to explain
2 one idea for implementing the final part of the
3 Commission's recommendation, addressing the remaining
4 impact of coding differences.
5 The solid red line represents our estimate of the
6 overall impact of coding intensity on MA risk scores. As
7 you can see, a policy that reduces all risk scores by the
8 same amount disadvantages some contracts, while allowing
9 other contracts to retain a significant amount of revenue
10 from higher coding intensity. A three-tier adjustment,
11 illustrated by the three yellow dashed lines, would group
12 contracts into low, medium, and high coding intensity
13 categories and then apply an adjustment for each category.
14 The adjustment for each category would be estimated based
15 on the coding intensity of the contracts in that category.
16 CMS has used these low, medium, and high coding intensity
17 categories previously when selecting contracts for risk
18 adjustment data validation audits.
19 Given the coding intensity recommendation you
20 made in the March 2016 report, my part of the presentation
21 requires no action. My presentation today was designed to
22 give you an update on the impact of coding differences, to

1 provide some additional detail about the extent of
2 variation in coding intensity, and present an idea for the
3 Secretary to implement the Commission's recommendation that
4 offers significant equity across plans. I also want to
5 remind you that, if implemented, the recommendation would
6 result in savings to the Medicare program.
7 I will now turn the presentation over to Scott to
8 discuss MA benchmark calculations.
9 DR. HARRISON: Thank you, Andy.
10 Let me start with a little background on MA
11 benchmarks. Benchmarks are county-specific, risk-adjusted,
12 and serve as bidding targets for the MA plans. They also
13 represent the maximum payment rate for MA plans in a
14 county.
15 Each county's benchmark is determined by
16 organizing the counties into four quartiles based on their
17 per capita risk-adjusted fee-for-service spending.
18 Counties are ranked by average fee-for-service spending;
19 the lowest spending quartile of counties have base
20 benchmarks set at 115 percent of local fee-for-service
21 spending. The next quartile of county benchmarks is set at
22 107.5 percent of fee-for-service spending, followed by a

1 quartile set at 100 percent of fee-for-service spending.
2 And the highest spending quartile has benchmarks set at 95
3 percent of local fee-for-service spending.
4 Conceptually, low fee-for-service spending
5 counties have benchmarks higher than fee-for-service in
6 order to help attract plans, and high fee-for-service
7 spending counties have benchmarks lower than fee-for-
8 service to generate Medicare savings.
9 As I noted, the starting point for calculating a
10 county benchmark is the estimate of the county's fee-for-
11 service per capita spending.
12 CMS calculates average risk-adjusted per capita
13 fee-for-service Part A and Part B spending for each county.
14 The calculation includes spending for all fee-for-service
15 beneficiaries. All are included whether they have both
16 Part A and Part B or they have Part A only or Part B only.
17 The main problem with this approach is that MA
18 enrollees must be enrolled in both Part A and Part B. And
19 our most recent data show that only 87 percent of fee-for-
20 service beneficiaries are enrolled in both Part A and Part
21 B. And we have found that beneficiaries who are in both
22 Part A and B have higher average spending than other fee-

1 for-service beneficiaries.

2 There are several issues arising from the
3 inclusion of the Part A-only beneficiaries in the fee-for-
4 service spending calculations. The big spending difference
5 between all fee-for-service beneficiaries and those with
6 both A and B arises because 12 percent of all fee-for-
7 service beneficiaries have Part A only. And their average
8 spending is much lower than the average spending for those
9 with both A and B. This results in an underestimate of
10 fee-for-service spending comparable to MA spending and,
11 thus, an underestimate of MA benchmarks.

12 Now, I should not here that we've found those
13 with Part B only do not significantly affect the average
14 spending numbers.

15 The Part A-only effect on the benchmarks varies
16 because there's a lot of variation in the percentage of
17 Part A-only beneficiaries in the fee-for-service population
18 across the country. The share of A-only reached 25 percent
19 of beneficiaries in some counties and as low as 3 percent
20 in others. And as I will detail on the next slide, Part A-
21 only beneficiaries are growing nationally as a share of
22 fee-for-service beneficiaries.

1 Over the last few years, a high percentage of
2 Medicare beneficiaries have joined managed care plans, and
3 a higher percentage of those remaining in fee-for-service
4 Medicare have not enrolled in Part B, meaning they are A
5 only.
6 From July of 2009 to July 2015, the percentage of
7 beneficiaries in Medicare managed care plans rose from 24
8 percent of all Medicare beneficiaries to almost 32 percent.
9 Of those remaining in fee-for-service, the percentage of
10 beneficiaries who have both Part A and Part B has declined
11 from about 89 percent in 2009 to about 87 percent in 2015.
12 That decrease is due entirely to the increase in the share
13 of A-only fee-for-service beneficiaries, shown on the third
14 row here, from about 10 percent to about 12 percent of fee-
15 for-service beneficiaries.
16 In the Medicare program as a whole, and not shown
17 on this slide, there was only a modest increase in the A-
18 only share from about 8 percent in 2009 to about 8.5
19 percent in 2015. But that increase is amplified as all of
20 the increase is contained in the fee-for-service population
21 because beneficiaries who are not enrolled in Part B cannot
22 enroll in Medicare managed care plans. Thus, as more

1 beneficiaries enrolled in A and B join plans, those
2 beneficiaries remaining in fee-for-service are less likely
3 to be enrolled in both Part A and Part B.
4 We found total average fee-for-service risk-
5 adjusted spending for beneficiaries enrolled in both Part A
6 and Part B about 1 percent higher than the average spending
7 for all fee-for-service beneficiaries. However, those
8 counties with higher proportions of Part A-only
9 beneficiaries -- say 15 to 25 percent -- are likely to have
10 had larger reductions in their fee-for-service spending
11 numbers due to the calculation being based on all fee-for-
12 service beneficiaries. Alternatively, counties with
13 significantly lower shares of A-only enrollment may not
14 have been significantly affected by the current benchmark
15 calculation process.
16 As MA penetration continues to grow, we expect
17 these calculation issues to grow. Higher MA penetration
18 leaves fewer, and perhaps less representative,
19 beneficiaries on which to calculate fee-for-service
20 spending. The fee-for-service calculation could be
21 corrected to ensure that the population that is used to
22 calculate the fee-for-service spending is representative of

1 the expected spending for MA beneficiaries.

2 Because by law beneficiaries must have both Part

3 A and Part B to enroll in MA, it might be more equitable

4 for CMS to calculate the county-level fee-for-service

5 spending on which the MA benchmarks are based using only

6 fee-for-service beneficiaries who have both Part A and Part

7 B. This way the calculations would be more reflective of

8 MA enrollment.

9 Compared with the current CMS process of

10 calculating county-level fee-for-service spending based on

11 all beneficiaries, we estimate that using the average fee-

12 for-service spending of only beneficiaries with both Part A

13 and Part B in the benchmark calculations would increase

14 benchmarks by about 1 percent nationally and, thus, result

15 in an increase in payments to MA plans on the order of

16 about $20 billion over 10 years.

17 Counties with 15 to 25 percent of their fee-for-

18 service beneficiaries in Part A would likely have higher

19 increases, up to 3 percent. Areas such as Pittsburgh,

20 Denver, Albuquerque, Portland, Oregon, Hawaii, and several

21 areas in California have 20 percent or more of their fee-

22 for-service beneficiaries without Part B. These areas all

1 have MA penetration rates over 47 percent, and the
2 estimated effects of using only beneficiaries with both
3 Part A and Part B on fee-for-service spending could have a
4 significant effect and result in higher benchmarks in areas
5 like these.
6 We look forward to your discussion and are
7 interested in learning whether the Commission is interested
8 in making a recommendation to change the calculation of
9 fee-for-service spending that determines the MA benchmarks.
10 DR. CROSSON: Great. Andrew, Scott, thank you
11 very much.
12 We'll now take clarifying questions.
13 DR. HOADLEY: A couple of questions. Andy, on
14 risk adjustment, the number that you show on Slide 5 that
15 overall 2015 would be 4 percent higher, what's the
16 comparison? What number were we looking at a year ago?
17 DR. JOHNSON: 3 percent.
18 DR. HOADLEY: 3 percent. So it's actually
19 getting to be a larger --
20 DR. JOHNSON: Yes.
21 DR. HOADLEY: And, Scott, I think I asked some of
22 this last year, but when you look at the Part A-only folks,

1 you talk about the fact that Medicare is a secondary payer
2 for active workers, income-related premium folks maybe who
3 opt out of Part B and so forth. But we don't have any
4 numbers, is that right, from CMS on those different
5 categories?
6 DR. HARRISON: We do not have numbers on the
7 different categories. They must exist somewhere. We have
8 not found them.
9 DR. HOADLEY: Yeah. And with the Medicare
10 secondary payer, I mean, those are still part of this
11 population that you're looking at?
12 DR. HARRISON: The plans get a reduced payment
13 for people with -- a significantly reduced payment,
14 obviously, for people with --
15 DR. HOADLEY: If they enroll in MA.
16 DR. HARRISON: Yes.
17 DR. HOADLEY: But they're still in the
18 denominator for the fee-for-service calculation.
19 DR. HARRISON: I'm not clear. To be in, I think
20 you have to have had a period where you're actually in so
21 they can measure you. I think a lot of the people that are
22 Medicare secondary payer aren't that, you know, for a long

1 period of time. So that gets a little dicey.
2 DR. HOADLEY: I mean, because, clearly, that
3 population is drawing -- in many cases drawing almost
4 nothing from their Medicare benefit.
5 DR. HARRISON: Right. And the other thing I want
6 to note is that this is -- for the Part A-only people,
7 we're only looking at the A spending.
8 DR. HOADLEY: Okay, right.
9 DR. HARRISON: So they're not included in the B
10 denominator.
11 DR. HOADLEY: Okay. But even there, I mean, many
12 of those -- certainly the secondary payer people are
13 unlikely probably to incur any kind of Part A cost because
14 their primary insurance is probably picking up all or most.
15 DR. HARRISON: You would hope.
16 DR. HOADLEY: Right.
17 MS. WANG: Are risk scores -- when the comparison
18 is on this A/B, A and B, or A-only phenomenon, when risk
19 scores are compared to fee-for-service, are they compared
20 to A and B enrollees, beneficiaries?
21 DR. HARRISON: No, they're much lower. So --
22 MS. WANG: No, no. Does the comparison group

1 also include Part A-only beneficiaries or is the comparison
2 -- the risk score comparison when you do these analyses --
3 DR. HARRISON: When you do this -- on Part A
4 only, right, I would have a risk score that would be
5 calculated, but I wouldn't have any Part B diagnoses, so
6 it's usually a very low risk score.
7 MS. WANG: So is the coding intensity adjustment
8 comparison of MA plans who have only A/B compared to a
9 group that's A/B and in addition A only that --
10 DR. HARRISON: No, they were not done that way.
11 MS. WANG: Okay.
12 DR. HARRISON: When we did the comparison, we
13 took only people with A and B.
14 MS. WANG: Got it. Okay.
15 The other question I have, I'm just curious about
16 this with the A/B phenomenon. When the ACA sent benchmarks
17 as a percentage of fee-for-service, do you know whether or
18 not the fee-for-service that they were, you know, aiming at
19 included A and B only or also this cohort of A only? I
20 mean, the question is --
21 DR. HARRISON: Yeah, that's what we're -- right,
22 that's what we're trying to get at, that when CMS

1 calculates it, they include people who are A only.

2 MS. WANG: Yes, but when Congress set, you know,

3 the 115, 107, and half 100 and 95, do you know whether or

4 not in their definition of a low-cost area versus a high-

5 cost -- would this possibly --

6 DR. HARRISON: They did not take any of that into

7 account.

8 MS. WANG: Meaning that they included A-only

9 beneficiaries in their estimate or --

10 DR. HARRISON: They just said average fee-for-

11 service.

12 MS. WANG: Average fee-for-service.

13 DR. HARRISON: There's secretarial discretion on

14 how to measure it.

15 MS. WANG: I just am curious. You know, this is

16 a totally different conversation, but if this

17 recommendation or this observation about sort of limiting

18 to people with A and B only has implications for the level

19 at which the percentages against fee-for-service are set.

20 Do you know what I'm saying? If there is an area, if there

21 --

22 DR. HARRISON: That's what we're saying the

1 problem is. It's that there is a mismatch.
2 DR. MILLER: Can I take a shot at this?
3 The way I would answer her question is,
4 implicitly, Congress said all of fee-for-service. A few
5 years back, depending on how far back you go, this wasn't
6 really an issue. There wasn't this big difference between,
7 just to keep it simple, the A-only population. So what
8 we're saying in this analysis is if you set the MA
9 benchmark using A plus B, it would move up. It would move
10 up a lot in certain counties, a little in some counties, or
11 maybe none in some counties, but it would move up, and so
12 on net, this is increasing the benchmark.
13 Now, here's the second thought, I would say, to
14 try and answer your question as directly as possible.
15 Implicitly, the 95 and the 115 is off of whatever that
16 baseline is. Are you okay with that?
17 MS. WANG: Right.
18 DR. MILLER: So we are talking about should we
19 make a recommendation to move that benchmark up about a
20 percent across the country, and then implicitly all of the
21 95, 115 would drive off of that new baseline.
22 MS. WANG: Right. I guess the question I have

1 is, Is there a further thought that the 95 and 115 would
2 need to be recalibrated if the estimate of underlying fee-
3 for-service spending was higher? I don't know.
4 DR. MILLER: I feel like we might be talking past
5 each other. I'm saying it would -- and maybe we do need to
6 just talk about it in more detail. The 95 percent number
7 would change too because if it came up a percent, that
8 whatever that dollar amount would --
9 MS. WANG: It would be 95 percent of the
10 additional percent.
11 DR. MILLER: Yes, right.
12 MS. WANG: So I'm saying maybe it would be 96
13 percent of the new fee-for-service equivalent or 112
14 percent of the new fee-for-service equivalent because the
15 base you're comparing against is different. That's all.
16 I just wonder whether it extends that far in
17 implications.
18 DR. CROSSON: Right. But, I mean, from a dollar
19 point of view, you arrive at the same point, I think.
20 You're just saying, "I'm going to take 95 percent off of a
21 different number instead of making the level of variation
22 off of that number."

1 DR. NERENZ: Well, if I can try to paraphrase, if
2 you're talking past each other, I may be in the middle.
3 [Laughter.]
4 DR. NERENZ: I think what I was hearing is that
5 if the effect of including only Part A, Part B would be to
6 raise the benchmark, you could then counter that effect by
7 changing the 115 number or the 95 number, and you could
8 bring it back to budget-neutral. Is that --
9 DR. MILLER: But our point here -- I'm surprised.
10 I am surprised by -- our point here is we think what's
11 happening right now is not fair to the managed care plans,
12 that the proper baseline is -- since I can only enroll an
13 A/B person and you're comparing me to an average, that
14 includes some people I can't even enroll. The whole point
15 of this exercise, it's not budget-neutral. We're saying
16 there's some dollars that should probably go back into the
17 baseline to benefit the plan.
18 MS. WANG: Right. And I'm actually not speaking
19 from the perspective of being in an A plan. When the
20 percentages against fee-for-service were established, there
21 was an assessment of lower cost areas that needed a higher
22 percentage and higher cost areas that it was appropriated

1 at a lower percentage.

2 I am simply asking are some of the implications
3 include only A/B as the fee-for-service comparator, that
4 those assessments of what's high cost and low cost might
5 change, so that in a budget-neutral scenario, there is a
6 redistribution of the percentage because there is a new and
7 better -- so the example of the counties that were given as
8 an example, that there is a high penetration of A only,
9 there's also a very high penetration of MA. So that's kind
10 of interesting. This is just observational.

11 DR. MILLER: And I do think it's possible that
12 given that this phenomenon doesn't occur uniformly across
13 the country, if you went back and reset everything, you
14 might find small differences or some differences in the
15 percentages of here's the counties that are here, you know,
16 95 and 115.

17 For the purposes of at least how we opened this
18 conversation, this is something that we were thinking of
19 that we wouldn't go back and recalculate it. As a
20 technical question, it could potentially have some
21 implications for that. Given the fact that these counties
22 aren't distributed uniformly across the country and where

1 they would fall on each of those quartiles maybe would
2 affect those percentages a bit, and maybe it's a further
3 thought. But the idea here is right.
4 DR. CROSSON: Just to be clear, as it stands,
5 this is not a budget-neutral proposal.
6 MS. BUTO: If I could just add one thing, I think
7 Pat is assuming greater precision in coming up with these
8 percentages in the legislation than probably existed at the
9 time it was written. I mean, there were some rough
10 justices, I guess, the way I would describe it and the way
11 they came up with the numbers.
12 DR. CROSSON: Okay. Craig, I think, is next.
13 DR. SAMITT: Right. Thanks.
14 Great job with the paper. It was very clear.
15 I was intrigued by Slide 7, and I was curious
16 predominantly about the outliers to the far right, but I
17 remember reading that there had been some -- one of the
18 other alternative proposals to consider was a risk
19 adjustment, risk-coding adjustment specifically for outlier
20 pools as opposed to affecting everyone, including these
21 three tranches. And I know you talked in the paper that
22 doesn't have to be just three tranches. It can be more.

1 So you can even envision to the far right. There's an even
2 higher adjustment.
3 But did you look at -- I think it may have been
4 referenced in Kronick's paper in 2014 and even prior CMS
5 proposals. Have you looked at an outlier-only adjustment
6 as opposed to either an across-the-board adjustment or a
7 triple-tiered adjustment as another alternative?
8 DR. JOHNSON: We haven't looked at an outlier
9 adjustment only, mainly because I think most of the
10 contracts have some level of coding intensity or increasing
11 risk scores above fee-for-service. So, even if it is a
12 small amount, that it is consistent over time over a couple
13 of years that we've done this analysis that it shows up
14 regularly, and I think that's the main reason for not
15 focusing on just the highest end.
16 DR. SAMITT: I'll come back to it again in Round
17 2.
18 DR. CROSSON: Bruce.
19 MR. PYENSON: I have a couple of questions for
20 Andy, and let me compliment you on the report, really a
21 terrific report.
22 The two questions are -- the first is referencing

1 the CCIIO March report on risk adjustment, different
2 context applies to the HHS risk adjuster, and that's
3 concurrent, not perspective, of a bunch of differences.
4 And they're recommending and going to use drugs for, I
5 think, seven or eight categories of their HHS HCCs.
6 Forgive me if this has been discussed before I
7 got here, but I would ask your thoughts on whether that
8 would be an idea in addition to the two-year span on risk
9 adjustment, what your thinking is about that.
10 DR. JOHNSON: I think CMS has been pretty
11 hesitant to include any measures of utilization in the risk
12 adjustment in order to avoid any adverse incentives. I
13 think the HHS risk adjustment uses the drug information
14 only to adjust severity of given HHCs.
15 MR. PYENSON: The biggest example is probably --
16 it's to confirm a diagnosis, for example. There's, I
17 think, two categories where they're doing a severity. For
18 example, someone who has insulin and is not coded with
19 diabetes would be presumed to have diabetes, sort of a flag
20 mostly.
21 DR. JOHNSON: I don't know if the Commission has
22 taken a position on --

1 DR. MILLER: Well, this may predate both of you,
2 if I am remembering properly.
3 So Dan did some work on risk adjustment -- I want
4 to say a few years ago -- and talked through some of these
5 different ideas.
6 Andrew is correct, and the Commission also
7 expressed these cautions that with these prospective
8 approaches, there has to be a distinction between just
9 utilization or those kinds of adjustments because you're
10 basically starting to return a prospective system to a
11 cost-based or utilization-based system. So there was real
12 caution in putting prospective types of measures in.
13 Although, as you've pointed out, there are
14 careful ways you can do it and also utilization that you
15 can pick that is less gameable. So if you say somebody
16 falls and breaks a hip and that's a prospective adjustment,
17 that's not something that's gameable, whereas if you say
18 I'm going to put in the amount of drugs that you use, then
19 obviously there's a real incentive to do it.
20 My sense on the drug world -- and, again, I think
21 you said this -- is there's markers to confirm diagnoses as
22 opposed to counting numbers of scripts or utilization, that

1 type of thing.

2 But I also thought there was a -- and now I've
3 walked off the end of the pier of what I remember, but I
4 also thought these models are built in fee-for-service, off
5 of fee-for-service, and in fee-for-service, there's still
6 something of a disconnect of who has drug information and
7 who doesn't because not everybody is enrolled in drugs. So
8 bringing the drug stuff in would have to be thought
9 through. That's not a "hell, no," but there's a little bit
10 of a mismatch.

11 And then on the more general point on the
12 perspective would be if you went in that direction, it
13 would be picking almost sentinel events that were un-
14 gameable, so that they made sense in the risk adjustment,
15 but then didn't just turn it into a cost-based -- that's
16 not quite the right word, but utilization-based adjustor.
17 And we had some of that discussion -- I don't know -- two
18 or three years ago. I'm forgetting.

19 MR. PYENSON: A second question, which is there
20 is a process for submission of risk score information and
21 transition from RAPS to EDPS. I'm not sure if it's clear
22 how that would interact with your findings. Do you have a

1 sense of that?

2 DR. JOHNSON: Eventually, starting next year for

3 2016 risk scores, when the risk scores are based on a blend

4 of both RAPS and EDPS, we would include that information on

5 estimating the overall difference in MA risk score growth

6 compared to fee-for-service. So I think we'd have to see

7 what the analysis shows next year first before making any

8 judgment on how to further address that.

9 DR. CHRISTIANSON: So, on Jay's list, we have

10 Warner, Bill, Brian, and Kathy. So, Warner?

11 MR. THOMAS: One of my questions is on the

12 adjustment, this kind of three-tiered adjustment that

13 you're contemplating. I know there's several adjustments

14 that are being considered or are already implemented in MA.

15 I mean, do we have a full understanding of what the total

16 adjustments will be, once they're all fully implemented?

17 It seems like there's a lot of moving parts, some that are

18 already implemented, some that could be being proposed.

19 DR. JOHNSON: So the two specific adjustments to

20 address coding intensity or at least that clearly have an

21 impact on coding intensity are the phasing in of the new

22 model. So that is taken into account in the payment blend

1 in the bottom row here, and then subtracting from that, the
2 5.16 across-the-board adjustment that CMS implemented.
3 That's where we come up with the resulting 4 percent
4 difference, at least for 2015, and that's before, as Bruce
5 mentioned, any encounter data effect it might have.
6 MR. THOMAS: So then what would the cumulative --
7 what's the potential cumulative adjustment? Are those
8 additive? Do you have to add those together or --
9 DR. JOHNSON: It would be roughly the 10 percent
10 overall estimate that we have of the full difference
11 between MA and fee-for-service.
12 MR. THOMAS: So the 5 percent is included in the
13 10? 5.1?
14 DR. JOHNSON: Yes, yes.
15 MR. THOMAS: Okay.
16 DR. JOHNSON: So it's 5.16 plus 4. With rounding
17 it, it comes up to 10.
18 MR. THOMAS: So then this 10 percent that's being
19 contemplated there, is that inclusive of the new
20 recommendation as well, or is the new recommendation on --
21 would be on top of that?
22 DR. JOHNSON: So the recommendation from last

1 year would get rid of the 5.16 percent and do two years of
2 data, remove health risk assessment diagnoses, and then
3 make an adjustment after those two are in place.
4 MR. THOMAS: Okay. All right. Thank you.
5 MR. GRADISON: The question has already been
6 covered. Thank you.
7 DR. DeBUSK: First of all, thank you for a great
8 chapter. It was sort of exciting to read.
9 I had a question on page 19 of the reading. As
10 you talk about doing contract-level coding intensity, you
11 speak to grouping contracts into different categories --
12 high, medium, and low coding intensity. And I had a
13 question there about circularity. How would you tell the
14 difference between a contract that has a high degree of
15 coding intensity versus a plan that just has a higher
16 acuity patient? Because it seems like if you had the
17 information to put them in the appropriate category, you
18 would already know the adjustment. So it seems circular to
19 me.
20 DR. JOHNSON: So there is -- I mean, the way that
21 we did this analysis is looking at the enrollees in a
22 contract in 2015 and then looked at their past history

1 based on how long they were continuously enrolled in MA,
2 and we compared those change estimates to the fee-for-
3 service, similar cohorts of similar length of enrollment.
4 So, at the contract level, there's some
5 consistency over year, but it moved a little bit. So
6 that's why we suggested that there be a grouping of
7 contracts. Contracts did not tend to jump from the low
8 category to the higher category with the specific numbers,
9 so that this grouping was a way of sort of combining like
10 contracts into an estimate that's predictable from one year
11 to the next.
12 DR. DeBUSK: So, basically, once you learned your
13 reputation for, say, being a highly intensely coded plan,
14 you sort of stayed in that category, then?
15 DR. JOHNSON: I think that is either something
16 for the Commission to take a stance on or for CMS in
17 implementing the policies, how frequently assigning
18 contracts to a level would happen and whether or not that
19 happens prospectively or after the fact as implementation
20 issues.
21 DR. DeBUSK: Thank you.
22 DR. JOHNSON: Thank you.

1 DR. CROSSON: Kathy.
2 MS. BUTO: I think I understand this, but I
3 wondered if you could walk through again the budgetary
4 effects or the supposed budgetary effects or estimates
5 related to first addressing the coding intensity issues and
6 then taking out Part A only. So, obviously, they're moving
7 in different directions. Is the Part A only adjustment
8 which will raise the payments to MA plans much smaller, I
9 guess is the way I'm thinking about it, than taking out --
10 or much larger, I guess is the question. Will the amount
11 go up by such a great amount that by taking the -- doing a
12 more thorough job on coding intensity, they'll still
13 benefit from the two things happening at one time?
14 DR. JOHNSON: I think all of our estimates show
15 the coding intensity adjustment to be larger than the MA
16 only.
17 MS. BUTO: Than the MA only -- or the Part A
18 only?
19 DR. JOHNSON: Part A only. Excuse me. Yes.
20 DR. HARRISON: There could bed plans who operate
21 in counties that would get, say, a 3 percent bump in the
22 benchmark, and they're low coders. It could be that they

1 would end up actually benefitting on that, possibly. Don't
2 know.
3 DR. CROSSON: Okay. Do we have all the
4 clarifying questions, or have we missed anyone? Alice and
5 Jon.
6 DR. COOMBS: So I had a question regarding the
7 impact of employee on the calculation going forward. Is
8 that a significant effect in terms of predicting the Part
9 A, Part B participation?
10 DR. HARRISON: So you're talking about people
11 over 65 working, whether that --
12 DR. COOMBS: Yes, yes.
13 DR. HARRISON: So, typically, they would be in
14 Part A and then not sign up for Part B until they needed
15 to. So, if they still had employer coverage, they probably
16 wouldn't sign up for B.
17 DR. COOMBS: So, as regions change based on the
18 employment in that age group, different areas -- say the
19 employment for a 70-year-old might change the dynamics
20 within certain geographies as opposed to others.
21 DR. HARRISON: It could, and CMS pays plans.
22 There's a special Medicare secondary payer adjustment that

1 they use when they pay plans, so they pay plans much less
2 if Medicare is --
3 DR. COOMBS: And so there is some kind of
4 knowledge about a variation, a regional variation of that,
5 or how does that work?
6 DR. HARRISON: I assume there is a regional
7 variation, and it's taken into account when the rates are
8 set. And every plan has a different Medicare secondary
9 payer adjustment.
10 DR. COOMBS: What percentage range is it? Do you
11 have a number?
12 DR. HARRISON: We don't know. It's going to be
13 less than -- it's going to be less than 12 percent, but we
14 don't know.
15 DR. COOMBS: Okay, okay.
16 DR. CROSSON: Jon, and then I saw -- sorry.
17 DR. CHRISTIANSON: Paul said maybe he can jump
18 in.
19 DR. CROSSON: Oh, you're jumping in on that.
20 DR. GINSBURG: So sorry about the geographic
21 variation in the Part A only.
22 You mentioned the cities that have the highest.

1 It sounds like all knowledge economies -- Denver, Portland,
2 California. That's probably where we'd expect the highest
3 rate of labor force participation over 65, so I suspect
4 that's --
5 DR. HARRISON: Does Portland have any people over
6 65?
7 [Laughter.]
8 DR. CROSSON: Look around the table, please.
9 DR. MILLER: You can see Scott is very pleased.
10 [Laughter.]
11 DR. CHRISTIANSON: You started off by, I think,
12 correctly saying that the fee-for-service sector doesn't
13 have an incentive to completely code, and the MA sector has
14 an incentive to -- I think the words you used -- generally
15 aggressively code. So I thought it might be useful to
16 review for the Commission the evidence for why Congress has
17 taken the position, it seems like implied, that the problem
18 is in the MA sector. The MA plans would say, "We're
19 accurately coding," and yet Congress had said we need to
20 reduce -- you know, basically reduce payment to account for
21 the fact that there's this more aggressive coding.
22 Can you review for us the evidence that would

1 lead us to assume that the problem is overappropriate
2 coding in the MA sector that needs to be reduced or whacked
3 down by 5 percent every year?
4 DR. JOHNSON: I see it as sort of a conceptual
5 framework issue in that the payment policy is based on fee-
6 for-service, diagnostic, and spending information because
7 that's currently the only data set available to make the
8 link between those two sets of information and to estimate
9 the set of risk score coefficients.
10 So in order to produce accurate payments to MA
11 plans, there is a necessary adjustment to ensure that
12 there's similar levels of coding in both MA and fee-for-
13 service, and to make sure that when the numbers of HCCs
14 identified for a particular enrollee are different, that
15 the dollar amounts get adjusted at the end through this
16 coding adjustment.
17 DR. MILLER: Can I also take a shot at it?
18 DR. CROSSON: Yeah.
19 DR. MILLER: So I'm kind of making this up and
20 trying to put it in, you know, civilian terms -- well, for
21 everybody. I know Jon has a deeper understanding of this.
22 So in a sense, what you do is you go into fee-

1 for-service. That's the complete database. That is what
2 the benchmark is based on. And you go through, and you say
3 there's a set of -- you know, there's a set of
4 relationships, and you build the relative relationships in
5 the risk model using that. And in a sense, you're
6 implicitly saying there's a block of dollars and you have
7 distributed them across people and said this is how it
8 would work or this is the relationship of those dollars.
9 Then there's a second step. So you've built this
10 model, and it sits out there, and you say each time you
11 code on this, there's a dollar increment in your payment.
12 And so if that was built using three codes per person --
13 just pretend that that's what happened -- and then somebody
14 had an incentive to more -- and this isn't incorrect, but
15 an incentive to go find each and every code that that
16 person could possibly be coded on, they could come up with
17 five codes or six codes. Okay? Because your dollar amount
18 just follows how many codes you are, you are not
19 necessarily back at that implied total spend that you built
20 the model out of. So if you built the model out of $100
21 and said on-net there's $100 in a population that looks
22 like this, and then said, okay, now, tell me your codes,

1 and I came up with, instead of three, six codes for each
2 person, you end up spending more than $100.
3 And what you're seeing over time is that fee-for-
4 service coding grows like this and MA coding grows like
5 this [indicating], and the difference is what they're
6 spending above what they would have spent if it was the
7 same sets of codes that came out of what the model was
8 built on.
9 As I listen to myself, I realize that's not
10 clear.
11 [Laughter.]
12 DR. CHRISTIANSON: What you're saying is it's not
13 an issue -- if I understand what you said, it's not an
14 issue of accuracy of coding; it's an issue of trying to
15 make everything fit within a given dollar amount?
16 DR. MILLER: Yeah, and that's -- thank you, Jon,
17 and I think you were just being nice, and I appreciate
18 that. Yeah, that is what I was trying to say. It doesn't
19 necessarily mean that the plans have coded inaccurately.
20 It may truly be that the person has, you know, multiple
21 conditions that in the fee-for-service world it wasn't
22 worth an extra dollar to code. But now when you step out

1 of the fee-for-service framework and get your payment on
2 the managed care side, it is definitely worth the trouble
3 to go find that code, and you just don't end up back to a
4 budget-neutral dollar, like Jon said.
5 MS. WANG: So that's very clear. There is sort
6 of a brute force kind of like get back into the original
7 pot of dollars that we started with. You know, I think
8 that the coding intensity discussion is very confused --
9 not confused, but complicated by a lot of incoming. You
10 know, you have this chart on page 7 that shows this extreme
11 coding behavior among some plans that drives risk scores up
12 and leads people to believe there's kind of gaming or
13 people are just doing this to get money. And then there
14 are plans that think they're doing their job by identifying
15 previously unidentified conditions so they can work on
16 them, and that shows up in what's called coding intensity
17 because fee-for-service didn't catch them.
18 I do wonder what the implications are, though,
19 because my understanding is that within ACOs, ACOs also are
20 gathering risk scores -- is that true -- when they compute
21 against their baseline? There is a risk score adjustment
22 there. So I think that there's a bigger implication here

1 that any -- if we're saying that any change in the capture
2 of HCCs and conditions that somebody is identifying because
3 they're working on them must be by brute force returned to
4 zero, to the fee-for-service -- I think we've got a
5 problem.
6 So, you know, I do -- I think that the focus on
7 eliminating the worst effects of sort of the revenue
8 maximization from coding activities is very, very
9 legitimate and needed to be addressed. But I'm a little
10 bit worried about the underlying philosophy that says,
11 whether it's an MA plan or an ACO or any kind of value
12 base, we have to return by brute force back to net neutral
13 to fee-for-service.
14 DR. MILLER: But there are a couple things in
15 there, and just to be, you know, very direct about this,
16 I've had my own travels among managed care plans, and there
17 are lots of managed care plans that are pointing fingers at
18 each other and saying actually they aren't -- that there
19 are people who are aggressively engaged in revenue -- and
20 you've acknowledged that. And so even among managed care
21 plans, there's a lot of finger pointing of like this is
22 going on, they've hired these consultants, and they're just

1 maximizing.

2 The second thing I would say about the ACO -- and
3 this is, you know, with two seconds of thought, and so I
4 don't feel real confident in it. If it's happening and
5 there is some coding that results in fee-for-service, more
6 coding that results in fee-for-service as a result of the
7 ACO, then the comparison baseline off of fee-for-service
8 should go up. And so, you know, in theory, whatever these
9 calculations are should catch that.

10 The other thing I would say is some people in the
11 managed care industry say, well, you know, if we would just
12 move to an encounter-based risk model, we wouldn't have to
13 worry about this scoring -- or I mean this adjustment. And
14 there's some truth to that because you'd be kind of
15 renormalizing to the behavior of the plans. But even
16 there, keep in mind that if another plan codes a lot more
17 than your plan, then they're going to -- of that revenue,
18 they're also going to draw more out of it there.

19 So I think even if this problem were to switch
20 and say it should be more of a managed care phenomenon, I
21 still think among the plans there would be finger pointing
22 and questions about, well, shouldn't you be going after

1 certain types of plans? I don't know that the problem goes
2 away entirely --
3 DR. CROSSON: All right --
4 DR. MILLER: -- even if you move off of fee-for-
5 service. I'm sorry.
6 DR. CROSSON: We've moved away from clarifying
7 questions into content here, so let me ask, are there
8 actually clarifying questions? If not -- Warner, and then
9 we're going to move to Craig and go into the content.
10 MR. THOMAS: Just real quick. I had asked
11 earlier about the aggregate change, which you've indicated
12 here. Do you have a range of -- you know, because I
13 understand this is an average across all -- across the
14 country. Do you have a regional or a market look at what
15 these variations look like or a plan look at what the range
16 of -- I mean, I see this, but I guess at the end of the
17 day, what would be the calculated impact of -- or the
18 estimated impact of all these changes kind of on plans kind
19 of across a broader spectrum, you know, a range of change?
20 DR. JOHNSON: I think the -- I mean, the way that
21 we have described and estimated the impact of the
22 Commission's recommendation is that using two years of

1 diagnostic data would have somewhat of a broader effect
2 across plans, but might affect certain HCCs where fee-for-
3 service coding is more inconsistent across years. So that
4 might have a differential effect across plans. Using
5 health risk assessments would also have a differential
6 effect across plans. And then when you -- so 1 to 2
7 percent and 2 to 3 percent is the aggregate numbers. I
8 don't think we've done an analysis to figure out exactly
9 how much the first policy would do. Last year, we did put
10 up some graphs about the impact of health risk assessments
11 across plans, and the graph looked similar to this one
12 where there was a big right tail. But then the remaining
13 portion is this 5 to 7 percent, which we estimated would be
14 -- you know, introduce some inequity across the contract.
15 So I don't know that we've put an estimate
16 together for specific contracts of how each of the three
17 policies would work together, but there is evidence that
18 we'd be tending in the right direction so that there would
19 be larger adjustments for plans that have higher coding
20 intensity and smaller for plans at lower coding intensity.
21 MS. BUTO: Very quick, and this sort of goes back
22 to my question that's related to what Warner was just

1 asking. So the only number we have in the paper is the $20
2 billion over 10 years increase in the benchmarks. And I
3 think what's helpful to know is what is the cumulative 10-
4 year number roughly for the adjustment that we're talking
5 about making, because that feels like it's going to be a
6 lot bigger. But I don't know -- I don't have a sense of
7 what those two are. So the number that we see is the $20
8 billion, but my sense is that overall this is going to be a
9 fairly significant hit.

10 DR. JOHNSON: So the $20 billion estimate over 10
11 years from using A and B beneficiaries to calculate the
12 benchmark matches up against what we say is a 4 percent
13 increase in coding in one year. Scott's estimate comes up
14 to about 1 percent per year, so there is a differential in
15 each year, and that would be expected to continue forward,
16 you know, in parallel. There would continue to be higher
17 impact from coding recommendation than using A and B.

18 MS. BUTO: Right, but you don't have a rough
19 number of what that impact is?

20 DR. MILLER: That's something we can work through
21 and come back to [off microphone]. The way I think about
22 it is that the Commission made some recommendations on

1 coding, and a lot of those recommendations were driven by
2 the equity issue that you see here in a couple, two, three
3 ways, and some savings come out of that. And the point I
4 wanted to put across to you guys and get you to understand
5 is if you want to go after the A/B issue, which is sort of
6 a different, you know, equity issue, there's probably
7 something of -- you don't have to worry about the fact that
8 you're spending the $20 billion because you've already made
9 recommendations on savings, is kind of the thought process.
10 DR. CROSSON: Okay. So let's go into the
11 discussion. Could you throw up Slide 14 just to remember
12 we have a question on the table as well? Craig, you're
13 going to start off.
14 DR. SAMITT: Thanks very much, Jay.
15 I'd start with sort of the context that I've
16 practiced in and led provider organizations in both the
17 fee-for-service Medicare and the managed MA world, and I'm
18 going to focus most of my remarks around the risk intensity
19 adjustment, because this isn't just a coding issue. This
20 is a clinical management issue that the practice patterns
21 and the clinical models are different and distinct in many
22 respects in the practices and the fee-for-service world

1 than the practices in the MA world. And so in many
2 respects, I echo Pat's concerns that we're painting a risk
3 intensity adjustment with a broad brush when in all reality
4 you've got good performers and you've got bad actors.
5 And while certainly a three-tiered approach, or I
6 would even argue it should be four or five tiers, is better
7 than a single tier, I'm concerned, when you look at Slide
8 7, that you can't tell which contracts are good actors and
9 which contracts are bad actors. And in many respects,
10 we're penalizing everyone.
11 What I'm most concerned about is you've got
12 complex Medicare populations that are being served by
13 organizations that need accurate risk adjustment coding to
14 support the resources needed to manage their care. And the
15 intensity adjustments may very well dismantle or diminish
16 the ability for those practices to do that.
17 It may just suggest that the risk adjustment
18 methodology overall, to Mark's point earlier about is there
19 an alternative, is just generally flawed because we can't
20 easily tease apart what is a risk adjustment for the sake
21 of coding only and what is true intensity, because these
22 practices are investing greater resources to support that

1 care. So I have concerns about the adjustment overall.
2 Certainly, again, the tiering is better, but it still feels
3 to me as if it's inadequate.
4 I also would tag onto Jon's comment. You know,
5 we talk about the MA part of the risk intensity adjustment
6 as kind of the flawed part, but I'm concerned about the
7 fee-for-service side. So, you know, what do we do to
8 encourage not just appropriate coding but appropriate
9 management and appropriate identification of disease state
10 in fee-for-service as much as may exist in Medicare
11 Advantage? And so it's not referenced much in the paper.
12 I think it's underappreciated. But to what degree does the
13 MACRA legislation move this needle? Should we think about
14 a requirement for more accurate coding and diagnosis in
15 fee-for-service through MACRA? And, you know, it's
16 mentioned in the paper that ACOs do focus on coding, but
17 maybe it's a significant both undercoding and
18 undermanagement issue in fee-for-service that needs
19 attention. And I guess I'd be interested if MACRA would
20 advance that.
21 We didn't talk about this in the clarifying, but
22 I do agree kind of with the removal of special needs plans

1 from this analysis, and it wasn't clear to me in the paper
2 how we would think about risk intensity adjustment at all
3 in the SNP population. But you could argue that SNP
4 selection is true intensity selection, that these complex
5 patients would choose to be part of SNP plans. So I would
6 imagine that if we do remove SNP, it would be done in a
7 non-budget-neutral manner in that SNP truly is excluded,
8 and if we think about intensity adjustment, if we must,
9 that it's the balance of MA versus fee-for-service as
10 opposed to siphoning off resources from risk intensity
11 adjustment in MA because we're pulling out SNP.
12 And then, finally, just a comment about the
13 benchmark A/B. I am in support of this recommendation. It
14 seems rational. It doesn't seem appropriate that
15 benchmarks would be set for A or B as opposed to A and B.
16 And I would be in favor of that recommended change.
17 DR. CROSSON: Thank you, Craig.
18 Scott, Andrew, let me just ask a question in
19 follow-up to what Craig said. So the type of coding
20 process or diagnostic identification that is inherent in
21 the ACO payment system, is that different from or the same
22 as what exists in ma?

1 DR. JOHNSON: I don't know if I know for sure,
2 but I think that to the extent that there are incentives in
3 ACOs to code more completely, that those efforts would be
4 captured in our comparison fee-for-service group.
5 DR. MILLER: And, also, David wrote me a note
6 that there is actually an adjustment that is done in the
7 ACOs if they see that the coding is exceeding --
8 MR. GLASS: There are limits on [off microphone].
9 DR. MILLER: Right. So some of the same behavior
10 that's being applied on the MA side is applied on the ACO -
11 -
12 DR. CROSSON: I'm sorry. So CMS makes an
13 adjustment?
14 MR. GLASS: Yes [off microphone].
15 MR. PYENSON: Under MSSP Model 1, risk scores for
16 existing patients can't go up by more than --
17 MR. GLASS: The demographic [off microphone].
18 MR. PYENSON: I'm sorry?
19 MR. GLASS: The demographic [off microphone].
20 MR. PYENSON: Yeah, just the demographic, people
21 get older. But they can go down.
22 Now, one of the dynamics here, the reason why

1 using two years of data is such an important thing is that
2 codes disappear, right? You see something like, I don't
3 know, 20 percent of HIV/AIDS patients where we know there's
4 no cure not being coded in the next year, and that's been a
5 challenge for MSSPs until they figured out they have to do
6 a better job of coding, because risk scores are allowed to
7 go down for Model 1. So it's a very different incentive
8 for the ACOs than for the MAs.
9 DR. CROSSON: Thank you for that.
10 Okay. So let's go to continue the discussion.
11 Can I see hands for people who want to -- so let's start
12 with Jack and move this way.
13 DR. HOADLEY: So I agree with some of Craig's
14 comments in terms of the need to think more about getting
15 things right on the fee-for-service side, but I kind of
16 look at the exercise we're in here as more of sort of a
17 math and mechanics issue. So the mechanics is the sense
18 that a couple of the references has been to, that if you
19 don't happen to have an encounter in a given year in the
20 fee-for-service system, there just may be no mechanical way
21 that that diagnosis shows up. And that's part of why we
22 have the two-year recommendation is to say, well, if that

1 encounter about your HIV, you didn't happen to see any
2 physician because things are stable, and maybe you had an
3 encounter where you broke an arm, and the orthopedist has
4 no particular reason to put an HIV diagnosis code on,
5 that's no longer in the data set. So it's those kinds of
6 mechanical things.
7 And, sure, it would be better if each physician
8 sort of recorded more of the full history because,
9 obviously, that orthopedist wants to know if the person has
10 HIV or diabetes or whatever as part of treating the
11 orthopedic issue, but mechanically, that's not just the way
12 it happens. So it seems like that's part of our -- we're
13 just sort of trying then to correct the math, that when we
14 do a calculation with fee-for-service data and then the MA
15 world is just doing things differently, mechanically, that
16 we're just trying to get the math to line up. And I think
17 sometimes the rhetoric becomes "Oh, we're correcting the
18 incorrect coding intensity on the MA," and some of it, in
19 particular, things we've illustrated on the nonmedical
20 encounters may be about that. And that's, again, one of
21 our other recommendations.
22 But to the extent that it's just in the system

1 differently, it seems to me like we're just kind of
2 correcting the math, and we should maybe be careful not to
3 -- I don't know that we have done this wrong in our reports
4 or anything, but just in general, when people are talking
5 about it, talk less about, oh, well, the MA plans over-
6 code. They just code differently, and so we're trying to
7 reconcile it. And that's kind of the way I think about it.
8 And I think the suggested alternative goes in
9 that direction to try to get the math even further right
10 among the MA plans, and that goes to the equity. And that
11 comes back on the other issue where I think I also agree
12 with the recommendation, and I think it's partly that when
13 we started doing this or when CMS started doing this, the
14 amount of people in this box of Part A only was smaller, so
15 it didn't matter so much. And you made this point. It's
16 growing, but it's also growing unevenly, and those are
17 reasons to say it creates some inequity. So there's a
18 logic to fixing it, just like the inequity in the graph
19 that you showed on the risk scores builds the case to make
20 the kinds of corrections we see there. So I think we're
21 going in the right direction on both of these issues.
22 DR. CROSSON: Kathy.

1 MS. BUTO: So I really like two of the
2 adjustments that you're recommending for dealing with
3 intensity, the two years of data, and then excluding the
4 diagnosis, which diagnoses only documented through health
5 risk assessments. I think those are pretty solid.
6 I also like the tiers, the fact that we made an
7 effort -- and I think this was your design -- to group
8 plans by coding behavior. I think that's really a good
9 direction to go.
10 I'm queasy, though, about this whole notion of
11 just taking the residual, and it goes back to, I think,
12 what Craig and Pat were saying, which is I'm not totally
13 sure that we should take all the residual back. My sense
14 is some of it. Not knowing any other way to do it, I guess
15 what I'd prefer to see is for CMS -- or for there to be
16 some way to audit or look at this issue of coding intensity
17 on a sample of plans, maybe in the tiers, in such a way
18 that you could actually develop at least another data point
19 to test our assumption that the whole residual needs to be
20 adjusted for.
21 So that's the only part that really gives me
22 pause. I don't know that there's a good way to do that

1 without spending a lot of money to do an audit like that,
2 but it just strikes me that at some point, we need to know
3 whether that assumption is totally correct, that the whole
4 residual needs to be adjusted for. So that's my only
5 concern.
6 DR. CROSSON: Paul and then David.
7 DR. GINSBURG: Yeah. Well, I think the
8 recommendations on Part A only are very good.
9 I was particularly struck when you showed how
10 certain metropolitan areas, this is a big deal for, and so
11 I think that could be --
12 I think Craig's comment about looking into ways
13 to get better coding in fee-for-service is very intriguing.
14 One thought I had, the degree to which areas with higher MA
15 penetration or higher ACO penetration would actually
16 influence coding and fee-for-service in the way that
17 management often does have spillover effects and influences
18 practice patterns in the fee-for-service sector.
19 I presume you could just look at the fee-for-
20 service trends in those areas with high MA penetration and
21 see if they're different from others, and so I'm not sure
22 what you do with it. Other than have influence go from MA

1 and ACOs to fee-for-service, I don't know of any other way
2 to actually influence fee-for-service coding because the
3 incentives are fee-for-service incentives.
4 So I think I'll stop there.
5 DR. JOHNSON: Can I add to that point? That we
6 did look at the comparison of MA contract-specific coding
7 to national fee-for-service and then a separate comparison
8 to local fee-for-service areas based on the service area of
9 the MA contracts, and it did make some difference for
10 individual contracts. We did not look at whether or not it
11 aligned with MA penetration rates, but overall, there was a
12 little bit of change, and it seemed to be fairly random.
13 DR. GINSBURG: I have one more comment that I
14 forgot about. Kind of an overlay to this whole discussion,
15 thinking back to our premium support discussion is that one
16 of the major issues about going forward with premium has
17 always been is the risk adjustment good enough in the sense
18 we're dealing today with risk adjustment which -- I mean
19 risk coding which has a threat to the trust funds that's
20 going to cost the program more than it should, whereas
21 under premium support, it can drive up the prices of the
22 fee-for-service plans, in a sense, lead to a situation

1 where there's a bigger share of MA than what the
2 beneficiaries would really like because it's distorted the
3 price signal. I don't think we want to get into that
4 today, but I just wanted to point it out for context.
5 Frankly, after reading your paper, I was actually
6 much more optimistic about the ability to do premium
7 support and not have it be really impaired by risk-coding
8 issues.
9 DR. CROSSON: David.
10 DR. NERENZ: This is going to be an arithmetic
11 question, but I want to walk through a little exercise. I
12 am particularly thinking about the effect of this change on
13 movement of counties among the quartiles, so just walk with
14 me a little bit. And let's use Portland as the example,
15 even though there aren't any over-65 people there. We'll
16 use it anyway, whatever county that is. I don't know that.
17 But they would be an example, I guess, of this
18 problem, if it's a problem, that they have a lot of folks
19 there who are Part A only. So, therefore, that depresses
20 the estimate of fee-for-service spending. That is a
21 starting point.
22 Now, it seems like, then, the immediate effect,

1 all else equal, is it puts them in either the 107 percent
2 or even the 115 percent because they're a low per-capita
3 thing artificially.
4 Now, I guess one thought is that part of the
5 relief is present in the model already, then, because they
6 get to bid against the 115 percent of that artificially low
7 estimate. So part of the problem, I would say, is perhaps
8 already solved, but let's keep going, if I'm good so far.
9 Then if we do this, the effect is we're going to
10 now peg that county's estimate to Part A/B only, and it's
11 going to go up. Okay. But that's not automatically a
12 benefit because what it might do is drop them from the 115
13 quartile to the 107 quartile, and it may be that it's a
14 wash, then, maybe, or they drop to the 100 quartile. I
15 don't know. But that will happen, right, if this occurs?
16 DR. HARRISON: Yes. Counties could go both ways.
17 That's right. Yes.
18 DR. NERENZ: Well, but in this example, the
19 counties presumably that this would help, in some cases,
20 wherever they sit at the margin, they may drop into a lower
21 quartile and may lose whatever benefit they were going to
22 get. And we haven't modeled that.

1 So I understand that across all MA plans, doing
2 this might kick payments up 1 percent or so, but I'm just
3 trying to make sure that we all understand that some of the
4 relief to this Part A-only problem is already baked into
5 the formula, I think, in the sense that they will -- all
6 else equal, more likely fall into these 107 and 115
7 quartiles.
8 DR. HARRISON: Yeah. It's distributional. I
9 mean, no county would see more than a 3 percent raise, but
10 it could cross over.
11 DR. NERENZ: No, but it's quartile. I mean,
12 somebody is at the margin --
13 DR. HARRISON: Yeah.
14 DR. NERENZ: -- and some of them are going to
15 fall. Okay. All right. So there's that.
16 Then I guess if that's so -- I guess, now to
17 follow on Craig's -- just simply to be more accurate and
18 fair, I guess this still might be okay, but only if it's
19 easy to implement because I just think the effects finally
20 on the ground may be small relative to whatever
21 administrative hassle there might be. So if it's easy to
22 implement, I'd say go ahead.

1 Then I guess the last thing, it seemed like in
2 other areas of our discussion, we have made the point one
3 way or the other that, in general, MA plans are not
4 underpaid, and that seems to be part of our premium support
5 discussion. And it's popped up other places. Now, if
6 that's so, I guess I'd say I'd probably figure out better
7 ways to use $20 billion over 10 years than here.
8 DR. CROSSON: I missed one thing in what you
9 said, David, when you said if it's simple to implement.
10 Are you talking about that adjustment, or are you talking
11 about somehow fixing the quartile, the fall from one
12 quartile to the other?
13 DR. NERENZ: No, it would be this specifically.
14 DR. CROSSON: That, that, that.
15 DR. NERENZ: I assume if you leave the quartile
16 things in place, if you leave the specific 100, 107 --
17 DR. CROSSON: Right, right.
18 DR. NERENZ: -- if it's just simply
19 administratively really easy to implement this, then, yeah,
20 okay. Go ahead. But I don't think the effects will be
21 profound.
22 DR. CROSSON: I thought where you were going was

1 saying hold harmless, counties, which would fall --
2 DR. NERENZ: No, no, no.
3 DR. CROSSON: Okay. All right.
4 DR. NERENZ: How many man-hours or women-hours
5 does it take to make this change happen?
6 DR. CROSSON: Yeah, yeah.
7 DR. NERENZ: Some things are easy; some things
8 are hard.
9 DR. CROSSON: Do you want to respond?
10 DR. MILLER: The only thing I -- I was going to
11 respond to a different point, and my take, Scot, would be
12 to respond to the point that you two just had. My take on
13 this would be it wouldn't be terribly difficult to
14 implement. We would expect CMS to come up with their own
15 estimate and see where they ended up, and then they would
16 start publishing county benchmarks that were A/B instead of
17 total fee-for-service. That's my sense.
18 And I don't mean to discount. They have to think
19 through it. They have to get the risk adjustment right.
20 They have to do all that, but this isn't a thousand moving
21 parts.
22 You did also say something else in the midst of

1 all of that. We don't think managed care plans are
2 underpaid, I think was your construction. There's two
3 things I wanted to say in response to a couple of comments.
4 One is you may recall from yesterday, Jeff hit
5 this point really quickly. We're about 105 percent of fee-
6 for-service, and part of that is because of the coding
7 effect. The Congress is going to continue to pay attention
8 to that, and one way to look at the coding recommendation
9 we've already made is if you do anything here, at least do
10 it more equitably. So, at a minimum, kind of keep that in
11 mind.
12 Then I'm going to say this. I think everybody
13 understands this, but sometimes the tenor of the comments
14 are not entirely -- I'm not entirely sure. Looking at you
15 two, make sure this sentence is correct. If fee-for-
16 service coded exactly the way MA plans coded, it's not that
17 there would be 10 percent more dollars. There would be 10
18 percent less. Everybody gets that. Because sometimes I
19 feel like I'm in rooms with managed care plans and they're
20 sort of saying, you know, fee-for-service -- and this whole
21 bit about fee-for-service is wrong, MA is wrong, whatever,
22 and I think Jack's points are on point, and our vocabulary

1 should be.

2 But if they coded the same, there would be no

3 additional dollars in the system. I just want to make sure

4 that everybody gets that.

5 DR. CROSSON: Bill.

6 DR. HALL: Going around now?

7 DR. CROSSON: Yeah.

8 Sorry. Did I miss you? I'm sorry.

9 MS. WANG: Okay. Very interesting conversation.

10 I want to go back because Craig and Kathy's

11 comments about the risk score intensity in particular, I

12 think, are very important to consider.

13 While we are trying to figure out the perfect

14 system, though, to capture this, I want to go back and ask

15 people to stare at Slide 7 again to understand really what

16 it means to tier the impact of any kind of coding intensity

17 adjustment. In the current system, the solid line is --

18 again, I call this "brute force" -- is a way for Medicare

19 to recover the amount of money that they deem they need to

20 recover, rightly or wrongly. Plans below the solid line

21 are getting the same cut, so that their risk scores may

22 actually fall below one because they're just getting that

1 10 percent cut. Even if their coding intensity is 2
2 percent, they're getting a 10 percent reduction in the risk
3 score, and the dotted-line tier above the solid line is
4 being subsidized by that because that 10 percent dollar
5 amount is being recovered.
6 I think that not only is this an incredibly
7 important sort of advancement to ensure equity in the way
8 that the current coding intensity adjustment is applied, it
9 also -- I realize that we don't know kind of the sort of
10 composition of what's driving this distribution of risk
11 score increases, but to the extent -- to the extent that
12 organizations are investing a lot of dollars and collecting
13 risk scores, this creates a really perverse incentive to
14 just keep doing that and driving that up because you're
15 never going to get cut more than the across-the-aboard
16 amount.
17 So I think it is extremely important. It's in
18 the slide deck, and I appreciate that it has been raised
19 again as something to ensure more equitable distribution of
20 the coding intensity adjustment, while we are grappling
21 with what that adjustment should be and whether it should
22 be and what the composition is. So this is an incredibly

1 important element of ensuring equity.

2 As far as the A/B issue is concerned, also, it

3 has to make sense, right? You have to sort of have an

4 apples-to-apples comparison. I thin David's comments about

5 sort of maybe noodling over the implications of that to

6 overall -- the quartiles of the benchmarks is important to

7 note. I don't know if it's an automatic thing that happens

8 or if that's by statute. Who's in which quartile, I

9 honestly don't know.

10 But I also would observe that despite the flaws,

11 managed care, MA penetration in those counties is

12 extraordinarily high. So maybe the problem is getting

13 worse, and what we're anticipating is that the fee-for-

14 service equivalent calculation is going to sort of degrade

15 and be more of a problem in the future. But at least from

16 the establishment of that methodology to the present, it

17 doesn't really seem to have affected the attractiveness of

18 MA plans. It's just interesting.

19 DR. HOADLEY: Can I follow up on that?

20 DR. CROSSON: Jack.

21 DR. HOADLEY: In looking at that Slide 7 -- and I

22 think you said this in the presentation -- this does not

1 also incorporate what might be the impact of our second
2 recommendation on excluding the diagnoses. If that
3 recommendation works as it's been designed, that would also
4 deal with that right-hand tail, we would speculate. I
5 mean, maybe we don't quite -- can't document that. Is that
6 right?
7 DR. JOHNSON: That's correct. This is just an
8 illustrative example, and we expect that the first two
9 policies will dampen the significant increase on the right-
10 hand side.
11 DR. HOADLEY: And that would mean that the three
12 dashed lines might even do a better job of approximating
13 the adjustment.
14 DR. GINSBURG: I think what we're really talking
15 about is that the more we can do proposals like the two we
16 have about the two-year and the risk assessment thing, the
17 less residual we have to be faced with. So, clearly,
18 unless the ideas are erroneous, it seems like a big win
19 just to get that residual down.
20 DR. CROSSON: Bill.
21 DR. HALL: So it seems to me that a lot of what
22 we're talking about depends on our faith that the coding

1 around the country is uniform, that it represents, as I
2 think Craig alluded to, the quality of medical care or the
3 value of medical care that's being distributed.
4 I like the fact that you used bad actors and good
5 actors, Craig, in your description. This may have serious
6 implications.
7 The community that I work in has very high
8 Medicare penetrants -- MA penetrants, some of the highest
9 in the country, and the practical sequelae is that when I'm
10 active on our clinical services in the hospital, that
11 there's such intensity and interest in coding that the
12 diagnostic sheet that I'm asked to sign off for, let's say,
13 after a hospital admission, it doesn't necessarily reflect
14 what I think are the clinical factors that lead to
15 intensity and, therefore, more resource utilization.
16 Let me give you an example. Bruce, you mentioned
17 that HIV doesn't get coded sometimes, even though we know
18 it's there. So 20 years ago, HIV was a 100 percent fatal
19 disease, so that's pretty serious. Today, it's not. The
20 majority of Americans with HIV right now are over age 50,
21 and that will be true for the next 20 or 30 years. They're
22 leading normal lives.

1 So the fact that if I miss that diagnosis when
2 I'm filling out a diagnosis sheet, the coders will come in
3 and they say, "Dr. Hall, how could you possibly have missed
4 HIV in this patient? What kind of doctor are you?" Well,
5 I suppose I should have remembered that, and I will try to
6 remember that in the future, but it has almost no bearing
7 on the quality of care and the intensity of resource
8 utilization.
9 So from my standpoint, I think coding at the
10 local level is still pretty much of a black box, and to the
11 extent that we're assuming that that's a really reliable
12 indicator or as reliable as we would like it to be, I think
13 we may be going in kind of a wrong direction here. But
14 that's just, I guess, my personal clinical opinion on this.
15 So do we really believe that coding is that
16 accurate and that consistent across the country that we can
17 really use this as the data from that to make very sweeping
18 decisions here?
19 DR. CROSSON: Okay. Amy.
20 MS. BRICKER: I need some help really shoring up
21 something that I'm struggling with. On Slide 11 -- and
22 maybe this was a Round 1, but it's haunting me, so help.

1 Part A, not Part B. So the 12 percent from 2015 that are
2 in Part A not Part B is because, we gathered, they're
3 offered insurance or some plan through their employer?
4 DR. HARRISON: No. There are reasons why people
5 might not buy Part B. They may not be able to afford it
6 just outright. You know, it's a hundred-and-some-odd
7 dollars a month. There can also be high-income -- income-
8 related premium. So some people are actually paying close
9 to $400 a month for it, and they may just decide, "That's
10 not worth it for me," and so they don't sign up for B. And
11 we think there's more of that going on the last few years.
12 And so while there may be some Medicare secondary
13 payer in there, we think most of it is people choosing not
14 to buy Part B either because they just can't afford it or
15 they don't think it's a good deal.
16 MS. BRICKER: So they're uninsured.
17 DR. HARRISON: For the B portion.
18 MS. BRICKER: Okay. So where I was headed may
19 not actually be relevant. The question I had really was:
20 Do we have the ability to gather the claims information
21 from those employers? Not that we don't believe there
22 isn't, quote, Part B spending done elsewhere. It's just --

1 yes?

2 DR. HARRISON: So the other thing is we aren't

3 looking at the Part B spending for these people. It's just

4 that their Part A spending is lower. So, in other words,

5 you're not going to a doctor, maybe you don't get sent to

6 the hospital, so you're not using the Part A. It's the

7 Part A spending that's lower. So the Part B people -- the

8 people -- if you don't have Part B, they don't calculate

9 your Part B spending for those people, right?

10 MS. BRICKER: Right.

11 DR. HARRISON: They don't include them. But they

12 do include them on the A. And what we think is that if

13 you're less likely to buy B, you may be a lot healthier,

14 and you don't use services. And so not only are you not

15 using any B, you're also using less A, and you're using

16 dramatically less A.

17 MS. BRICKER: Okay. So just to finish my

18 thought, it was--

19 DR. HARRISON: Go ahead.

20 MS. BRICKER: If there was, quote, Part B

21 spending but paid for by someone else, are we able to

22 actually see that, require that, include that, versus

1 reducing our subset to just those that have A and B fee-
2 for-service?
3 DR. HARRISON: No, we're not. Now, if you were
4 Medicare secondary payer, though, I think you would still
5 kick in A claim. So I think we would still see --
6 MS. BRICKER: We see that, yes.
7 DR. HARRISON: -- their A.
8 MS. BRICKER: Because they've enrolled in Part A
9 because it's an entitlement or --
10 DR. HARRISON: Right.
11 MS. BRICKER: --versus -- okay. So I was just
12 hoping that we could, in fact, broaden the base versus
13 reduce the base. We're talking today about just including
14 A and B as the comparator and, in fact, could you expand
15 the base to include employer-offered Part B coverage as a
16 greater subset.
17 DR. HARRISON: Yeah, we don't have that data.
18 MR. PYENSON: I'm very supportive of the
19 recommendations, and just a couple of reasons why that may
20 not have come out in the discussion. But I think the
21 recommendations, especially on risk adjustment, tend to
22 level the playing field among MA plans, and in actually a

1 positive way. I know we have an interest in the stability
2 of the MA program as well as the fee-for-service program.
3 But I see the recommendations as likely reducing the
4 spending on vendors to optimize coding and perhaps also
5 reduce spending by the MA plans on home assessments, which
6 are a cost item for the MA plans.
7 So I think these recommendations will tend to
8 level the playing field and reduce what are perhaps
9 administrative but might also fall into medical management
10 spending by the plans.
11 I noticed an interesting almost counterpoint
12 between Craig and Bill on the role of coding in medical
13 management, and I think that's whether coding is good for
14 medical management or bad for medical management. And I'm
15 not -- I don't want to take sides on that issue, but I
16 think it's a -- I know within the world of coding geeks,
17 there's a -- and sort of risk adjustment geeks, there is a
18 concern that inefficient systems tend to have higher coding
19 in the fee-for-service world, that is, the more that you do
20 to patients, the more codes you generate, whether they need
21 it or not. I don't know that anyone is looking at that in
22 the managed care world, and I think that would be something

1 -- you know, since risk adjustment is not going to go away
2 and it's going to be with us for a long time, to understand
3 that sort of issue I think would be helpful.
4 That's it. Thank you.
5 DR. HALL: I'm not sure we're very far apart at
6 all on this whole thing. I was just struck by Craig's
7 suggestion that coding can represent a number of things.
8 It can represent true resource utilization, or it could
9 represent gaming. And to what extent do we know which is
10 which unless we know what the clinical sequelae are in some
11 of these things, Craig?
12 DR. SAMITT: And my remarks were purely based on
13 the fact that coding is really a side effect to some degree
14 of identification and documentation, and that's kind of the
15 way I see it, and that's why this is so important, that if
16 plans are truly identifying diagnoses that should be
17 managed effectively and, you know, resources deployed to
18 manage those, then, yes, they're going to get coded. My
19 concern is that those may not be identified in fee-for-
20 service. They're being identified appropriately in the MA
21 plans, and so getting better care, getting more managed
22 care.

1 MS. THOMPSON: Just a comment on coding. Having
2 come from a fee-for-service environment with very little
3 managed care and learning this in a very painful way, there
4 are other reasons to code and to accurately document than
5 just for reimbursement purposes, and that's around
6 communication to clinicians. So with the patients who are
7 going to a number of different providers, to communicate
8 clearly and accurately, again, is an important side benefit
9 to accurate coding, whether in fee-for-service or a managed
10 care program.
11 DR. DeBUSK: I support the benchmark being based
12 obviously on A plus B spending -- I think there's a lot of
13 merit there -- as well as the previous recommendations
14 regarding using two years' worth of data and getting away
15 from the risk assessments.
16 But then you're left with that residual. I know
17 everyone keeps bringing you back to Chart 7. And right
18 now, you know, the idea is this one size fits all -- I
19 mean, to Pat's point, you're using sort of the same club on
20 everyone. You find yourself in this -- I was mentioning
21 circularity earlier. You find yourself in this argument
22 of, well, how do I know -- maybe these patients just have a

1 higher acuity or is this plan aggressively coding or coding
2 more aggressively? To the extent that you try to stratify
3 that more and more -- let's say we go from three categories
4 to six categories, well, we just made that differentiation
5 much, much harder.
6 One idea that I wanted to place out there is
7 could we as a first cut just simply try to bifurcate the
8 populations, just to divide and conquer? Could we have a
9 good actor -- basically an adjustment that's applied to a
10 good actor and an adjustment that's applied to a bad actor
11 and just see if we could analytically split the pool in a
12 more automated way? Because what I worry about is, as we
13 go to more and more granular tiers, it devolves into a
14 situation where basically you'd have to audit everyone.
15 And I just don't see that -- I mean, that's not practical,
16 it's expensive. Could we go from a very blunt instrument
17 to a slightly less blunt instrument and see if that moves
18 us in the right direction and if we can do some of that in
19 an automated way?
20 I also wonder if there would be a spillover
21 effect if people knew you could get in the coding intensity
22 doghouse, if that alone would have a beneficial effect in

1 trying to move people into proper coding but not
2 necessarily, you know, negative coding behaviors.
3 DR. CROSSON: Brian, I'm just not quite clear, so
4 help me. I thought for a minute you were saying let's use,
5 you know, two segments as opposed to three, but now I think
6 what you're saying is something like why don't we just
7 change it for like the 90th percentile. Because I'm not
8 sure how you differentiate between the good and the bad, as
9 you call it.
10 DR. DeBUSK: My thought was that right now I see
11 that single line -- well, in the graph it's around 10
12 percent. The thought would be: Could you split that into
13 two populations and have a coding intensity adjustment
14 basically for the two populations?
15 Now, how would you base that? You know, you were
16 talking earlier, I believe, about the methodology that you
17 used -- which, by the way, I thought was very clever in the
18 article about how you looked at people who were in fee-for-
19 service and then transitioned in and looked at their
20 trajectory from there. I think some of the automated
21 methods that were referred to in the reading, I think the
22 larger the buckets you're willing to use, the more

1 effective or accurate those methods are going to be.

2 You know, just as a thought experiment, let's try

3 to go to 12 tiers. I think at 12 tiers the technique that

4 you are using here where you were following the trajectory

5 of the beneficiaries as they transition from fee-for-

6 service into MA, I think you would lose a lot of resolution

7 there. But I think if you use that same technique just to

8 simply establish two buckets and maybe an appeals process

9 or some way to get out of the coding intensity doghouse

10 should the analytics put you there, I think then you might

11 be able to take a first step toward applying the

12 appropriate adjustment to the appropriate population.

13 Did that help at all? I'm not going to set the

14 number at 90 versus 10 percent or 50/50. I'd love to see

15 what their analytics -- you know, if their analytics could

16 come back and say we know with 99 percent accuracy that

17 this 10 percent are the people who are aggressively coding

18 or adhering to some type of improper coding practice, maybe

19 they get the larger adjustment. And I just don't know

20 where that population would fall yet.

21 DR. CROSSON: Right. So I'm still unclear as to

22 how the segmentation would be created. I thought for a

1 minute I heard you say something like we would track plans
2 where there was a significant acceleration from the
3 presumed level of --
4 DR. DeBUSK: Like in the reading, the way they
5 did the cohorts -- and, again, please correct me as we go,
6 but I think you were looking at specific groups of people
7 that maybe started in fee-for-service and then some of them
8 stayed in fee-for-service, others transitioned into MA, and
9 you could see those diverging trajectories. And I would
10 assume that we could identify individual plans where those
11 trajectories were more aggressive.
12 I could appreciate the fact that different plans
13 have people who start at different places. To me it seems
14 like it would be easier to spot plans where patients
15 suddenly get much, much sicker over three years or five
16 years as opposed to other plans where they have a more
17 steady course.
18 DR. CROSSON: Right, so that's what I thought you
19 were saying, looking at those plans with acceleration of
20 apparent diagnoses. So I guess -- sorry?
21 DR. DeBUSK: I'm trying to avoid -- every time I
22 want to stratify -- you know, I love the three levels, and

1 you wonder, well, could there be five levels? Could there
2 be six levels? How close could we get? I keep slipping
3 into that argument, though, that you're going to have to
4 fall back on audits. And I keep thinking that individual
5 audits or plan-level audits is just an expensive,
6 impractical idea.
7 So it makes me bounce back into the analytics
8 realm, and I'm thinking, is there an automated way to group
9 these populations?
10 DR. CROSSON: So I guess one question is -- maybe
11 for Scott and Andrew -- if we were to take a look at that,
12 if we were to say let's just take a look at some subset of
13 plans where we have this differential acceleration from the
14 time that the beneficiary joins the MA plan and what their
15 assumed risk is at that point, to what it becomes after,
16 say, three years, would that differ -- and I know you can't
17 answer this accurately, but would that differ substantially
18 from what is present on that slide? In other words, those
19 plans would be perhaps the same that are depicted on the
20 right side.
21 DR. JOHNSON: That's essentially what we have on
22 this slide, and I like the idea. I think our first cut at

1 the analysis would say that some plans, you know, like on
2 the right-hand side, tend to be obviously more aggressive.
3 But then there is a gradient of mixture between, you know,
4 normal increases due to better coding, and maybe then a few
5 with more aggressive coding. So I think our first cut
6 would say that it doesn't quite break down by contract in
7 the same way that there are good and bad contracts that we
8 could apply an adjustment to. I think that's what led us
9 more towards a few more categories than good and bad.
10 DR. CROSSON: Okay.
11 MR. THOMAS: I'll be brief because I know we've
12 been on this for a while.
13 First, I agree with the recommendation on making
14 sure we compare to folks that are in A and B. I think that
15 makes a lot of sense.
16 Just my comment on this, and I would echo Craig's
17 comments, that, you know, I think there are -- there's a
18 lot of difference, frankly, between the proactivity of
19 providers in MA, especially if there's risk involved,
20 versus fee-for-service. And I think, unfortunately, you
21 know, in that graph there you've got a lot of folks that
22 are probably doing things very right and are very proactive

1 and are identifying HCCs and diagnoses and whatnot that are
2 very appropriate that are not identified in fee-for-
3 service. And I'm sure you have folks in there that are not
4 doing that. And, unfortunately, they're all in this case
5 going to be treated the same. And I just think that that
6 is -- that to me is a concern. I'm not saying I have the
7 answer to how that gets dealt with. But that is definitely
8 a concern. And, you know, I would say that, you know,
9 frankly, there's probably better -- in many cases, there is
10 better identification of the appropriate diagnosis in MA
11 than there is in fee-for-service, especially given many of
12 the arrangements with the provider side of the delivery
13 system.
14 The second piece is I continue to be concerned
15 about the multiple changes we have going on in the risk
16 adjusters and the coding adjustments and what the aggregate
17 changes will be -- not on average but when it comes down to
18 specific geographies or specific plans. And it seems to me
19 that there probably ought to be some more work done to
20 understand the specificity of that and really what the
21 range is going to be, because you can look at this, you can
22 say -- you could have a range from a couple of percent to

1 it could be, you know, high teens potentially. And I think
2 it would be helpful to understand the materiality of that
3 range, and once again, maybe breaking it into three tiers
4 is the right way to do it because you have such differences
5 here.
6 But I just would like to understand more the
7 aggregate of many of these changes -- you know, many that
8 have just been put in, and we really don't know what the
9 impact is going to be of some of these changes that have
10 been already instituted, because we haven't had enough run
11 at what the impact's going to be on the risk scores.
12 So that's just the concern I have of layering
13 additional changes on top of things that have happened that
14 we really don't understand the impact that they've had on
15 the plans in the different regions. But, overall, the
16 recommendation I agree with. I just am concerned about
17 layering other changes on where we don't understand the
18 impact of what's been put in place already.
19 DR. CROSSON: Yeah, very good points, Warren.
20 I'd just make a couple of comments, because I think I heard
21 the same frustration that I heard from Brian a few minutes
22 ago, which is, you know, that, unfortunately, we don't have

1 a way -- with the current measurement process, we don't
2 have a way of differentiating at a given level of coding on
3 the part of a plan, whether, in fact, that is simply
4 recording more diagnoses for individuals, and that
5 individual, if in fee-for-service, would have less
6 diagnoses recorded as opposed to the situation I think that
7 Craig and others have referred to where, in fact, the plan
8 providers in this case for the most part are, in fact,
9 identifying and then appropriately managing conditions
10 which are being missed in fee-for-service. And I suspect
11 that both situations exist, and I think we're somewhat
12 hamstrung right now by the fact that we can't do that, we
13 can't make that differentiation.
14 The other point I'd make is in terms of your last
15 comment about sort of, you know, overall what's happening
16 with MA. We are going to have an MA report at the next
17 meeting, as I understand it, that will update sort of the
18 situation with respect to the difference in payment between
19 fee-for-service and MA and, among MA, different types of MA
20 plans. So we'll have a better look next month, at least at
21 this point, at the aggregate impact of these changes.
22 MR. THOMAS: And I can appreciate that. I think

1 it's just important that we understand that -- because I
2 think sometimes the tenor is that, gee, these are all just
3 bad actors and there's just, you know, inappropriate
4 coding. And, once again, I'm sure in that graph there is
5 some of that. But at the same time, I think there are some
6 folks that are doing exactly the right thing, and I can
7 appreciate that. It will be helpful to look at the overall
8 report to see if we understand more about what these other
9 changes are driving and then have that understanding as we
10 look to make any additional changes in risk adjusters going
11 forward.
12 DR. CROSSON: Okay. Scott, Andrew, thank you
13 very much. We'll move on now to the last presentation and
14 discussion.
15 [Pause.]
16 DR. CROSSON: Okay. Now we're going to have a
17 presentation in our continuing work on trying to simplify,
18 clarify, elevate, and in other ways improve quality
19 measurements, and we have a few ideas on the table. Ledia
20 and David, take it away.
21 MS. TABOR: Great. Good morning. Today, we'll
22 provide an updated analysis on three population-based

1 outcome measures that the Commission has discussed using to
2 measure Medicare quality. Following the presentation, we
3 would like your input on the measure results and next steps
4 for our analysis of these measures.
5 First, we will review the Commission's direction
6 to simplify quality measurement in Medicare using a small
7 set of population-based outcome measures.
8 Next, we'll provide an update on the prototype,
9 healthy days at home measure, we have been developing.
10 Then we'll discuss updated analysis using PPA and
11 PPV measures in Medicare.
12 Finally, we'll lay out ideas for future research
13 for your discussion.
14 The Commission has become increasingly concerned
15 that Medicare's current quality measurement programs are
16 too complex, burdensome for providers, and rely on too many
17 clinical process measures that are, at best, weakly
18 correlated with health outcomes.
19 The Commission has discussed a direction that
20 would simplify current Medicare quality measurement by
21 using a common, small set of outcome measures across
22 providers. Medicare would measure quality in a local area

1 using population-level outcome, patient experience, and
2 low-value care measures for each of Medicare's three
3 payment models.
4 The quality measures could be publicly reported
5 to beneficiaries, providers, and policymakers to allow
6 comparison across models and organizations nationally and
7 within market areas. The results could also be used to
8 reward high-quality MA plans and accountable care
9 organizations in a market area.
10 Many have pointed out the complexity and burden
11 of the new Merit-based Incentive Program, or MIPS. As a
12 simpler alternative to MIPs, we could explore applying the
13 population-based measures to fee-for-service clinicians in
14 a market area.
15 I will now discuss the healthy days at home
16 measure, which measures the number of days per year that
17 beneficiaries are alive and out of health care
18 institutions, like skilled nursing facilities. This
19 measure takes a comprehensive view of a population's health
20 in a way that is easy to understand.
21 The Commission discussed the measure concepts
22 last year and thought that the measure could be used to

1 compare performance across payment models.

2 Healthy days at home is not triggered by any
3 event in particular. Beneficiaries are followed for the
4 entire calendar year. Healthy days at home is calculated
5 by subtracting from 365 days, the days in which
6 beneficiaries' claims data suggest they were in less than
7 optimal health or unhealthy, such as days in acute care
8 facilities or acute care hospitals, post-acute care, and
9 mortality days.

10 The Commission has been working with a team from
11 the Harvard School of Public Health to test our prototype
12 "healthy days at home" measure. A critical step in the
13 development of the measure is to develop a risk-adjustment
14 model to make sure the measure reflects an organization's
15 quality of care rather than underlying patient severity.

16 Using linear regression, we developed a model
17 that included age, sex, and disease burden, since those are
18 common patient severity variables. We also included market
19 effects in the model to control for market-specific
20 practice patterns that may mask the effects of the other
21 variables.

22 The Commission has discussed the importance of

1 accounting for socioeconomic status in quality measures, so
2 we also included race, ethnicity, and Medicaid status,
3 which can be proxies for income or State health policy.
4 We found that disease burden had the greatest
5 impact on healthy days at home. Age and sex had about the
6 same impact. Medicaid status had some effects, but adding
7 Medicaid did not increase the explanatory power of the
8 model. Race and ethnicity had no significant impact.
9 We did some further analysis to understand the
10 effect of Medicaid status on healthy days at home, but how
11 to deal with the possible effects is still an open question
12 as we wait for more clarity on accounting for SES in
13 quality measurement.
14 To better understand the Medicaid effect, we
15 considered whether the effect of Medicaid status varied by
16 market. We divided market areas into quartiles based on
17 the proportion of Medicare beneficiaries with Medicaid in
18 the area, the rows. We also divided markets into quartiles
19 based on health day at home performance, the columns. If
20 the proportion of Medicaid beneficiaries in a market area
21 had no effect on healthy day at home rates, then we would
22 expect that each quartile of healthy day at home

1 performance would be about 25 percent.

2 In the markets with the highest proportion of

3 Medicaid, 32.2 percent of market areas were among the

4 lowest-performing quartile on adjusted healthy days at

5 home.

6 In the markets with the lowest proportion of

7 Medicaid, 37 percent of market areas were among the

8 highest-performing quartile on adjusted healthy days at

9 home.

10 It appears that the proportion of beneficiaries

11 eligible for Medicaid in a market may have some market-

12 level effect on healthy days at home, which emerges at the

13 highest and lowest concentration of Medicaid status.

14 Medicaid status, representing State health policy, may play

15 a role in healthy day at home rates. We could continue to

16 explore healthy day at home rates among peers in markets

17 with a similar share of Medicaid beneficiaries, as we have

18 done for hospital readmissions and MA stars.

19 We calculated healthy day at home rates adjusted

20 for age, sex, disease burden, and market-fixed effects.

21 The mean adjusted healthy day at home for all

22 populations in all market areas is 346.2 days healthy and

1 at home.

2 To assess the face validity of the measure, we
3 also calculated healthy days at home rates by different
4 population segments. We would expect that older
5 beneficiaries with multiple chronic conditions and severe
6 chronic conditions like congestive heart failure to have
7 fewer healthy days. We did find that that older age and a
8 chronic conditions burden was associated with fewer healthy
9 days at home and more variation in older populations with
10 congestive heart failure.

11 The Commission is interested in monitoring the
12 progress of ACOs, so we calculated adjusted healthy day at
13 home results for beneficiaries attributed to ACOs in 2013.
14 We found small differences between ACOs and non-ACO fee-
15 for-service across all the population segments, with ACOs
16 having slightly better healthy days at home.

17 This was a proof of concept analysis to see if we
18 could calculate healthy day at home results for ACOs and
19 compare payment models in market areas. We hope to
20 continue to refine the ACO calculations.

21 Now we are going to move on from healthy days at
22 home and discuss our analysis of the potentially

1 preventable admissions and potentially preventable ED visit
2 measures.
3 PPAs and PPVs are population-based measures
4 designed to examine the ambulatory care system in a defined
5 area like the market areas that we used for the healthy day
6 at home analysis. It is not a measure of individual
7 hospital quality. PPAs and PPVs are based on the premise
8 while not every PPA and PPV can be averted, comparatively
9 high rates of these events points to markets where
10 beneficiaries may be admitted to the hospital or getting
11 the treatment in an ED unnecessarily. There is likely a
12 need for improved care coordination and access to care in
13 those areas with high rates.
14 In the past, MedPAC has contracted with 3M Health
15 Information Systems to use its definitions of PPAs and PPVs
16 and their software.
17 Hospital stays can pose risks to patients,
18 particularly the elderly. Adverse events represent a
19 prominent risk, including hospital-associated infections,
20 medication errors, device failures, and pressure injuries.
21 PPAs include admissions for conditions that might
22 have been prevented by using coordinated care; for example,

1 short-term complications of diabetes, asthma, and
2 migraines; and second, procedures whose appropriateness has
3 been questioned by clinical experts or might have been
4 avoided with medical treatment, such as back procedures and
5 spinal fusion.
6 This analysis excludes hospital readmissions
7 within 30 days of the index admission because readmissions
8 is a separate concept measured in another population-based
9 outcome measure. Also, in a previous analysis, we found
10 that PPA results are comparable, whether including or
11 excluding readmissions.
12 Hospital EDs are not the ideal venue for
13 treatment of non-urgent acute conditions and management of
14 chronic conditions and can encourage overtreatment, since
15 ED providers who do not know a patient's medical history
16 may err on the side of providing too much care.
17 PPVs include ED visits for medical conditions
18 that might have been prevented by coordinated care -- for
19 example, asthma attacks and migraines -- and, second,
20 conditions that could have been addressed through other
21 sites of care, like primary care or urgent care centers for
22 conditions like upper respiratory tract infections or

1 gastrointestinal diagnoses.

2 The measure of PPVs excludes the ED visits that

3 resulted in an inpatient admission because those visits are

4 captured by the PPA measure.

5 To compare performance between areas, the 3M

6 methodology makes two types of adjustments. First, the

7 number of preventable events is weighted by the type of

8 services and relative resource intensity of the events to

9 reflect the relative burden of different events on the

10 health care system. For example, a PPV for a migraine

11 that results in an MRI and administration of a costly drug

12 consumes more resources than a PPV for a respiratory

13 infection that results in a general antibiotic.

14 The second adjustment attempts to control for

15 differences in the underlying health status of the

16 population, using age and burden of chronic illness, as you

17 would expect.

18 Since, again, the Commission has discussed the

19 importance of accounting for SES in quality measures, we

20 also performed a linear regression of the PPA and PPV rates

21 using race, ethnicity, and Medicaid status as proxy

22 variables for SES.

1 We found that the regression coefficients were
2 all very small. So it appears adjusting for age and
3 disease burden accounts for nearly all patient-level
4 effects, so we did not include any additional variables in
5 the adjustment methodology. However, if this preliminary
6 work progresses and the Commission wishes to pursue, we
7 will sort markets by relevant SES variables to determine
8 whether these effects are present across market areas.
9 In 2014, PPAs accounted for about 15 percent of
10 all fee-for-service Medicare hospital admission claims,
11 excluding readmissions, with a national average of about 41
12 PPAs per 1,000 beneficiaries.
13 PPVs accounted for about 75 percent of all fee-
14 for-service Medicare non-admission ED visit claims, with a
15 national average of approximately 291 per 1,000
16 beneficiaries.
17 The 75 percent PPV rate may be surprising, so I
18 would like to point out three things when interpreting
19 these national numbers. First, the denominator, or total
20 ED visits, is for a subset of the Medicare fee-for-service
21 population. For example, we excluded beneficiaries who
22 died in 2013 or 2014 or who had Part A or Part B only at

1 any point during those two years. Second, PPV excludes
2 admissions. Third, these numbers are broad estimates; for
3 example, the PPV calculation errs on the side that most
4 non-emergent procedures and diagnosis could have been
5 handled in another site of care.
6 Even with these broad interpretations, these
7 numbers demonstrate opportunities to improve the quality of
8 care received by Medicare beneficiaries.
9 We calculated PPA and PPV rates at the local
10 market area level, as we did for the healthy days at home.
11 The rates are presented as a ratio of the actual rate to
12 the rate that would have been expected, given the
13 population's age and burden of chronic illness. A rate
14 below 1 is better because the market area has less than
15 expected PPAs or PPVs.
16 We found that PPV and PPA rates varied by market
17 area.
18 PPV rates showed about double the variation,
19 between the 9th and 10th percentile, than the rate of PPAs.
20 We also analyzed PPA and PPV rates for ACOs and
21 fee-for-service-only beneficiaries in five different local
22 market areas to compare relative quality within a market

1 area for different payment models, as envisioned in the
2 Commission's alternative quality concept.
3 We chose five market areas that had a high number
4 of ACO beneficiaries and for geographic variation. Across
5 the markets, the percentage of fee-for-service
6 beneficiaries in ACOs ranged from about a quarter to a
7 half. The number of ACOs in the areas ranged from about 5
8 to 11.
9 The reference point for each measure is 1.
10 Overall, ACOs tended to have slightly better PPA and PPV
11 rates than fee-for-service only.
12 ACO PPAs were better in three of the market areas
13 -- Houston, Minneapolis, and Orlando -- with rates less
14 than or close to 1.
15 ACO PPVs were better than fee-for-service in all
16 of the markets.
17 Looking at PPA and PPV rates within a market
18 area, across markets, and nationally may allow policymakers
19 and providers to understand opportunities to improve care
20 within those markets.
21 As discussed in the beginning of the
22 presentation, we could explore applying the population-

1 based measures to fee-for-service clinicians in a market
2 area.
3 Some of the market areas we used in this analysis
4 are large, so using them to represent fee-for-service
5 clinician quality may not be appropriate. Within a local
6 market area, we could measure PPA and PPV rates at the
7 hospital service area level, or HSA, which is a smaller
8 geographic unit that is more similar to the ambulatory care
9 environment clinicians affect.
10 We explored this concept by identifying which
11 HSAs were tied to one local market area, then calculating
12 PPA and PPV rates for each HSA, and comparing those rates
13 across those HSAs.
14 In the market area that we looked at, the mean
15 PPA rate was .98 and for PPV was 1.17. We identified 13
16 HSAs that had a range of market of PPA and PPV rates, .55
17 to 1.26 for PPAs and 1.15 to 1.64 PPVs.
18 If these measures are statistically reliable, the
19 range of HSA rates supports the concept of measuring a
20 smaller geographic unit within market areas and perhaps
21 holding fee-for-service clinicians accountable to their HSA
22 rates.

1 If the Commission would like, we will continue to
2 evaluate the measures and their potential to compare the
3 quality of care for Medicare beneficiaries. After
4 answering any clarifying questions, we would like to
5 discuss your reactions to the measure results and these
6 ideas for future analytic work on all three measures.
7 Thank you.
8 DR. CROSSON: Okay. Thank you very much, Ledia,
9 and David as well.
10 Who has clarifying questions? We'll start with
11 Brian, Bruce -- I'm going to do this more slowly so I don't
12 screw it up -- Bruce, Brian, Amy, Bill H., John, Pat,
13 Alice, Paul, Kathy, Jack. Gotcha.
14 DR. MILLER: Yeah. It's all you all.
15 DR. CROSSON: Yeah.
16 [Laughter.]
17 DR. CROSSON: Right. Let's start with Bruce --
18 I'm sorry. Brian, Brian, Brian.
19 DR. DeBUSK: First of all, I'm so wildly
20 supportive of what you guys do and like this work so much,
21 I was almost afraid to ask a question. But as you can see,
22 I got past it.

1 [Laughter.]

2 DR. DeBUSK: First of all, on page 18 of the
3 reading, I noticed that for the healthy days at home you
4 used the -- to assist disease severity, you used HCCs. And
5 then I noticed as we moved over to the 3M methodology for
6 the PPAs and the PPVs, you moved to these clinical risk
7 groups, the CRGs.

8 So my first question is: Could you speak to
9 shifting the methodology and also speak to how feasible it
10 would be to use a standard methodology, say all HCCs, for
11 doing disease severity?

12 And then the second question I had was the
13 healthy days at home measure by its definition saturates at
14 365 days. I mean, it tops out. Have you looked at the
15 engineering equivalent, say a mean time between failures?
16 And did that go into your calculation of maybe doing MTBF
17 versus a measure that would top out? And did that factor
18 into any of your analysis?

19 MR. GLASS: I must say I never thought I'd get to
20 use the term "mean time between failure" again.

21 [Laughter.]

22 MR. GLASS: Because I used to have to actually

1 deal with that all the time in maintenance. But, no, we
2 didn't think about using that. We wanted something that
3 would be really easy to understand for a beneficiary who
4 could say, "Hey, look, this ACO looks like a better chance
5 of keeping me healthy and at home than the one over there."
6 So, no, we didn't think about that, though we could explore
7 it, but I think it might be hard to -- you know, for many
8 people to comprehend.
9 DR. MILLER: Does anybody want to tell us what
10 that means?
11 MR. GLASS: Oh, mean time between failure? So if
12 you had a jet engine, you'd like to know what the mean time
13 between failure is
14 DR. CROSSON: You would like to know it a lot.
15 MR. GLASS: Yeah.
16 [Laughter.]
17 MR. GLASS: So you could figure out how to do
18 maintenance on it.
19 DR. DeBUSK: The other issue, too, is that
20 there's a whole host of engineering tools that you could
21 then bring into play for the analytics around mean time
22 between failures because you'd inherit all that as well.

1 DR. MILLER: Here we would be talking about mean
2 time until somebody dies or somebody --
3 MR. GLASS: Or has one of these events.
4 DR. MILLER: Or has one of the events okay.
5 DR. CROSSON: I think David's point is that while
6 one may be more accurate and perhaps, as Brian suggests,
7 you know, allow for greater differences because the time
8 would extend infinitely, the optics of it, the
9 marketability of it sounds different to the -- could sound
10 very different to the average beneficiary, or something
11 like that.
12 MS. TABOR: For the first question, we used for
13 healthy days at home the HCC model just because it's
14 available, it's known, it's commonly used when risk-
15 adjusting outcome measures. And the clinical related
16 groups is a 3M methodology. It kind of came with the
17 package of using their prototype, which, again, was just a
18 prototype. We're just testing the concept, not saying that
19 the 3M methodology is the way to go. But I think in theory
20 we could use HCCs across all the measures. And I think
21 we've heard before from the Commissioners the importance of
22 having common risk adjustment across the measures, so we'll

1 keep that in mind.

2 MR. PYENSON: I want to echo Brian's comment.

3 I'm real hesitant to ask any questions because this is

4 really great. But one technical question: The midyear --

5 how do you handle midyear entries in the healthy days at

6 home?

7 MS. TABOR: They had to be enrolled for 365 days.

8 That was one of the conditions to be included in the

9 denominator.

10 MR. PYENSON: So midyear enrollees are excluded.

11 MS. TABOR: Exactly.

12 MR. PYENSON: Another question related to the 3M

13 methodology and HCCs. I think AHRQ, Agency for Healthcare

14 Research and Quality, has similar metrics that are open

15 source, ambulatory care, sensitive admissions, and I think

16 they've developed ER metrics that are similar. And, you

17 know, part of my question is there's a real virtue in open

18 source, which is, yeah, there's private sector risk

19 adjusters that claim to be better than HCCs and so forth.

20 But there's really a virtue in having open source, and I

21 wonder if you looked at how well they compare.

22 MS. TABOR: We did look at the AHRQ measures. We

1 didn't do any kind of sophisticated analysis, but one
2 reason we wanted to use these 3M measures was because
3 they're comprehensive, they cover all conditions; whereas,
4 the AHRQ prevention quality indicators, PQI measures, are
5 condition specific. They look at diabetes versus heart
6 failure versus pneumonia. So we wanted to kind of test
7 this concept of a comprehensive -- and, actually, the
8 Commission does track those PQI measures in our March
9 report.
10 And then as far as the PPV, the last I look, the
11 AHRQ measures were a little -- they were not fully
12 developed yet, but we can continue to track those because
13 we know the open source is a good point to --
14 DR. MILLER: And, traditionally, you know, we're
15 way back at proof of concept stage here. We're just
16 talking about a measure and all that. If for some reason
17 CMS were to take up something like this, they would go to
18 an open source type of approach, go through rulemaking and
19 comment to sort of say this is how we're doing it. And
20 sometimes the way that works, either they develop a
21 methodology just completely new, or they might go to, say,
22 a 3M or whoever has developed this and contract with them

1 to develop an open source owned by the program type of
2 thing. The notion that this would go forward as policy,
3 which we're way, way away from, using a proprietary group
4 or whatever the case, would not be the case.
5 MS. BRICKER: I can't help but be reminded of the
6 discussion we had yesterday around stand-alone EDs, and
7 Slide 16, Houston looks like it's performing quite well
8 with respect to preventable ED visits. This data, though,
9 is from '13 and '14, and yet Houston is leading the pack
10 for stand-alone EDs based on '16 data. And I'm curious if
11 we're able to actually bring those two together, if we
12 think there's value in that to see how Houston actually
13 would be impacted, to refresh this data, you know, with
14 something that's more current when that's available to us,
15 to see if that, in fact, just having more access to stand-
16 alone EDs because I don't feel well versus it truly being,
17 you know, because I feel like I need to be hospitalized, of
18 course, just because of an access, it's just across the
19 street, it's easy, I see it, they're everywhere, if there
20 actually could be some correlation there to just additional
21 access of stand-alone EDs.
22 MR. GLASS: That will be fun to keep track of. I

1 think we're going to update one more year?
2 MS. TABOR: Yes.
3 MR. GLASS: Yes, so that will still be '14, not -
4 - that will probably be before that phenomenon.
5 MS. TABOR: It's an interesting concept, though.
6 DR. CROSSON: Good. Thank you.
7 DR. CHRISTIANSON: Did you want [off microphone]?
8 MR. GAUMER: I was thinking the same thing that
9 Amy was, and I think this is probably a year issue. So,
10 you know, the phenomenon is probably going to show up in
11 '14 and '15. They were certainly around in '13 and doing
12 their thing, but to a lesser degree. So I imagine that the
13 '14 data may show different numbers. Not sure it would
14 jump above one. There might be something else going on
15 here, too, but I'm unclear what that is.
16 DR. CHRISTIANSON: Okay. So two things. One is
17 I just continue to be really annoyed by the name of this
18 metric. I mean, if you have somebody who is, as an
19 example, experiencing really severe arthritis, taking their
20 medication, is in severe pain, and then telling them that
21 they're having a healthy day at home is just tone deaf.
22 And I don't think we can drop off "healthy" because as part

1 of the metric, we have home health visits, which presumably
2 you get at home, and that raises the other question of
3 whether you guys have looked at this metric not using home
4 health visits as part of it. It strikes me that doing that
5 penalizes ACOs and MA plans that are trying to manage
6 chronic illness aggressively, keep people out of the
7 hospital, keep them out of the emergency room, and have a
8 program that involves home health visits, and you get
9 penalized for that program under this metric, which doesn't
10 make a lot of sense to me.

11 So one way to think about this is what happens --
12 I mean, maybe they've already done the analysis without
13 including home health, and I understand why it's there.
14 But I don't think it's the right incentives for the way
15 we're trying to compare outcomes across different delivery
16 systems which are going to use different ways of trying to
17 manage care.

18 MR. GLASS: Well, if you're using home -- we
19 switched to home health visits, by the way, rather than the
20 length of the home health episode or time between first and
21 last visit to de-weight it some from last time. But if
22 it's successful in keeping people out of hospitals, et

1 cetera, then I don't see why we'd be penalizing you. Yeah,
2 you'd get --
3 DR. CHRISTIANSON: Because you're subtracting
4 days that --
5 MR. GLASS: But presumably you're not having the
6 other days in there --
7 DR. CHRISTIANSON: That doesn't mean you're not
8 penalized --
9 MR. GLASS: -- so it would outweigh --
10 DR. CHRISTIANSON: You might get an offset down
11 the line, but it doesn't mean you're not penalizing for an
12 aggressive in-home program.
13 DR. MILLER: Can I also just say one thing? I
14 think conceptually I see your point, but there has been --
15 we've looked at home health utilization and sort of
16 bouncing from home health agency and hospitalization rates
17 related to home health use, and there has, at least at a
18 national level, been very little relationship between that.
19 I believe there can be one, but --
20 DR. CHRISTIANSON: And that's what we're talking
21 about going forward. We're trying to get people incentives
22 to manage care effectively. If that involves home visits,

1 fine. No, my question was more have you looked at this
2 measure eliminating that, and do you get real different
3 results in terms of your analysis when you don't include
4 that? Then you could change it to "days at home."
5 MR. GLASS: Yeah, we did it with and without last
6 year. I don't think we did it this year. We could look at
7 it again. It is one of the bigger ones. It's like three
8 days, you know, on average.
9 DR. CROSSON: This is going to be an odd comment,
10 but I have to say my own personal experience is that the
11 term "healthy" changes over the decades. I'll leave it at
12 that.
13 [Laughter.]
14 MS. WANG: Actually, I think this is great work,
15 but I think the questions that Amy and Jon asked are
16 questions that I also have. First of all, I think it's a
17 great clarification on the 3M and the PPV, so that's just
18 to clarify. That is just for purposes of proof of concept
19 and analysis, because the fact is I think most people are
20 using HEDIS measures. But this does not presuppose that
21 the 3M, you know, measures are better. It just introduces
22 more complexity because I think people are orienting

1 towards the HEDIS measures.

2 MS. TABOR: That's correct, and this is just a

3 prototype.

4 MS. WANG: So it's just an analytical exercise.

5 MS. TABOR: And there is no HEDIS measure,

6 unfortunately, for these two concepts yet.

7 MS. WANG: Well, there's a new HEDIS measure for

8 the prevention, for the potentially avoidable that plans

9 actually are going to be subject to in 2017, and I can't

10 remember the acronym, but yeah, there is. Okay. In any

11 case, okay, this is just an analytical exercise. Do you

12 have -- so I think that the concept is really interesting,

13 whether you call it "healthy" or "days at home" or

14 whatever, and it involves a lot of value judgments about

15 the tradeoff between home health, for example, is better

16 than inpatient or are they all equally, you know, counted

17 against you.

18 Putting it in the other extreme, to Amy's

19 question, do you have any concern that this measure would

20 look good, for example, in a rural area that does not have

21 a good health care delivery infrastructure? It doesn't

22 mean that people are healthier, but it does mean they're at

1 home more because, you know, the nearest hospital is far
2 away, there are no home health services in the community,
3 there are no IRFs, there are no -- I mean, does this adjust
4 for those kinds of access issues?
5 The other thing I wanted to ask you about was
6 whether you were considering looking at -- if we go to
7 uniform measures, the risk adjustment and the adjustment
8 for, for want of a better word, socioeconomic status
9 becomes critically important. And one of the things that I
10 noticed was that there really wasn't anything yet
11 considered around sort of community resource
12 characteristics in the SES, and that is, there's been a
13 fair amount of work around that, you know, access to
14 primary care, do you reside in a health profession shortage
15 area? I think there's been some correlations to sort of
16 the rate of homeownership in communities and correlation to
17 health status, poverty levels in local communities, things
18 of that nature. I just wondered if that was kind of going
19 to be on your list at some point to examine.
20 But, you know, going back maybe to the first
21 question, I'm sorry, I jumbled them all together, but is it
22 possible that healthy days at home could look good, meaning

1 you have more days at home, simply because there's no --
2 the delivery system infrastructure is different from place
3 to place?
4 MS. TABOR: One way we did try to account for
5 that is by adjusting for market effects, so taking into
6 account the practice patterns within each individual market
7 area and adjusting to each beneficiary for that.
8 MS. WANG: Could you explain a little bit more
9 about what that means, market effects and local market?
10 What is that exactly?
11 MS. TABOR: It's a very complicated statistical
12 methodology that our very smart contractors used, but the
13 best way I can kind of explain it is that it is taking into
14 account that the different market areas do have kind of
15 different healthy days at home because of practice patterns
16 and kind of the delivery system within each market. So
17 they did an adjustment to allow comparison across the
18 market areas.
19 MR. GLASS: And so --
20 DR. MILLER: It's like coming through and, you
21 know, you do your standard -- we're talking about healthy
22 days at home, right? So I'm trying to visualize what I

1 read. So, you know, think of you have a regression
2 equation, you have your healthy days at home. But before
3 you report out, you adjust for the demographics, you adjust
4 for their conditions. Then you put in dummy variables for
5 the different markets that they're in to try and take into
6 account the very two things you're saying -- supply
7 differences, practice differences. We tested out some SES;
8 you know, either it washed out or had some odd effects.
9 And then what you're basically saying is the
10 variation that you see here left would be over and above
11 what happened to be present from market to market on supply
12 and utilization, is kind of the way -- which is what you
13 said just a few more sentences.
14 MS. TABOR: Much better.
15 DR. CROSSON: On this point?
16 DR. NERENZ: Yes, on this point. Thank you. If
17 we look at Slide 7 then, again, to clarify, the analysis
18 here is looking at numbers that are not adjusted for market
19 characteristics the way you just described? Would that be
20 true?
21 MS. TABOR: They are adjusted for market fixed
22 effects.

1 DR. NERENZ: Okay. Because then I'm trying to --
2 because then this is looking at the effect of Medicaid
3 above and beyond a market factor? Because it would seem to
4 me that the market-level adjustment brings with it all
5 kinds of SES and infrastructure effects and all sorts of
6 things. It just captures it without identifying it and
7 pulls it out statistically. So when we're looking at 7,
8 we're looking at the effect of percent Medicaid with a
9 market factor already pulled out --
10 DR. MILLER: You keep saying Medicaid, but you
11 mean Medicare [off microphone].
12 DR. NERENZ: Well, Medicaid.
13 PARTICIPANT: No. Medicaid [off microphone].
14 MR. GLASS: No, but the market fixed effect, I
15 think, if I may say this -- and tell me if this is correct
16 -- that's being put in when you're doing the risk
17 adjustment modeling to understand the true effects of, say,
18 patient severity. And it's kind of taking into account
19 that healthy days at home may differ from one area to
20 another. Say one area tends to use lots of home health,
21 the market fixed effect would be able to adjust for that
22 when you're trying to figure out the parameters on the

1 other -- on the other things like severity.
2 DR. NERENZ: Yeah, but it would be -- just for an
3 example, I'm envisioning some enormous set of dummy
4 variables, for example, where, you know, Detroit's a
5 market, Topeka's a market, northern Minnesota's a market,
6 however you define a market. And just having that yes-no
7 variable for market just brings with it every possible
8 characteristic of that market -- practice patterns,
9 infrastructure, SES, poverty. It's all in there. It just
10 all gets pulled out at once, right?
11 MR. GLASS: Well, when you're figuring out the
12 correct parameters for the other variables, but then when
13 you report healthy days at home for that market, it's not
14 like you're dividing, you know, beneficiaries in that
15 market by that amount.
16 DR. NERENZ: No, no, and I'm not saying that's
17 wrong necessarily. I'm just trying to understand when we
18 look at the effect of Medicaid --
19 MR. GLASS: Yeah, so I think --
20 DR. NERENZ: -- it's above and beyond and all
21 that.
22 MR. GLASS: Right. So, I mean, the -- yeah, so

1 the earlier results show that as a beneficiary-level
2 adjustment. It doesn't seem to add to the explanatory
3 power. But when you look later, after you've done all
4 that, it does seem to have this change at the market level,
5 which is I think what Pat was talking about. This may be a
6 proxy for all sorts of other things.
7 DR. MILLER: But you are referring to Medicaid
8 [off microphone].
9 MR. GLASS: Medicaid. So I think this is where
10 it shows that it seems to be a proxy for lots of other
11 things that might be happening.
12 DR. NERENZ: Yeah, well, people often interpret
13 it as an income effect, and within states it is indeed
14 that. But then if you've also got income picked up as a
15 market -- part of that market variable, that -- I'm just
16 trying to understand what's moving when here.
17 DR. MILLER: You're going to go back to your
18 questions, right? Well, because I -- well, I don't want to
19 forget you. I didn't want to move on and forget your
20 question.
21 The other thing I'm trying to remember from our
22 urban and rural analysis, Jeff -- and I just need a nod

1 here; I think you know what I'm about to say -- we didn't
2 see tremendous differences in levels of utilization.
3 DR. STENSLAND: Almost exactly the same --
4 [speaking off microphone].
5 DR. CROSSON: Can you repeat that for the record?
6 DR. STENSLAND: [Speaking off microphone.]
7 So we looked at things like how many physician
8 visits did they get, how many home health days did they
9 have, how many SNF visits, how many admissions, how many
10 prescription fills did they have, and it was almost exactly
11 the same for urban, for rural, and even for frontier areas
12 of rural, so really sparsely populated areas. And,
13 essentially, they were getting the same volume of care.
14 They might be just traveling further for it.
15 DR. MILLER: It is a surprise, which is why I
16 wanted to work it out.
17 MS. WANG: It's very interesting, because what
18 does that do to regional variation?
19 DR. MILLER: Well, you see, what's really
20 interesting -- because a lot of people walk around with
21 this in their head and which is why I think it's worth the
22 opportunity to pull it out, even though it's off point and

1 Jay is going to kill me.

2 MS. WANG: He'll kill me too.

3 DR. MILLER: But I'm going to go down for a good

4 cause.

5 The geographic variation a lot of people carry in

6 their head is urban, rural, but that's really not how

7 geographic variation works in the country. You can think

8 of the country as a big rectangle. There's kind of a

9 diagonal. The Southeast has really high utilization, urban

10 and rural. The Northeast has low utilization, middle,

11 central, that kind of stuff, low utilization, urban and

12 rural. And it really expressed that way, and people tend

13 to think they're seeing rural effects, depending on how

14 they look at the data, when really what you're doing is

15 catching the geographic effect that's more urban and rural

16 in different parts of the country.

17 MS. BUTO: But could I just ask Jeff?

18 Did that include all of these facility-based

19 services -- inpatient, rehab, psych, skilled nursing -- at

20 long-term care hospital? Because the availability of some

21 of those facilities in some of these other regions --

22 Frontier, for example -- it would be hard to imagine you'd

1 have similar access to these kinds of specialty providers.
2 DR. STENSLAND: Not things like long-term care
3 hospitals. You're not going to get a lot of LTCH use in
4 rural Montana, but you would have similar things on
5 inpatient days, SNF days, visits, home health use,
6 prescriptions, those things, and then when you aggregate
7 all of it together on average, the amount of service use
8 adjusted, kind of allowing some substitution like across
9 from SNFs and LTCHs, then it was really very similar within
10 a State. You're going to see some urban areas in Louisiana
11 really high, but you also see rural Louisiana as equally
12 high, or you'll see someplace like Wisconsin, you have some
13 urban areas that are really low. But you'll see rural
14 areas low also.
15 DR. HOADLEY: Is ED use one of the measures you
16 looked at in that?
17 DR. STENSLAND: I don't remember.
18 DR. HOADLEY: Okay.
19 DR. CROSSON: Okay. Let's come back. Pat, are
20 you still on? Pat, are you done?
21 MS. WANG: No. I don't know if you wanted to
22 have the opportunity on the SES, whether you're considering

1 using -- looking at additional variables. Especially, what
2 I think is kind of missing is the community resource kind
3 of whole element, bucket, whatever.
4 MS. TABOR: I will say the National Academy of
5 Medicine has been doing a series of reports on using --
6 adjusting SES for Medicare quality measurement, and they
7 did recently release a report about data availability and
8 looking at these different SES factors, and it was kind of
9 after we had done all this work. So they did sort
10 variables into data that's available now versus data that
11 we wish was available. So we can plan, if the Commission
12 would like, to keep looking at those variables and kind of
13 taking into account that perhaps not everything is
14 available now, but as data gets available, the SES
15 adjustment -- or how to handle SES could get better.
16 DR. CROSSON: Okay. Alice.
17 DR. COOMBS: Thank you very much.
18 I thought -- my thinking was just like Jon about
19 the health days at home, and we brought this up before. I
20 think we actually discussed this before.
21 So the question I have is, What about combining
22 your linear regression with the PPV and the PPA, having the

1 whole notion of the healthy days at home with the home
2 health, to see if there's an effect for those two
3 indicators? Because I think it would be a great place for
4 MedPAC to be in the position of simplifying a population
5 measure, if you could bring those two together, that
6 challenges the MIPS and as on a population scale, to look
7 at the population health outcome. It would be incredible
8 if those things could kind of fit together.
9 DR. CROSSON: Okay. Paul.
10 DR. GINSBURG: Yeah. I wanted to raise the
11 question about how mortality fits in with your other
12 measures, and my concern is that someone dies in January,
13 and they have this enormous impact, mortality. It's going
14 to wipe out everything else, and I'm really thinking that
15 there may just not be a good way to have mortality be part
16 of this and whether we just have to have it as a separate
17 measure. Mortality is very important, but I think it just
18 blows away all the other things you're looking at.
19 I don't know if you've examined when you've been
20 crunching numbers that agree to it. A lot is really driven
21 by mortality rates.
22 DR. CROSSON: I had the same concern. I think --

1 correct me if this is not correct, but since overall, on
2 average, people die roughly, equivalently -- I know there
3 are peaks in the winter with flu and all that, but more or
4 less, isn't this problem, because it could be a problem, a
5 function of an end, the number of observations that you're
6 using for the measurement pool that you're using? And if
7 it's, in fact, very large, it would wash out, but in some
8 circumstances -- for example, if you were applying this
9 measure to ACOs and it includes ACOs with small
10 populations, you could have that effect. Is that right?
11 DR. GINSBURG: Actually, that is not what I was
12 concerned about.
13 DR. CROSSON: Oh. Sorry.
14 DR. GINSBURG: I mean, I think that this overall
15 approach of looking at large populations is a great
16 contrast with MIPS, which is looking at too small units to
17 be meaningful. But I think it's really a matter of whether
18 the mortality measure just inadvertently dominates the rest
19 of it.
20 In a sense, I remember Brian's first comment
21 about time between failures, and that that way of thinking
22 might actually be a way to help resolve this. But I think

1 at the moment, I'm really concerned about that our healthy
2 days at home is really mostly a mortality measure.
3 DR. CROSSON: Sorry to persist, and then Brian.
4 But it would only dominate if all the individuals happen to
5 die in January, but you're going to have people who die in
6 December as well. And then it would be a very minor
7 impact, right?
8 DR. GINSBURG: But I think just the -- I think
9 the -- just areas with higher mortality rates are going to
10 have much lower healthy days at home. That's the concern
11 as opposed to what --
12 DR. CROSSON: I see. Okay. So geographically as
13 opposed to --
14 DR. GINSBURG: Yeah, because that's how we're
15 using this, for geographic areas.
16 MR. GLASS: We can look at that distribution.
17 So, on average, it's like 8 days, I think. It's mortality
18 days, which is the biggest, I think, but we could look at
19 how that's distributed and see if there's a big meaningful
20 difference among areas.
21 DR. CROSSON: I'm sorry. Brian, you --
22 DR. DeBUSK: I remember you had addressed that

1 concern. You and I had a chance to talk about that
2 earlier, too, about this issue about mortality. Not to
3 push a specific point of view too far, but in a mean time
4 between failure mentality, you know, that mortality would
5 simply be one of many failures. Being admitted into a
6 hospital, being admitted into an inpatient psychiatric
7 facility, that would just be another point of failure along
8 the way. The nice thing is then the mortality wouldn't
9 contaminate -- you wouldn't have that issue of did you pass
10 in January, did you pass on December 30th, because that
11 would just be one failure in the meantime between failure
12 calculation.
13 We might need a better marketing term for it
14 because no one is going to want to look up their MTBF.
15 But the idea, I think some of the issues that we
16 faced in the PQRS with these top-down measures -- I mean,
17 imagine someone trying to pick an ACO to join, and they
18 say, well, someone who meets your category, here's one ACO
19 that averages 362 days, and here's one that averages 365
20 days -- well, 6, leap year -- 365 days, you'd be separating
21 such small delineations.
22 One of the things I was going to ask you to do,

1 but I wasn't in a particularly snarky mood, was the --
2 [Laughter.]
3 DR. NERENZ: -- was your chart on page 9 -- on
4 Chart 9. Replot that with the y-axis as zero, and look at
5 what that graph looks like. It looks like a PQRS measure
6 at that point.
7 MR. GLASS: Yeah. But don't get attached to
8 these numbers because --
9 DR. DeBUSK: Oh, I know.
10 MR. GLASS: -- it's very preliminary, and the
11 comparison population isn't quite right.
12 DR. DeBUSK: But the good news is a lot of the
13 things that Paul was raising about issues like timing of
14 mortality and all that, engineers solved those problems
15 with calculations like MTBF, but the really good news is
16 I'm not going to bring that up again.
17
18 [Laughter.]
19 DR. DeBUSK: So thank you.
20 DR. MILLER: Sort of like a time between, you
21 know, when-he-brings-that-up measure.
22 [Laughter.]

1 DR. CROSSON: Right. Median time. Never mind.
2 [Laughter.]
3 DR. CROSSON: Kathy.
4 MS. BUTO: My question, I think, is pretty
5 simple, I think, how soon we'll be able to do a healthy
6 days at home calculation for MA. In other words, when are
7 we going to have enough encounter data to do something like
8 that? I mean, going back to the real purpose of this, it
9 was to simplify, come up with simplified measures of
10 quality across fee-for-service MA and ACOs, right? So it
11 would be good to know what that MA number is.
12 DR. MILLER: We feel that, and I think there is -
13 - I don't want to promise anything soon. We have slow
14 churning through that data. We found issues, some of which
15 we've put in front of you, and so there's a slow march
16 there. I wouldn't expect this to come up quickly that we
17 could say, "Oh, and here's the MA version of this." I
18 think we're still a bit out on that. So I wouldn't expect
19 to see it this cycle, and I'm hoping either late this cycle
20 or early next cycle to try and bring some encounter data
21 into the discussion, where I wouldn't even be using it in
22 this context, just some basic -- "This is what we find.

1 Here's the errors and the problems and the missing
2 whatever. And we have it. It's slow-going."
3 MR. GLASS: I mean, theoretically, if we had it
4 and it was cleaned up and all that sort of thing, I would
5 think you could do the same calculation.
6 DR. MILLER: Yeah. Conceptually, it should fit
7 the framework. Your question is right on point.
8 DR. CROSSON: Jack.
9 DR. HOADLEY: I have a couple, I think are
10 straightforward questions. First is, How did you, in fact,
11 define your Medicaid measure? I don't think you talked
12 specifically about it today.
13 MS. TABOR: It's the number of partial or all
14 duals, really, is what it was as a measure of --
15 DR. HOADLEY: Okay. Similar measure of whether
16 somebody got dual eligibility.
17 MS. TABOR: Yeah. Well, they're partial or full.
18 DR. HOADLEY: And then on Slide 9, this is
19 nationally all ACOs aggregated, all non-ACO individuals
20 aggregated?
21 MS. TABOR: So it's actually by market area --
22 DR. HOADLEY: Okay.

1 MS. TABOR: -- and then aggregated by market
2 area.
3 DR. HOADLEY: So if there is a market that has no
4 ACOs in it, that doesn't show up in this?
5 MS. TABOR: Exactly, yeah.
6 DR. HOADLEY: And then, third, on the healthy
7 days at home measure, have you looked at any -- you've got
8 some nice ways to look at comparisons across chronic
9 conditions and some of those things. Is there any way to
10 look at some kind of a correlation to health status,
11 perceived health status, if there's stuff you could pull
12 off of CAHPS or somewhere to test that? Because, I mean,
13 getting into this question some others have raised about
14 what does it mean to be healthy, measuring the chronic
15 conditions is obviously a good way to do that, but maybe it
16 would be interesting to see how it lined up as well or not
17 as well with self-perceived.
18 MS. TABOR: That is interesting. That's a good
19 idea, so we'll look into that.
20 DR. CROSSON: Clarifying questions. Bruce.
21 MR. PYENSON: Ledia, I'm curious about how to
22 handle custodial care. It looks like you're tabulating SNF

1 days, which are paid by Medicare, but if a person is
2 institutionalized, being paid by Medicaid, that's
3 considered at home.
4 I think through some data manipulation, you can
5 attribute people who are institutionalized through the
6 Medicare data, and how that might work in this model from a
7 policy standpoint, I think having a measure that connects
8 big area of Medicaid expense to Medicare and integrates the
9 two has appeal to me because it talks to Medicare and
10 Medicaid integration.
11 But from a technical standpoint, what do you
12 think about that?
13 MR. GLASS: Well, this came up, I guess, last
14 year when we discussed this measure, and I guess the
15 thinking was, A, that's they're home. So you can't just
16 say days in a nursing facility because outsourced
17 everything, and so we didn't include that. If you include
18 it, okay, someone is living in a nursing home 365 days a
19 year. What would you do? You can't say --
20 MR. PYENSON: Well, but on a population average
21 trait, there's huge variability among regional variation.
22 MR. GLASS: You mean put it in as a risk

1 adjustor?

2 MR. PYENSON: No. As an actual measure that some

3 places keep people in home better than others, not their

4 nursing home home, but their real home.

5 MR. GLASS: Yeah.

6 MR. PYENSON: That's, as you know, a huge cost

7 issue for Medicaid.

8 MR. GLASS: Sure. But I guess -- yeah. As I

9 remember the conversation from last year, I think the

10 problem was, A, it could swamp the thing. But, also, could

11 an MA plan or an ACO have a big effect on whether someone

12 was in a nursing home or not? And I guess there are

13 programs and things, but --

14 DR. MILLER: And that's what my recollection of

15 this is too. So that was my recollection of this too.

16 I think part of the reason, to David's point is -

17 - and David's point is -- and Ledia's point is the market

18 effects variable was trying to get in there in a very broad

19 way, try and capture differences, and if your point is

20 geographically people end up in the nursing home

21 differently -- and I mean the maintenance-level nursing

22 home -- there's something in there to try and adjust for

1 that.

2 But I recall the conversation the way David does.

3 It's also the measures that end up in this are supposed to

4 be ideally things that the actions of the MA plan, the ACO,

5 or the fee-for-service environment can actually -- would be

6 held responsible for -- or influence it, actually. Maybe

7 that's a better word.

8 MR. PYENSON: I can appreciate that, but that's

9 Medicare-centric. So if you had an integrated program,

10 that would be a very budget important kind of measure.

11 Another clarifying question, I have observed in

12 the data that home health is very strongly negatively

13 correlated with chiropractor use. I don't know if others

14 have --

15 DR. CROSSON: What?

16 MR. PYENSON: Chiropractic. I'm not sure why --

17 or physical therapy. I don't know if you've seen that in

18 the regional data.

19 MR. GLASS: I don't think we've looked at that.

20 MR. PYENSON: Okay.

21 DR. CROSSON: I'm sorry. Bruce, just to clarify,

22 the more chiropractic use that is being enjoyed, the less

1 home health?

2 MR. PYENSON: The more chiropractor and physical

3 therapy, the less home health, and perhaps because a lot of

4 home health is rehab-oriented. If you combine the two of

5 those as swappable services, that might have a different --

6 a better fit.

7 MS. TABOR: We could take a look at that.

8 DR. CROSSON: Okay. Seeing no more clarifying

9 questions, we'll move to the general discussion. Let's put

10 up the last slide again, just to remind folks to go back to

11 the engineering analogy for a minute. We're still in R&D

12 with respect to these measures, so suggestions to Ledia and

13 David about support for or other suggestions about future

14 directions are in order as well as other comments, and,

15 David, you're going to start.

16 DR. NERENZ: Yeah, thanks. I'm generally

17 supportive of this line, and I made that same comment last

18 month when this was in front of us. The intent of the

19 comments last month was sort of cautionary on technical

20 details, but generally a good direction, and thank you for

21 taking us down this path. And I think that's still the

22 spirit of the points I'd like to make this morning.

1 First of all, just to play off a comment Mark
2 made, clearly we are not measure developers; we're measure
3 stewards in the NQF sense. And there's only so much we can
4 do before it has to get passed on in the form of a chapter
5 or recommendations, and I recognize that's so. So there's
6 only so much we're going to be able to do with this model
7 and that model, and that's fine.
8 And I'm trying to think of what ground should be
9 covered sort of between here and the pass-off point. One
10 specific thing -- and this then relates to the last bullet
11 there -- I just wanted to confirm. I thought part of what
12 we were trying to do here was look at measures that would
13 be and could be used for comparison of individual ACOs
14 within an area, individual MA plans within an area. So I
15 guess that's something I'd like to see, that to the extent
16 we have data that would seem to be the next thing we'd want
17 to look at before we then passed this on and said these are
18 measures that could be used in that context. So I'm seeing
19 you nod. That's good. I certainly would like to see that.
20 I do commend and thank you for the attention to
21 race, ethnicity, and the Medicaid effects, and as Pat has
22 pointed out, you know, there are many other SES-type

1 variables that could be brought in if what we're doing is
2 basically characterizing market areas or community, because
3 there's a rich set of variables drawn from census, drawn
4 from area resource file, drawn from a number of places.
5 There are some indexes now of community deprivation. There
6 are all sorts of things. And I was curious about the
7 extent to which a whole lot of that had already been folded
8 into this market variable. But I think probably it's
9 better to have them explicitly tested in the model for
10 transparency and just see how many of these things matter
11 and then people know that they're adjusted. So there's
12 more you can look at, but, again, you can't do everything,
13 and at some point a measure developer has to pick it up and
14 go.
15 On Slide 9, if we could just have that -- and
16 there are other examples, many of -- page 13, 14 in the
17 chapter. And I'm going to play off Brian's point here.
18 You know, these are really going to be tight distributions,
19 at least on the healthy days measure, and maybe on the
20 others as well. We're going to be looking at differences
21 of one or two points out of a total range of -- you know,
22 total topped at 365 on the one measure. And I'm just going

1 to guess, but we don't know yet, that if we start looking
2 at charts of individual MA plans or ACOs, we're going to
3 see charts that look a lot like this. And as Brian pointed
4 out, if you actually set the Y-axis base at zero, they're
5 going to look the same.
6 Where I was going to go with this is in the
7 domain of clinical outcome measures, particularly the self-
8 reported measures, there's the concept of minimum
9 clinically important difference, or MCID, measures like SF-
10 36, measures like EQ-5D. The concept is a lot of
11 psychometric work goes into deciding how big a difference
12 or how big a change do you need to see for it to matter to
13 patients. And then you can use it to say how big a
14 difference between treatment A and treatment B is actually
15 worthwhile, or how much -- you know, if a person was
16 considering a surgical procedure, how much benefit would
17 you need to say it's worthwhile doing it? The concept
18 exists. There's a literature on it. I use it in things
19 that I do with spine surgery. Other people do things.
20 It's out there.
21 We don't really have that here, and I know we
22 can't do the psychometric work, but I'm wondering if we

1 could at least put a toe in the water or, you know, bring
2 it up in a report and say as this works its way out,
3 somewhere or other we're going to have to decide or at
4 least have somebody think about how big a difference
5 matters. And, you know, Brian already gave the example.
6 If I'm looking at two ACOs and one's 355 and one's 357, do
7 I care? Should I care? And particularly in comments I
8 made last month about signal and noise, until somebody has
9 risk adjustment down really tightly, that 355 to 357 may be
10 noise and no signal.

11 So there are some things, I guess, we can bring
12 all the way to ground, but at least I think could be
13 discussed in a report and make sure people know these are
14 concerns.

15 Now, with that in mind, it was interesting -- can
16 we get -- oops. Don't have it back yet. Right side of
17 Slide 9, one of the -- and the corresponding distribution
18 chapter in the report, when we only look at the people with
19 CHF, the measure is not so much topped out. And the
20 measure actually has a broader range, and it may suggest
21 that as this moves into implementation, it may be more
22 informative if it's set in a denominator population like

1 that where actions by an ACO or actions by a plan could
2 actually move the needle on this more than in just an
3 unselected population, many of whom are perfectly healthy
4 and they're sitting at 365 right now.
5 Okay, last thing. Everything I like about this,
6 except one thing. On page 24-24 -- and it's mentioned in
7 one of the bullet points here -- there's discussion of
8 using these measures to replace existing physician measures
9 and essentially hold physicians accountable for these
10 measures in their area.
11 Now, I'm willing to listen to input from my
12 clinicians colleagues here, but that just strikes me -- and
13 I'll say it -- as just a bad, bad idea, and I don't know
14 how I could possibly support it. I think that's actually
15 tangential to what's going on here, and I was a little
16 surprised to see it.
17 All of the historical precedents I can think of
18 that are bad -- but, again, others may see it differently -
19 - SGR being the more prominent example, I just don't think
20 we go ahead by holding individuals or groups accountable
21 for the collective behavior of something over which they
22 have no control. Everything else about this I like. I

1 think we're fine. It's a nice direction. I really have
2 trouble with that.
3 DR. MILLER: It is about trying to go into a
4 market area -- and this is something that the Commission
5 talked about in some other settings -- and being able to
6 walk into D.C. and say, How does MA, how does ACO -- and
7 you didn't finish the sentence, but I think you see it --
8 how does fee-for-service as a system -- you know, we've
9 talked. I knew you knew that. But I also wanted to make
10 sure everybody else got it, so that on something of a
11 comparable basis you could see how these different delivery
12 systems are doing.
13 The second thing is, as you said, there's very
14 small -- the topped out point, Brian made the point as well
15 on healthy days at home, definitely an issue. And I think
16 you nicely zeroed in -- and I would get everybody else to
17 track on this. Part of the reason we're parsing it out by
18 populations and multiple chronic conditions is precisely
19 for that reason.
20 But I would also say -- and I think I'm right
21 about this -- the PPVs and the PPAs have a lot more
22 variation than this measure has, healthy days at home.

1 MS. TABOR: They do, yes, especially if --
2 DR. MILLER: Right. So there's three --
3 everybody's kind of talked about healthy days at home, I
4 think mostly because the title of it is really catchy, Jon.
5 [Laughter.]
6 DR. CHRISTIANSON: Yeah, we want MedPAC to be
7 telling Medicare beneficiaries that when they're at home,
8 they're healthy [off microphone].
9 DR. MILLER: Right. Everybody's focused on that
10 one. It does draw a lot of attention. But the other two
11 have a lot more variation to them, so keep them -- just
12 keep that straight.
13 The MIPS thing, you know, I expected that to kind
14 of set you off potentially, and -- well, I don't mean that
15 in a -- we've had enough conversation, yeah, I know, but I
16 think there is a dilemma, a policy dilemma, and the reason
17 I want you guys to think about this as you go through it is
18 there's also a lot of consternation around MIPS, you know,
19 the burden of collecting the measures, the fact that you
20 don't have comparability because people can kind of pick
21 their own measures, the fact that, you know, depending on
22 how the arithmetic is done, the effects could be quite

1 dramatic. And sometimes, some Commissioners have said,
2 well, maybe you go to more of an aggregate measure and say
3 I know this isn't about your individual and specific
4 performance, but, you know, it's how the delivery system
5 does in general. And to the extent that a physician or a
6 provider says I don't want to be measured this way, it
7 creates an incentive to move into more of an ACO-type of
8 environment. Those kinds of conversations have been made.
9 But I think your point is well taken. It is the
10 difference between whether you measure what this individual
11 person does or whether you measure the outcome for a
12 population that that provider touches, and that's a huge
13 philosophical question.
14 DR. NERENZ: Mark, just to sharpen my point, I
15 worry about asking clinicians to be responsible for members
16 of populations who they do not touch, and I think that's
17 where this regional things strikes me -- ACO, okay, MA
18 plan, okay, region for individual fee-for-service docs --
19 DR. MILLER: And fair enough, and I think what
20 Ledia was trying to say is she'd have to drive it down to a
21 smaller unit if you were to use it that way, and she used
22 hospital referral region as an example, but it may be

1 incomplete.

2 And the only last thing I want to say -- and this

3 is going to be touchy, too, but we've had enough

4 conversations. I think your point about how much

5 difference does it make -- and you had a term for it, and

6 then Brian's bringing his terms in, it's killing me. So I

7 think that's a really fair comment. I also think you guys

8 should keep that in mind for SES, because once you control

9 for demographics and conditions and take other

10 characteristics into effect, what often happens in these

11 models is they're present but their effects are very small.

12 And that's what we keep running into here. So that I think

13 also is something to keep in mind.

14 DR. NERENZ: That's fair [off microphone].

15 DR. CROSSON: You know, having said that, I have

16 to say for myself if I have one year and I'm not in the

17 hospital and I have another year and I'm in the hospital

18 for three days, it may be only -- and those were

19 preventable -- it may be only three days out of 365, but

20 with respect to my subjective sense of health and quality

21 of life, it's a big difference.

22 DR. HALL: I think this was a great report and a

1 really important study. And we've kind of tried to pick
2 out the flaws rather than say that, you know, this is a
3 really good start. I know many of us consider that the
4 pursuit of perfection is always the enemy of the good, so I
5 think we've made a lot of very important points here.
6 What I took away from this in a general sort of
7 way is that however we define HDAH, there is variability
8 and, not surprisingly, a lot of that variability has to do
9 with socioeconomic status, to the extent that Medicaid is a
10 surrogate measure of SES.
11 On the other hand, the PPA and PPV variances
12 don't seem to be directly related to Medicaid status or
13 SES, and so that there might be some widget in there that
14 we can work with.
15 And we've pointed out some flaws or warts in the
16 system, what do we mean by health? And I think that's a
17 valid concern, not really a criticism.
18 So it seems to me that at the 30,000-foot level,
19 the next steps we might want to consider would -- I sort of
20 hear the voice of a former Commissioner here, Mary Naylor,
21 who at this point would be bouncing up and down and hitting
22 the table, and when you called on her, she said, "It's all

1 about function, stupid." So I think in honor of Mary, I
2 need to bring that into our discussion.
3 So I think the next steps on this would be
4 particularly if we're going to look at HDAH as a stretch
5 goal, then some of the comments that have been made here
6 are interesting. For instance, you mentioned that it's
7 associated with chiropractic here. And I think it probably
8 is, but that's also a surrogate measure for paying
9 attention to functional status of patients, which is not a
10 stretch goal. We're getting much better at that. And I
11 think that's really what we'll probably end up going to be
12 saying, is can people do things that are necessary to stay
13 independent at home if we tweak the system in some way.
14 That's how I would define healthy days at home. And
15 there's already an abundant literature that suggests that,
16 and it might lead us to say that within an ACO environment,
17 such things as a simple measurement of can people do the
18 things that allow them to be at home, which generally means
19 taking care of your personal needs, a certain degree of
20 ambulation, et cetera, Mary would say that the model that
21 she's popularized around the country which uses usually
22 nurses in a different sort of observational status in the

1 home could make a huge difference. That might be another
2 next step in this.
3 Also, this may be a perfect example to look at
4 other things the Commission has been looking at, such as
5 the utility of telemedicine. It seems to me that so far
6 that's a tool that's desperately seeking justification or
7 existing. But we now know that we can make many of these
8 measurements of quality of life at home very, very easily
9 and very inexpensively through that, and that may be a next
10 step.
11 So I think we really are doing something here
12 that's very important, particularly in a world where we're
13 going to be talking about payment for bundles of care,
14 looking at a much more comprehensive look at how
15 populations are doing. So I'm really encouraged by this,
16 and perhaps we're better at picking flaws than imagining
17 how we can take these initial observations and working them
18 forward. So I think we're on the right track.
19 DR. CROSSON: Thank you.
20 DR. SAMITT: This was an awesome chapter, a great
21 presentation. Thank you.
22 I'm in support of moving forward in all the

1 dimensions that you describe. To jump onto Bill's
2 comments, I think we should be careful for us to not be
3 overly critical, especially this early, of innovative new
4 ways to measure quality. And the comment we should not let
5 perfection be the enemy of good I think is very relevant
6 here, to Bill's point.
7 You know, we venture in this direction because,
8 as I remember it, we wanted to accomplish a few things from
9 a quality measurement standpoint. We wanted to try to move
10 more toward outcomes focused as opposed to process focused.
11 We wanted to minimize complexity and maximize understanding
12 in quality. And we wanted to hold providers accountable
13 for things that they can control. And it feels to me that
14 these measures hit on all of those cylinders. They're not
15 perfect, but I think these are the types of exact things
16 that we should be considering that will now allow us to
17 compare performance between MA and ACO and fee-for-service.
18 I empathize with David's concerns about, well,
19 what do we do with fee-for-service since fee-for-service is
20 not an organized unit like MA and ACO? And I'm confident
21 that we can sort that out, but I do endorse future research
22 in this realm.

1 DR. REDBERG: I just wanted to briefly agree with
2 my physician colleagues. I think it's a really important
3 measure. The chapter was really well done, and whatever we
4 end up calling it, certainly the idea of healthy days at
5 home is really important to our beneficiaries. So I would
6 favor moving forward with it and working out the details.
7 DR. HOADLEY: Yeah, I think this also represents
8 some really good work in moving us forward, and I keep
9 trying to use sort of a face validity test on this. And I
10 think what you've given us is, you know, a number of good
11 signs that your measures are meeting a face validity test,
12 and then some of the discussion has said some questions of
13 where there are other things you could test. I think the
14 ADL idea, again, like my earlier suggestion, my health
15 status, if there's a way to capture that at the right sort
16 of measurement level, it would be really interesting to see
17 how those line up. And, you know, if nothing else, it will
18 teach us what this measure does and doesn't do.
19 You know, when I see the PPV measure, I look at
20 that 75 percent that you highlighted, and that makes my
21 face validity, you know, alarms kind of start to ring a
22 little bit. And I think trying to figure out whether that

1 means it's just -- and you said there's some data issues
2 and so forth, but whether that means we need to go back and
3 think further about what that is or whether there's a
4 reason to think that, in fact, there is a whole lot of
5 misuse or potentially preventable use of emergency rooms,
6 and maybe that high number actually reflects something
7 about how our health system goes. But it seems like -- and
8 then your goals for further research, you know, you don't
9 say explicitly there, but implicitly it's continue to make
10 sure these measures are working. And I think what you've
11 captured -- and we saw it in whichever slide it was that
12 showed the ACO versus the fee-for-service comparison, it's
13 a process of doing those kinds of things to both look for a
14 hint at results -- and you were very careful to keep
15 caveating, "Don't go very far with these numbers yet." But
16 as we do each of the things you say here, hopefully the
17 amount of these are worth looking at versus, well, these
18 illustrate but let's be careful about them, that balance
19 will change as we begin to figure out ways to either gain
20 confidence in the validity of the measures or to refine the
21 measures to make them better. And I think that's going to
22 be the challenge, is we're going to want to start looking

1 at the results as results, and we've got to keep testing
2 them against the validity, and yet this is a good way to do
3 it, so trying these things and each of those results will
4 give us a sense of is that what I would have expected.
5 Sometimes it's not what I expected, and there's a good
6 reason for it, like the rural stuff we were talking about.
7 Sometimes it's okay, yeah, we seem to be capturing that.
8 So I think that's going to be the tension for both you guys
9 doing the analysis and for us reading the analysis.
10 DR. CROSSON: Kathy.
11 MS. BUTO: I think this is really important work,
12 and I want to commend you on getting a good start.
13 I would support the slide, all the points on
14 future research, but I would also make sure that you don't
15 lose sight of the MA analysis. And I'm wondering if there
16 might be a way for you to at least take a look at PPA for
17 MA, maybe not the whole healthy days at home thing, but one
18 of the measures to see how it's beginning to stack up, just
19 so we begin to bring that into the mix.
20 I want to agree with Dave that I think for a
21 consumer, patient, or beneficiary, having something by
22 major condition, diabetes or COPD or something like that

1 would be probably more helpful, even back pain.
2 And, thirdly, I've been struggling thinking about
3 fee-for-service and how this would apply in a comparison,
4 just like Dave, only not from the standpoint of how do you
5 hold everybody accountable when nobody is accountable, but
6 more, is there a way we can think about this in relation to
7 our increasing the role of the primary care physician? So
8 maybe there is some intersection there that doesn't look
9 like a penalty because I don't think we want to just
10 penalize primary care physicians, but is there a way to
11 increase their role in relation to monitoring and
12 overseeing and creating more accountability within fee-for-
13 service, since I think we want to raise the level or see
14 the level go up in all three sectors?
15 DR. CROSSON: Thank you.
16 Paul.
17 DR. GINSBURG: Yes. I also support moving
18 forward. I think this is very promising work. I regret
19 that we didn't talk more about PPA and PPV, which I think
20 are understandable, and I like the variation and I think
21 focus on important things.
22 I think HDAH, healthy days at home, is worth

1 pursuing. Maybe another potential refinement is to start
2 thinking about weighting the different components. I'm
3 just really uncomfortable when people take many disparate
4 things together and weight them equally, particularly if
5 there are some tradeoffs, like using more home health
6 visits to avoid hospitalization.
7 But I also think that we shouldn't strive for
8 just coming up with one measure of a health system or MA
9 plans. Since I don't think we're going to make some of
10 these calls on weighting, particularly weighting mortality
11 against some other measures, we may really think that the
12 goal should be, well, maybe five meaningful measures that
13 can be put in front of people and they make their own
14 judgments, just do their own weighting as to what's
15 important to them.
16 DR. CROSSON: Very good. Thank you.
17 Alice?
18 DR. COOMBS: So I, too, am very impressed with
19 the chapter. Thank you very much, Ledia and David.
20 A couple things came across my mind in that we're
21 looking at a spectrum of quality metrics, and I'm looking
22 at MIPS on one side and looking at population health

1 indicator on the other side. And I was just sitting here
2 thinking, well, if I were to put Jay asleep under
3 anesthesia for his gall bladder, there will be some things
4 as an anesthesiologist that I would have to -- according to
5 my MIPS, we check off like eight to ten things on a sheet -
6 - would want to make sure that I put you to sleep and I
7 woke you up, first of all.
8 DR. CROSSON: That would be good. That would be
9 good.
10 [Laughter.]
11 DR. COOMBS: That you went to the recovery room,
12 and you didn't have a cardiac arrest, and that you didn't
13 have an infection from the IV and a series of things that
14 we check off on our little MIPS sheet.
15 But then in the big picture, when I go to the PHO
16 meeting, having an indicator like this would be something
17 very important, not just for patients, but also for the
18 various entities that we contract with and we discuss,
19 because they're going to want to know how good are you.
20 And so this is another way to say how good are we doing for
21 the population that I'm responsible for in South Weymouth,
22 and so I think that this does that.

1 I would love to see something even more
2 simplistic as a provider. I know this will resonate with
3 Bill. It's that if you could put -- and I said independent
4 living index. Does that sound better than healthy days at
5 home, because you're living independent? If you could put
6 the independent living index as a part of the healthy days
7 at home, combine the PPA and the PPV, and have a single
8 something or another for patients, you give a patient too
9 many choices about variables, and that's not good. They
10 always tell us that too many choices are not good, but if
11 you give them something to interpret that's relatively
12 simplistic, you could break it out and say the components
13 of this next look like this.
14 So I think those are things that we can do on the
15 patient side, but also we need to do things for the
16 marketplace in terms of how we engage with the various
17 plans that are there that say that, "You know what? We
18 like what you're doing. We're impressed by your outcome,
19 and we think that the thing that you're doing is very good,
20 and we want to incentivize it in whatever means there is."
21 So the fee-for-service issue that David brought
22 up, I think, is a concern, but I think we have some other

1 things that we should be basing the fee-for-service on in
2 terms of me as a physician for specialty.
3 At the population health level, I think that's
4 very different in terms of how you contract. So I think
5 we're looking at some tiered kind of engagement.
6 One is Jay is going to wake up, and he's going to
7 go home, and that's really important. The other is how
8 well do we do with the group as a whole, and I think each
9 clinician cannot deny that they do play a role, but the
10 role that they play is aggregated with all of the doctors
11 together. So I think that's really important.
12 In terms of the mortality, I'm wondering if we
13 could take out the mortality altogether and just kind of
14 use it as an independent living index and say that's just
15 what we're doing; we're doing an independent living index.
16 If you're living, then this is what you're going to be
17 reading about.
18 For patients, I think that might be more
19 valuable, and you explain it, you're going to explain it as
20 these are the components of the independent living index,
21 or you can call it whatever you like.
22 DR. CROSSON: Thank you.

1 Pat.

2 MS. WANG: So thank you for the chapter. I think

3 it's important to continue the work on this, and maybe I'm

4 in a slightly different place on the days at home metric

5 than my colleagues here.

6 First of all -- and I appreciate the alternative

7 names. It sounds like we're landing on different names.

8 I'm not sure it's really -- I think, at least in my

9 experience, many Medicare beneficiaries are never going to

10 really live independently. It's a matter of functional

11 status, as somebody raised before, so maybe it's functional

12 days at home, but we're moving our sights down from healthy

13 to independent to something that I think might reflect --

14 DR. CROSSON: Alive.

15 [Laughter.]

16 MS. WANG: Alive.

17 I'm still not convinced -- and I am very happy to

18 engage in more conversation -- that the measure

19 distinguishes between appropriate utilization and

20 inappropriate utilization, because for many beneficiaries

21 who have multiple chronic conditions, there is going to be

22 utilization. And so, I mean, the tradeoffs, I think that

1 part of what care management or population health is trying
2 to find the right mixture of services for a beneficiary as
3 opposed to they're not going to receive any services, so
4 they can be at home more, more days out of the year. So
5 I'm not really persuaded by that because it seems to weight
6 everything equally.
7 I appreciate Mark's explanation about the meaning
8 of regional variation, and I have a deeper appreciation for
9 that. I still am not persuaded, though, that the rural
10 area in Miami does not look very different from the rural
11 area in Wyoming, and that the infrastructure there is not
12 so different that it doesn't skew the results of what
13 looked like days at home versus not at home, just because
14 of infrastructure issues. I'm still struggling with that.
15 I do think that it is important to continue the
16 work on this. The discussion about function and everything
17 reminds me of the Health Outcome Survey, because the data
18 to find out about functional status is difficult. Right
19 now, that is collected through survey kind of instruments -
20 - the uniform assessment instrument for folks who receive
21 long-term care at home. In the MA world, the Health
22 Outcome Survey asks beneficiaries to rate: Do you feel

1 that your health is better this year than at this time last
2 year? Are you more or less depressed this year than last
3 year this time. So there are elements like that that we
4 should be aware of. There's no encounter claim kind of
5 system to assess that sort of functional status. So some
6 of those might be interesting to bring in.
7 As the thing gets refined, though, I wonder
8 whether the other sort of gut feeling I have about this is
9 that this might be appropriate more at the larger level of
10 analysis than as you get it finer and finer, and the reason
11 that I say that is I think that it is very important for
12 quality metrics to measure outcomes, so that you can have
13 some kind of objective assessment on how the system or the
14 actor is doing, but also to provide clear enough
15 information to the actor, whether it's a provider, a
16 physician, a hospital system, an ACO, or an MA plan of how
17 you get to that outcome. And I don't see that yet in the
18 way that this thing is constructed.
19 I'm not sure that an individual physician -- I'm
20 listening to Alice's comments really carefully here because
21 the fact that she thinks that this would be a good thing is
22 meaningful and is making me pause in this comment, but I

1 don't know whether a hospital system, an ACO, or even MA
2 plan knows exactly how you -- what are the component parts
3 to produce this result? So I'll just leave that there.
4 When it comes to PPVs and PPAs, those are very
5 important metrics. I think, Bill, the report itself
6 acknowledged that the SES adjustment that was attempted was
7 pretty limited compared to -- maybe you didn't say that,
8 but I think that the SES factors that you tried to adjust
9 for are sort of the smallest set of the SES adjustment
10 factors that are being written about today. So some of
11 those community resource issues, those are critical. If
12 you are living in an area that has a grave shortage of
13 primary care, you are going to go to the emergency room
14 more often. That is not reflected in this, and I
15 understand that there's no data source, but I think I would
16 encourage us to continue to talk to the folks who are
17 actively doing research in this area because they are
18 finding very important correlations.
19 And the final thing on that point, because
20 whatever -- so the idea of going to a smaller number of
21 uniform, more outcomes-driven measures is really, really
22 important and really good, but it ups the ante on

1 appropriate risk adjustment and adjustment for SES. That
2 becomes critically, critically important.
3 I do wonder whether -- to your point about you're
4 kind of limited and stuck by the data sources that are
5 available -- whether MedPAC should consider recommending or
6 doing work in the area of uniform data collection or data
7 sets around SES factors, whatever they may be, because
8 these systems in the future are going to have to use them
9 to make these adjustments, and it's not a tomorrow thing.
10 But, at some point, there does need to be some sort of
11 uniform way of collecting this information so that it can
12 be the basis of fair and consistent adjustment.
13 DR. CROSSON: Okay. Thank you, Pat.
14 Warner, last comment.
15 MR. THOMAS: I just have one quick question and
16 then a comment.
17 The question is, How are we handling hospice
18 days? I didn't see it in the calculation.
19 MS. TABOR: We didn't actually include it in the
20 model, which is a question that we have for the Commission
21 is whether to include it or not.
22 MR. THOMAS: Okay. I'm not sure whether we

1 should include it or not. I just was curious how it was
2 handled, so it's just not considered.
3 MS. TABOR: We didn't --
4 MR. GLASS: We did think about it and talked
5 about it last year.
6 MR. THOMAS: Okay.
7 I guess I have a little bit of a different view.
8 As I look at the data and I look at the chapter, I'm just
9 trying to figure what is actionable when I look at this,
10 and maybe we need to look at it with more specificity by
11 ACO or by region or whatnot, but I just have trouble
12 figuring out, okay, if I have this information, now what
13 would I do? Where would I go with it? And so I just throw
14 that out as something else to think about.
15 I know we're going to move forward with the work,
16 but I just would ask us to really challenge ourself. If we
17 get this data and we're 350 versus 348, what does that
18 mean? And is that a statistically significant variation?
19 Where would we go with this? So I just throw that out as
20 something to think about as you do your additional work.
21 DR. CROSSON: Okay. Good discussion. Ledia,
22 thank you. David, thank you.

1 We now have the opportunity for a public comment
2 period. If there are any members in the audience who would
3 like to make a comment, please come forward to the
4 microphone.
5 [No response.]
6 DR. CROSSON: Seeing none, we are adjourned until
7 the December meeting.
8 [Whereupon, at 11:54 a.m., the meeting was
9 adjourned.]
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