MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 3, 2016
9:48 a.m.

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

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

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

The second is the purchase of physician practices by hospitals.

The third is the merging of providers into an organization that accepts insurance risk, and this can occur when provider groups take on insurance risk through ACOs. It can also happen when insurers purchase physician practices. And both these two things have been happening.
As we go through this presentation, I will discuss how each of these types of consolidation in the health care industry are linked to Medicare policy. I will also point out how they are linked with other presentations you're going to hear today and tomorrow.

First, we'll discuss hospital consolidation. And as we stated in your paper, hospitals generally have significant market power. In about a third of markets, a single system has more than 50 percent of all discharges. In many small metro areas, there is only one hospital system. And there's no expectation that the FTC is going to materially unwind consolidated systems. Therefore, hospital market power is expected to be retained and possibly grow. So market power is simply part of our health care environment, and that has important implications for Medicare policy.

The literature cited in your mailing materials presents strong evidence that market power leads to higher commercial rates, and there's not any clear evidence that the higher costs are justified by higher quality.

On average, when we look at prices we see two things. First, the rates commercial payers pay hospitals
vary wildly from market to market and hospital to hospital. As we showed in your mailing materials, a high-cost hospital may have a negotiated rate for a head CT that's five times the rate at a low-cost hospital. What this suggests is that the markets are not working to bring prices down to a consistent level.

On average, we see commercial rates are about 50 percent above cost and well above Medicare. Now, we'll talk about these implications for the Medicare program.

So we and others have shown in the past that when nonprofit hospitals have more money, they tend to spend more money. And so higher non-Medicare profits are then often associated with higher costs of care. And the high costs of care mean larger losses on Medicare patients. Now, this creates pressure for Medicare to increase its rates.

However, we should note that, despite the losses, hospitals still have an incentive to continue to see Medicare patients, in part because Medicare rates continue to exceed their marginal costs. So there does not appear to be a near-term access problem. But over the long term, this growing gap between the commercial rates and the
Medicare rates is troubling.

The bottom line is that, at least in the short run, Medicare's administratively set prices partially insulate the taxpayers and the beneficiaries from the market power of hospitals.

Now I'll shift to talking about vertical financial integration. Recently, we've seen an increase in hospitals purchasing physician practices. When a hospital buys the practice, it then often starts billing for the services as a hospital outpatient service. This means that the program and the beneficiary will receive two bills. Instead of just getting a physician bill, they'll get a physician bill and a second bill for the hospital facility fee. The result is Medicare spending goes up.

In the commercial world, some hospitals are also paid facility fees for physician services. On average, this increases costs. However, the research by Neprash and Capps cited in your mailing materials suggests that hospitals may also negotiate higher prices for services after they acquire the physician practices.

One hope is that maybe once their practices are acquired, there will be better coordination of care and
maybe volume will go down to offset the price increase.  
But the Neprash article shows that overall outpatient
spending goes up, meaning there wasn't a volume offset to
the price increase, and there was no volume offset on the
inpatient side either to make up for the price increase.
So, in net, spending up.

In some cases, this vertical integration may
generate efficiencies. But the way the Medicare program
and the commercial payment worlds are set up, there is an
incentive to merge even when there will be no efficiencies
 gained. In fact, even if some inefficiencies are created
by the conversion of physician practices to a hospital
outpatient department -- possibly having to meet hospital
life safety codes, for example -- hospitals may still
convert to obtain the facility fees and the higher private
rates. Even in that environment, slightly less efficient
care.

This slide shows the growth in hospital-based
physician services. Hospitals are increasingly billing for
E&M services, echocardiology, and nuclear cardiology at the
hospital rates.

E&M services grew 22 percent in three years
compared to a decline in physician offices. Echocardiology and nuclear cardiology also shifted to the hospital site of care. So, in general, what we're seeing here is a shift in the location of services to the higher-cost site of care, and the current policy of differential rates across these sites encourages this shift.

In 2015, Medicare paid about $1.6 billion for hospital-based evaluation and management services, above what it would have paid in a physician office. This reflects the hospital facility fee. Similarly, beneficiaries paid an additional $400 million in cost sharing because they were paying the hospital-based rates rather than the physician office rates.

Now, Congress has started to address this issue. Going forward, at some point off-campus hospital outpatient departments will be paid the same rates as freestanding offices. This is part of the Bipartisan Budget Act of 2015. However, there are some exceptions to this new policy.

First, on-campus practices will continue to be aid the facility fees. In addition, there will be a grandfathering clause where existing practices continue to
be paid the facility fees.

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

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

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

Now we turn to the third type of integration. There have been managed care plans in Medicare for 40 years. In many cases the managed care plans are aligned with or own physician practices. The single entity then has responsibility for insurance risk and the provision of
As we discuss in your mailing materials, we see some providers acquiring insurers and some insurers acquiring providers. It is not clear that this model has large enough advantages to always win in the marketplace. In some cases, providers have divested their insurance arms in the past. In other cases, insurers have divested their physician practices.

Another option is the accountable care organization, or ACO. There is increasing interest among providers in being rewarded for managing population health. Providers can take responsibility for the health of their patients, and in models with two-sided risk, they can also take responsibility for the annual cost of care.

We now look to see how integration of insurance risk and provision of care in MA plans and ACOs has affected outcomes and costs.

First, the literature suggests that integrated models do have some small benefits.

First, HMOs do tend to provide better -- or perform better on process measures such as mammogram rates. But they are about equal on patient satisfaction.

HMOs can reduce use of services, but it is not
clear that reduction in the number of services will offset the plan's higher administrative costs on average. Certainly in some high-use markets, like Miami, we've seen that MA plans have been able to reduce the service use by enough so that they can bid below fee-for-service, meaning the reduction in service use was bigger than the extra administrative costs. In low-use markets, we haven't always seen this is the case.

In 2016, Medicare paid MA plans on average about 5 percent more on a risk-adjusted basis than fee-for-service. The 5 percent reflects MA bids, the extra cost of benefits, and the coding differences between MA and fee-for-service. So let's walk through this.

First, if we just ignored the coding issue and just looked at the cost of the basic A/B benefit and the bids provided by MA plans, we would estimate that the taxpayer paid MA plans 102 percent of fee-for-service costs for the A/B benefit and the extra benefits going to them, or 2 percent more. But as we discussed in the March chapter, last year MA plans also code more extensively than fee-for-service, and this increases the risk score of their patients and increases taxpayer spending. Or past
estimates suggest that this coding increased spending by
another 3 percent above fee-for-service. So the net effect
is a 5 percent higher payment from the taxpayer for MA care
than fee-for-service care. Now, Andy will give you an
update on this coding issue tomorrow. And in December,
Scott will update the 5 percent figure. It's possible that
MA plans have started to become more competitive with fee-
for-service in 2017 because there have been some changes to
bring the benchmarks down a little bit. That might bring
the relative cost of MA compared to fee-for-service down in
2017, and Scott will update you next month.

With respect to ACOs, in general there is
evidence that ACOs have been improving their quality
metrics, so some positive signs on quality. From a cost
standpoint, it has been about breakeven for the taxpayer.
And I want to emphasize that when we say the ACO and MA
costs for the taxpayer we've presented here are averages,
there are some markets where MA plans and ACOs do save
taxpayers money. These are often high-use markets.
Both the MA plan and the fee-for-service program
in general have had some success in reducing costs in these
high-use markets and even reducing overall regional
variation of care. I think you'll remember about ten years ago when Elliot Fisher came here to talk about ACOs, he led off with we have all this reduce regional variation, maybe ACOs could scrunch some of this regional variation. And we have seen some scrunching of that both in the fee-for-service program and certainly MA bids are tighter than fee-for-service.

So the policy question, the key policy question is: Do we pay for the structure or do we pay for outcomes? Now, there's a longstanding interest and widespread interest in improving care coordination, and the expectation is this will lead to higher-quality care and lower costs.

However, it is not always clear that the legal and financial integration will lead to true clinical integration or to efficiencies. The research indicates that it's hard, but not impossible, to generate efficiencies from these integrated models. And it may be difficult for us to distinguish which models are really providing value for the beneficiaries.

As we said, one thing we could do is level the playing field between the models and just set standards for
the outcomes. And then the most efficient model would be able to attract patients and win market share. In essence, we wouldn't have to determine up front what's a good model and what's a bad model or what the criteria for a good model or a bad model is. We could just set a level playing field and let competition illuminate which is the best model.

For each of the three types of consolidation, MedPAC has historically had a policy response. Horizontal consolidation can result in higher commercial rates and higher hospital costs. Traditionally, MedPAC has not recommended following the growth in private prices. In fact, update recommendations in the past have been constrained in part to the stated objective of keeping pressure on for hospitals to constrain their costs.

With respect to vertical integration, the Commission recommended site-neutral pricing for E&M visits as well as certain other services. Site-neutral would mean a level playing field. Therefore, vertical integration that truly does generate efficiencies would still happen with site-neutral pricing, but integration that is driven purely to capture larger Medicare facility fees or higher
commercial rates would not. As long as the merged entities are paid -- if we don't have site-neutral pricing and the merged entities are paid more, it will be hard for independent entities to be viable.

With respect to insurer and provider consolidation, one approach is to level the playing field between MA and fee-for-service and let the models compete with each other. Later today Eric will discuss how a premium support model could allow competition that would illuminate which is the most efficient model in each market.

Now, another consideration I'll just talk about briefly is ACOs. Some may argue that ACOs will be used as an excuse for providers to consolidate and generate market power. As described in your paper, in the St. Luke's case in Idaho, there was an example where providers argued that they needed to merge to improve care and move from volume to value. However, the FTC has clearly stated that anti-competitive mergers are not appropriate even in an ACO world. In cases where ACOs are not formed for mergers and they’re actually competing with each other, they may actually have some positive effects on prices in markets.
For example, in Boston there are several ACOs that compete with each other. Physicians in these ACOs have an incentive to refer patients to lower-cost providers in the Boston market. And there is some evidence in the literature that this has led to lower prices paid for these ACO patients, at least in the commercial ACOs. By aligning physician and patient incentives to look for less expensive providers, there may be a greater elasticity of demand where more patients shift to the lower-cost sites of care given any level of consolidation.

Now we shift to some possible discussion questions.

First, there is the overarching question of how to structure payments in the Medicare program. Should we structure the program to pay for a certain corporate structure or to pay for outcomes?

Second, should we continue to work on site-neutral payment issues, such as our site-neutral E&M recommendation?

Third, should we be moving toward a premium support model that provides equal support for all models? MA or ACO models would gain market share if they actually
provide more value to the beneficiary. But they would not
gain market share -- or they would not gain higher payments
or higher market share just due to having a particular
legal structure. This will be discussed in more detail by
Eric when he discusses premium support this afternoon.

I'll turn it over to your discussion.

DR. CROSSON: Thank you, Jeff.

We'll take clarifying questions.

DR. SAMITT: So when you talk about -- actually,
why don't I pass? Then I'll come back.

DR. CROSSON: Okay.

DR. HOADLEY: So I just wanted to ask you to go
back and remind me a little more about what we covered in
our site-neutral recommendations in the position. We
talked about E&M, and we went further than that on some
other areas. And then if there's a way to characterize
sort of how much of what we recommended was picked up in
congressional action, it seems like it's a pretty small
piece by only focusing on the new entity. I wonder if
there's a way to characterize sort of how much is done and
how much has been done.

DR. STENSLAND: So we initially said there should
be a site-neutral payment for E&M visits, the idea being
that evaluation and management visit in the physician
office is going to be pretty much the same as a management
and evaluation visit in a physician office that's owned by
the hospital. That was the first recommendation.

Then later there was a second recommendation to
add in some other services, and these were generally
services that were not needed on an emergency basis, like
maybe you'd do some echocardiography or something like
this. But this would be paid the same in both sites. And
our general recommendation was service-based, so for all of
these services, we're going to pay the same no matter where
it is. So level the playing field, let the volume go to
whatever happens to be the most efficient site of care, I
think is the general idea.

The Congress had a different approach, and they
were actually broader on the services. So whatever these
services are, you're not going to get the full outpatient
department rate if you set up a new off-campus hospital
outpatient department. So they're saying the on-campus
ones, for everything they still get the hospital outpatient
department. The existing hospital outpatient departments
that are off-campus still get it for everything. But those new ones would face something that would be similar to the physician office. And there was new regulations that came up by CMS this week, so we haven't digested them all, but it's not clear exactly how soon they'll make that transition until you really have site-neutral between the new outpatient departments and the physician offices.

DR. HOADLEY: The ones that would be covered on these new off-campus ones would be their full array of services?

DR. STENSLAND: Yes.

DR. HOADLEY: So that's where it differs also from our recommendation.

DR. STENSLAND: Yes, unless there's some exceptions, and maybe if you have an emergency room, you can still get the hospital outpatient departments for a certain number of services.

DR. HOADLEY: Okay.

DR. STENSLAND: If you set up as a hospital, a mini hospital, you still get the higher.

DR. CROSSON: Craig, do you want to come in now?

DR. SAMITT: Yeah. Thanks very much.
Jeff, my question is on Slide 9. When you talk about MA plan performance, you paint it with a very broad brush, but the topic of this presentation is about the consolidated or integrated plan provider models. Is there a way for us to actually tease apart MA plan performance of the subset of MA plans that actually are consolidated or integrated to see if the way that you are describing the plan performance translates from that broader pool to that narrow pool of plans?

DR. STENSLAND: There was a study by Austin Frakt and Roger Feldman, and one other co-author I don't remember, where they looked at all the different MA plans. And they categorized them into two groups, the MA plans that purely contract out with the providers and the MA plans that own the physician practice or own the hospital, and then they looked at what their bids were and what their performance was in the quality metrics. And their general finding was the performance in the quality metrics was a little bit better and the bids were a little bit higher, so there was kind of the hope that these integrated systems would somehow be able to reduce cost. At least in that one study, they didn't find it.
DR. CROSSON: And, Jeff, roughly, when was that?

DR. STENSLAND: I think this is about 2013 or 2014. It's in the --

DR. GINSBURG: Their study wouldn't have looked at contracts with integrated organizations. It was with only if the MA insurer owned the provider.

DR. CROSSON: Okay. Thank you for that.

David.

DR. NERENZ: On the bottom of Slide 2 -- thanks, Jeff -- there's a semantic question. You talked about providers taking an insurance risk, and ACOs, you used as an example. I thought in this discussion, there was a distinction that should be made between insurance risk and efficiency risk. At least others have made this distinction where insurance risk really has to do with a large pool of people and the kind of needs that come up from that pool of people, and that's why insurance companies have financial reserves, and they're regulated.

Efficiency risk would start with a finite burden of illness or need in a group, and then the risk is about the cost of meeting that need. And it's just different.

So the question is, Is that distinction
meaningful for this discussion this morning? I kind of think it is, but maybe it's not. And if it is, are the ACOs really taking on insurance risk, or are they only taking on efficiency risk? And should we use those words that way?

DR. STENSLAND: Maybe we should. I don't know how I could operationalize the difference. I think I understand what you're saying in the difference, but when I try to look at the data, if I can try to figure out whether the higher costs or the lower costs are due to inefficiency or due to some random variation in needs of the patient that I would -- you would kind of term as efficient insurance risk, at least on the surface, I can't see how I could use those -- use the data I have and separate it into those two different buckets.

DR. NERENZ: Others who have written about this -- I have not myself, so I'm just reflecting things I've read. One of the distinctions, for example, would be the degree of risk adjustment and the frequency of risk adjustment, so that if it's built into the ACO program, for example, presumably variations in the illness burden of the population are already factored out, so that you're not
actually at financial risk for that, that, I guess, to me
would be the main distinction.

Now, in either case, we're only talking about a
tiny fraction of risk, no matter what, whatever words we
use, but I just was curious about is -- I would have
thought, for example, that as an example of this idea,
groups taking broader capitation payment, less risk
adjusted would be a pure example of the concept. But I
just want to make sure I was understanding the words
correctly.

DR. CROSSON: Paul, are you on this point or just
in queue?

DR. GINSBURG: On this point.

You know, I think I agree with Jeff as far as --
I think the concept is very meaningful. I've often used --
heard the term "performance risk" versus "insurance risk" -
- impossible to separate it quantitatively.

But, really, I think what people would like is
for providers to be at risk for performance but not for
insurance risk. So, in a sense, that's where how much you
put into better risk adjustments or probably a lot of other
implications of that principle. So I think it's a really
important principle to think about.

DR. CROSSON: Kathy.

MS. BUTO: Jeff, do we have any data on volume changes or, I guess, in particular Medicare volume changes for hospital systems that undergo consolidation, kind of before and after? Do we see a volume effect where the volume goes up?

I see on Slide 4 that you talk about losses on Medicare admissions, I guess, in relation to commercial rates and the pressure on price, but I didn't see where we think there's a harmful -- as I'm thinking about what's the harm of consolidation, I think about two things. One would be potentially higher prices, and the other would be potentially some sort of additional admissions or additional costs that aren't justified, so anything we have on that.

And then my second question is, on the next slide, vertical integration, whether there are any instances where services provided in a physician's office and an outpatient department, where we think there might be justification for a facility fee, or in every case, is it our assessment that those services can be provided site
neutrally and a facility fee is really not justified? I don't know if you've looked at that.

DR. STENSLAND: First, on the volume effect, I'm not aware of any data, and I'm not aware of how the incentives would shift materially when they consolidate for the volume. If anything, the incentive for volume of a horizontal integration, it would probably go down to have more cases because you may have less excess capacity.

There is some evidence with vertical integration. At least when we did physician ownership of hospitals, we saw volume go up when the physicians own the hospital.

With the services, that there might be some justification, and Dan can just jump up and correct me if I'm wrong. But we did say there's certain things that we didn't want to have equal, and there were certain services that were used often for emergency cases. And so we didn't want to have those equal, and some of the idea there was that these hospitals have real emergency standby capacity costs, and so we want to pay for some of those standby emergency capacity costs by having higher fees for those services that might be needed in an emergency. But we wouldn't want to do that, say, for an E&M visit, which we
MS. BUTO: So have we specified what those are somewhere in our work?

DR. STENSLAND: Yes. There's a --

DR. ZABINSKI: [Off microphone.] [Inaudible.]

Also if the hospital had sicker patients, [inaudible.]

MS. BUTO: Right. But that would be a specific hospital as opposed to a policy that says --

DR. ZABINSKI: [Off microphone.] Well, as a general rule [inaudible] hospitals on average have a sicker set of patients [inaudible.]

DR. STENSLAND: I think he's talking about specific APCs, specific services. If the hospital tends to --

MS. BUTO: To see sicker patients in that category.

DR. STENSLAND: Yes. So, for this particular service, if the sick ones tend to go to the hospital and the healthy ones tend to go to the physician office, okay. Then maybe there's a differential in payment.

MS. BUTO: Okay. Well, it's helpful, I think, for us to be -- if we have any specificity around that, to
be clear, because I think the verbiage comes sort of across as if it's provided in the physician office, an OPD, and could be site-neutral, it ought to be, at least the implication.

DR. CROSSON: Okay. Rita and then Brian and Warner and Jon and Amy. Go ahead.

DR. REDBERG: Thanks for an excellent chapter.

I just started thinking a little bit more about facility fees when I was reading this, and sort of following on from what -- can you enlighten me a little more on sort of the history of facility fees and exactly what they are supposed to cover? Because I can't see a difference between a hospital outpatient department doing a lot of these services and a physician office.

DR. STENSLAND: So I'll give you my quick review, which probably is not that great, but initially, hospitals were paid on the basis of costs. So you were just -- whatever your costs are, we'll pay you that. And then they move the inpatient side to prospective payment, but the outpatient was still on cost. And then they moved the outpatient to prospective payment. So then they looked at, well, what are the relative costs of these services in the
hospital, and then they set the relative weights based on the estimate cost of those services.

So the estimated cost of the services, it must have been amount that hospitals are spending on these things is estimated to be greater on average than what's estimated in the physician office. And I think because we kind of started in that cost-based mentality, I think we kind of moved to that, the payment rates that kind of stemmed from those estimated costs, and then you could almost see this as moving more in a prospective direction of saying now we'll be moving more in a site-neutral direction, where if something can be provided for less cost in a physician office than it can in the hospital, even if the hospital has more cost, we wouldn't necessarily say we want to pay them more, because we don't want to keep the care in the higher-cost site. I don't know if that helps.

DR. MILLER: And, Rita, we've run into these conversations all over the place. You guys will remember when we got into the post-acute care world. SNPS are different than IRFs, which are different than -- and all of these things have their own little histories, and so you end up with this situation where you can have the same
patient in both settings and be paying very differently.

And this is another version of that.

DR. REDBERG: Consistently favoring a site-
neutral sort of structure, I think.

DR. MILLER: Well, I think in the last few years
in the Commission and to your point, Kathy, we went through
the criteria repeatedly and laid it out in the chapter and
discussed this, and we can make sure that we come back to
all that. But in the last few years, this is a problem
that the Commission decided to take on.

I mean, for 20 years in Medicare, everybody would
point to this problem, and you have to be very thoughtful
about how you go about it. I mean, Jeff was pointing out
there's certain excess capacity you do want to pay for.
The exchange, just to get it on the transcript, between
Kathy and Dan is that, systematically, I'm taking the more
complicated patients; maybe you want to recognize it, that
type of thing. But, really, just in the last few years,
we've been taking this on, and part of it was stimulated by
an uptick in the purchase of the physician practices, and
then clearly, there was -- there may have been other
motivations, but there was also that revenue motivation
there. And that kind of drove the issue. The E&M was the first version, and then we've gone from there over the last few years.

DR. CROSSON: Okay. We're still on clarifying questions. Let me check. I have Bill Hall, Brian, Warner, Jon, and Pat. Did I miss someone? Paul.

DR. GINSBURG: [Speaking off microphone.]

DR. CROSSON: Yeah. I had you earlier, but --

DR. GINSBURG: [Speaking off microphone.]

DR. CROSSON: Okay. Bill.

DR. HALL: I have a question on Slide 9, if you can put that up just for a second. I'm sorry. Twelve.

So the first bullet point there kind of stuck with me: Should we pay for results or corporate structure? There are a lot of unintended side effects of any form of consolidation, particularly if we look at what's happening around the country where large efficient systems start to acquire practices in surrounding areas, including rural areas. There's some hospital closures that did inevitably take place, and presumably, on the positive side, specialists might be available to go to these communities to provide services.
So I don't know how we work that balance out, but my clarification question is that are there any data anywhere to suggest that the overall health of an older population is either influenced positively or negatively by the degree of consolidation, which is, I guess, the endpoint that we're all seeking?

DR. STENSLAND: I think it depends on the type of consolidation. The horizontal hospital consolidation, I think that's really a mixed literature, but a little bit of the literature, if it leans any way, it's kind of leaning toward competition is maybe good for quality. It is better to have three hospitals competing with each other on quality rather than just have one where they don't have to compete, but the evidence there, I think, is very weak in either direction.

I think in the vertical integration evidence, at least when you're talking about providers integrating with the insurer, there I think you have some evidence of some possible quality benefits that we've talked about, at least on the process measures, tending to have better performance on process measures for these entities where the insurer and the providers are aligned.
DR. HALL: So I think this is an area we might want to take a look at. Particularly, on the one hand, we're constantly talking about improving population health in Medicare, and I don't think we know the answers to these questions right now.

DR. CROSSON: Brian.

DR. DeBUSK: If I can take us back to Chart 4. Your point here, losses on Medicare admissions creating pressure to increase Medicare rates, as that gap occurs between commercial and Medicare rates, I know we have our annual survey, but presumably, an increasing gap would result in access issues. And I know we have our annual survey, but do we have any longer term market-by-market -- is there a systematic way that we could measure when in a given geography that gap becomes problematic and creates access issues, again, particularly long term and particularly in a more focused way?

DR. STENSLAND: I think there's a couple things we could look at. The one is we could look at the occupancy in each market, and we tend to do that, to look across the different markets and see is there -- where the occupancy is full and maybe where you have some for-profit
hospitals that decide not to take Medicare. That would be
your two things going together, kind of a two-part test.
Is that happening? And we don't really see that happening
because we see generally occupancy around 60 percent in
most markets. So, in most markets, if you have excess
capacity and your marginal revenue is still bigger than
your marginal cost, you want to admit people, and so they
seem to be getting admitted. And we don't hear of any
problems of any hospitals saying, "No, we're not going to
take Medicare."

There's a few for-profit hospitals that have
decided, "Okay. We're just going to focus on non-Medicare
patients," some physician-owned hospitals, but they haven't
actually done that well financially.

So I think looking out there, when we look at the
data, occupancy and the incentives, we don't see any near-
term risk, but as you say, as that gap grows bigger and
bigger, it could be concerning.

DR. DeBUSK: Would we have a way or do we have a
process in place to detect that, to measure that, or is
that something that we'll just have to periodically check
on?
DR. STENSLAND: I don't know what we would do other than look at is there this excess capacity and do we hear any reports of hospitals not accepting Medicare patients, and we don't really hear of any of that happening at all, except for a few for-profit hospitals -- and they're never the dominant provider in the market -- so that that would come about.

DR. MILLER: The only thing I was going to say, you're answering the question directly. From a process point of view, every time we go through the update process, which I don't think you've been through yet -- it seems like you've been here forever, Brian.

[Laughter.]

DR. DeBUSK: I'm going to take that as a compliment.

DR. MILLER: It is a compliment. It was intended entirely as a compliment.

I think you're about to hit your first update process, and we do have a situation when we look at finances, we look at access. To the extent that we can, we look at quality. We can look at that, and I think some of the metrics that Jeff was saying there are the kinds of
things that you'll find in that analysis.

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

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

And so we have other ways we look at hospitals -- or physicians who are deciding not to take up Medicare or getting out of the program. There's a couple of different metrics that we try and look at. When we come up to that
next month, if you think there's some other places we should be looking, that would be a good time.

DR. CROSSON: Yeah, I mean, it's an interesting point, because I remember a few years ago when we were doing the update process and we went through the physician payment recommendation, we had sort of the same discussion. And I remember Glenn sitting here saying, well, okay, so there's not an access problem, but I live in south-central Oregon, and there are no primary care physicians accepting new patients. So that's just one example.

So I think there are -- most likely there are pockets around the United States where this comes into play.

DR. MILLER: And I don't want to overstate this too much. This is somewhat dates. There was a period when there were a lot of arguments being made that, you know, physicians were exiting the program in a big way, and it was Medicare rates that were driving it. And there was an attempt both by CMS and our efforts to look at markets that were indicated at hot spots for this kind of problem. And most of the analysis that came out -- all of the analysis that came out of it said it was more an issue of access for
anybody to get to a physician. So it would be a community that had a rapid increase in population, and the notion was that it wasn't so much that a Medicare person couldn't get a physician, it was anybody.

And then also you've seen some phenomena -- and Jack may remember this. There was the discussion about concierge types of activities, and, again, there, to the extent that they do it, they often say I'm not taking anybody's insurance, whether it's Medicare or otherwise.

And so the other little fault line I want to put into your thinking is that if there's an access issue, is it an access issue related to Medicare or is it an access issue related more broadly to some other demographic phenomenon? And, again, we'll get into all that next month.

MR. THOMAS: So, Jeff, it seems like you're talking a lot about consolidation. Did you look at or can we look at actual integration and clinical integration of services? I mean, you think about models like, you know, Kaiser, and there was a reference to Mayo Clinic in the ratings. But have you looked at -- especially as we look at the bundled payments or as we look at ACOs, that to me
there's a difference between consolidation and integration
of, you know, clinical services and clinical care. Any
thoughts about that as it relates to your thinking on
consolidation and the differences between those?

DR. STENSLAND: My thought is from a researcher
perspective or from a CMS perspective, it's very difficult
to distinguish from a truly integrated entity where people
are really talking to each other and cooperating and
improving care and an entity that just looks on the
surface, like they taught to the test to make it look like
they're doing this, but they really aren't doing it
underneath. And I think that is -- that difficulty of
distinguishing between truly good integrated entities that
are coordinating care and reducing costs and improving
quality and integrated entities that say they're doing that
but really aren't, it seems almost -- from at least my
perspective of trying to dig through the data, almost
impossible to distinguish between those two. And that gets
to the idea of, well, then let's just level the playing
field and say we're going to pay equal amounts across all
these different sites or different models. And then if one
model actually is more efficient and provides better care,
it will gain market share because its costs are lower, its output is better, the patients will come to it. And so, in a way, it's, I think -- from a researcher standpoint or a CMS standpoint of saying what are the good integrated entities versus the bad integrated entities is probably an impossible question to answer. But I think the good news, it's a question we don't have to answer because we can let the market sort it out.

MR. THOMAS: Did you see any types of characteristics like common electronic medical records for the entire continuum or things like that that would lead you to think differently about the types of integration or not that occur in these types of systems?

DR. STENSLAND: No, I think on the surface it always sounds really good to have everybody integrated on a common electronic medical record, and I think I would like that. And you certainly see high quality scores, like you said, from the Mayo Clinic, fully integrated for, you know, a long time, a hundred-plus years as an integrated group practice, and you see great quality scores there.

But some of the literature, when they look at it
to say, oh, do these large integrated multi-specialty group practices really have better outcomes than more of the smaller practices? And, you know, when I first started this, I thought, okay, this is what I'm going to find. But then you look at the literature, and it's really not so clear, and some of the researchers, like Larry Casalino, even arguing some of the small practices are doing better than some of the big practices.

So the research probably did not come out as I expected it would, and it didn't come out as clear as I had hoped.

DR. CHRISTIANSON: I just had a quick question, I think, for you, Jeff, on Slide 11, page 20 in the report. So these are the possible policy responses, and the last one seems to be a little murkier. It kind of falls under the category of other considerations, and the policy response seems to be we should encourage ACOs even more than we have in the past, because they're going to make physicians more price conscious.

And then I'm looking back in the paper, and there's a two-step process here, that ACOs are going to seek out and contract with more efficient lower-cost
providers. And then the second part of that is that providers are going to start competing with each other on price in order to be selected by the ACOs to contract with.

So the evidence that's provided here is basically, in the paper, the first step of that process for commercial ACOs. And for that one ACO in Boston, the researchers have evaluated a lot, and they find some evidence that that commercial ACO in that location has sought out lower-cost physicians -- not necessarily the second step, which is what we really sort of care about in terms of making physicians more price conscious. So that's, I guess, to be determined.

But has anybody in their evaluations of ACOs looked at these issues? Do we have any specific Medicare ACO data on whether this is happening? Because, obviously, this ACO that's being evaluated in Boston has a particularly kind of unique structure in a lot of ways relative to the way Medicare ACOs are structured. So how much evidence is really there on this topic that's really relevant to sort of this policy discussion point?

DR. STENSLAND: I think on the price side, really I think all we have in the commercial world that I'm aware
of is the Boston example of, yes, things are gravitating
toward lower price. And it's a unique market because
there's so many ACOs.

DR. CHRISTIANSON: But not necessarily that we've
seen physician responses in that market to compete on price
and drive price down.

DR. STENSLAND: That's only anecdotal, like
people saying, oh, now the doctors don't necessarily want
to be so high because then they won't get the volume.

DR. CHRISTIANSON: That's Rob Mechanic's work.

DR. STENSLAND: I don't remember. You probably
know it better than I do. But, yes, his study. I think on
the Medicare side it's much more limited because then the
price savings is not by going to a lower-price provider but
going to a lower-cost site. And I think we do see some
movement there, at least people trying to do things like if
the post-acute care is more expensive in a SNF than in home
health, we're going to try to reduce our SNF days and maybe
use home health rather than SNF. Maybe some shifting from
some of the higher-cost sites of post-acute care to lower-
cost sites of post-acute care.

DR. CHRISTIANSON: This is a discussion of making
DR. STENSLAND: Yes, and I think you can get the physicians to be more price conscious in the sense of I'm price conscious about how these different sites of care cost a different amount. And we're certainly seeing that by talking -- at least talking to some physicians saying, okay, now I'm in this ACO, I'm really quite conscious about how much it costs to send my person to an LTCH versus to a SNF.

DR. CHRISTIANSON: Which is a little different because in this discussion it's more about physicians being more price conscious relative to their own services that they're providing. It just seems like there's not a lot of firm evidence related to the Medicare program that -- I'm not saying that the story is wrong. It's just that the evidential base is not very strong to support it, maybe not as strong as some of the other policy considerations you're asking us to talk about. Do you think that's accurate or -- because you don't mention anything about Medicare ACOs in this context.

DR. STENSLAND: I think I probably didn't write it up as well as I should have, because when I was thinking
of being price conscious, I'm thinking of their price
conscious of the services that they're recommending,
whether they're referring somebody to this service or that
service and being price conscious about how much those
services cost as opposed to being price conscious about my
own prices and how those --

DR. CHRISTIANSON: Yeah, those examples are not
in the write-up at all, the ones you just provided.

MS. WANG: Just a quick question. I think
there's a theme, I think, from what I've heard a little
bit. Let me ask it a different way, you know, with the
caveat that Medicare ACOs are still a work in progress, you
know, there's a lot of different reasons for providers to
consolidate. And I think what we're discussing is kind of
parse what those are and whether [microphone static]. Has
anybody looked at it and does it make any sense to look at
whether there is any correlation between some of the types
of consolidation that you studied and an intent or
participation in Medicare ACOs? And is there anything
about the nature of the consolidation that, you know, could
be informative? I mean, you know, is using participation
in an ACO or stating a Medicare ACO indicative that
consolidating providers have an intent at least to move
into the direction of coordinating care and so on and so
forth, versus, you know, consolidation for other reasons?
I mean, does it even make sense to look at it?

DR. STENSLAND: I am not aware of anything that's
been published. There has been at least one paper
presented at meetings, you know, where they're kind of in
the process of looking at is there more consolidation in
markets with -- is there a correlation between the ACO
penetration in a market and the amount of consolidation in
the market? And I think they generally aren't finding
that. The general idea is there's already, prior to ACOs,
some reasons to integrate and consolidate, and the marginal
effect of the ACO might not be that great. But that has
not been published, and I'm just saying that's a little bit
of preliminary data.

DR. GINSBURG: As I have been mulling in my mind,
my clarifying question has grown bigger, so I'll get him
the next round.

[Laughter.]

DR. CROSSON: Okay. We'll call that a
"conditional mulligan" because you might find your first
shot turned out to be better than your second one.

Okay. So we are a little bit tight here. We've got about 20-plus minutes to go, and I want to have a good discussion here. But I'm going to ask for conciseness and -- although I think there are a lot of good points to make, if we can focus on emphasis here, "As a consequence of these findings, we should emphasize with respect to Medicare policy or payment the following," if you can do that. And we're going to start with Warner.

MR. THOMAS: So a couple of broader comments before I jump into that. I think one of the things that I would like to see us consider as we put together the chapter is to take a little bit of a step back and think about the context of what is driving provider consolidation and to think about consolidation in the industry in a broader context than just in providers.

So, for example, you know, what are the inputs that go into the cost structure of providers that are creating pressure for them, such as drug or device pricing? And what type of consolidation is happening in those types of pieces of the industry and/or the areas such as in the GPO and how that drives some of the pricing pressure? That
coupled with the fact that we see, you know, pricing pressures in, you know, Medicare pricing, the reductions in the MA premiums, which then pushes pricing down.

So I think all of those factors to me are critical as we think about what is driving this versus just that provider consolidation is happening. I think that we need to understand what the drivers are.

Similarly with physicians. I mean, it's not a situation where physicians necessarily want to join hospitals or necessarily want to come together. They're doing it out of the -- because of an industry challenge and because, you know, essentially through Medicare payment policy, ACO development, risk contracts under Medicare Advantage, that's driving more of this integration and consolidation. So I would like to see us think about, as we frame the chapter, that we frame it in the context of what's happening in the industry.

A couple other components, and then I'll get to the Medicare payment policy. So I do think that trying to make a bigger distinguish -- or trying to distinguish more between integration and clinical integration versus just consolidation would be important. You know, I think about
the work that folks have done in the industry and that I've seen in my experience. We are seeing quality outcomes get better as we move to a common electronic medical record across our entire system or across a large population of physicians. You see reduction in duplication of diagnostic testing because the availability of the information is there for physicians, so they don't repeat a CT study, they don't repeat an MRI or lab testing. So I think those types of components are very important for us to think about, as well as I think when you see a small organization join a large organization, you do see expansion of services in local markets as those larger organizations help them.

As it comes to payment policy, I would ask us to think about how we can continue to accelerate changing the incentives and getting away from the fee-for-service model into more of the ACO model and make those policies more robust. Obviously, there's new guidance and rules under MACRA, but I come back to that the ACO regulations are so burdensome that it is very difficult for smaller or mid-sized organizations to get into those type of payment models. I think if we really want to see a change in payment models and the way that the payment system is
approached, we have to change the incentive from a fee-for-service to more of a global pay model. I think we've heard Craig say this a couple of times.

But, you know, certainly it is -- to me, ultimately that's where you're going to see more clinical integration. That's where you're going to see more team orientation creating a better outcome for patients and a reduction in utilization and cost. But to me, until we make those global payment models and those incentives around the ACOs more robust and more attractive, we're just going to be working on the fringes. And I think if we were really going to put a lot of time and energy into this, I would really encourage us to continue to refine and make recommendations in the ACO world and make them more attractive for a broader swatch of physicians and hospitals, and to really incent more larger systems that are consolidated to go into more of the risk payments and the downside models of the ACOs.

DR. CROSSON: I think that's very well said. So can I see hands for comments? Okay. We've got a significant number, so we're going to start with Jon and go this way, and conciseness is next to holiness.
[Laughter.]

DR. CHRISTIANSON: Which I've never been accused of being --

DR. CROSSON: Which of those.

DR. CHRISTIANSON: Yeah, which of those. Yeah, either one.

So, under 11, I think we do continue with our response that we should not follow commercial prices. There's just a whole lot of evidence supporting that as a Commission.

I think I firmly support the site-neutral pricing, and as a vertical integration response, I think the premium support with a level playing field as the provider insurance integration response, it's less clear to me that we're ready -- should be ready to do that. There's a whole lot of things that go along with premium support, and I'm not sure we go down that road specifically as a response to provider insurance integration.

Then I'm still a little confused about what exactly the policy response is on the fourth bullet point, which is, I guess, be more in favor of ACOs because of this possible effect on making physicians more price conscious.
And then just as a way of finishing my thoughts, I think one of the things that we have to think about at some point is -- and it's hard in Medicare primary -- is our responses may have to -- what we would want to do might vary depending on the overall nature of market consolidation and not just the consolidation in each sector.

DR. CROSSON: Okay. David and then moving down.

DR. NERENZ: Yeah. This is on the second bullet point on Slide 12. I would say yes, with a couple caveats. I think there is, I'll say, a bare possibility and no more than that, that we could get into some penny-wise, pound-foolish sort of problems if there actually are some offsetting efficiencies in truly clinically integrated systems. I know the evidence for that is very meager at the moment, but it's at least plausible.

So we could conceivably think about some exceptions to site-neutral rules in situations, for example, where an organization could prove to CMS's satisfaction that the episode-level costs or per-capita costs were actually not higher. But even better yet, I think, would be to move to a two-part choice situation, and
this, say, could be offered to hospitals, since it's hospitals who mainly are in the up-down side of this HOPD site-neutral issue.

So here's the deal. Either you get fee-for-service payment, but it's got a site-neutral component, so you're going to get fee schedule payment for the outside clinic -- that's a deal you can take -- or you can take true prospective bundled payment, fixed price for an episode, and you can take that. And if you think you have offsetting efficiencies that you can step up to because you're clinically integrated, maybe you want to take that deal.

So I think as a broad policy direction, I would feel that that might not be a bad set of options. Either way, it kind of calls the question: Are there offsetting efficiencies, or are there not?

DR. MILLER: Can I just say one thing? In setting the bundle, what price you use to set that bundle would be crucial because, if you just have the site-neutral and a payment in there and then you build it into the bundle, then you haven't necessarily captured the efficiency.
DR. NERENZ: Yeah. I think in situations where there are a couple options that are really very rare now, I think CMS could be more aggressive in setting the bundled price because if it's set too low for an organization, the organization can make the other choice. So you wouldn't have to necessarily bake in the higher price into the bundle. You could take it down, and that essentially is how you call the question. You say, "You guys think you have offsetting efficiencies? Fine. You should be willing to take this price, because we've taken the higher component out of it," and let's step up and prove it, then.

DR. CROSSON: Alice.

DR. COOMBS: Thank you. I'll try to be brief. First of all, bullet No. 1, I basically don't think we should follow commercial prices.

For the vertical, for No. 2, the site-neutral pricing. I just want to call us back into remembrance of what we did with the ambulatory surgical centers. What we pointed out there was that hospitals did take on sicker patients, patients that ambulatory centers were not willing to take on, and so there were some -- not just typical standby capacity issues. There was improved access to
other supporting services that were really important for what we thought was important. This is very different in that it's physician offices moving directly on campus in that sense, but it might be that in some areas that those physician practices gain access from improved quality by them being on the very campus. I'm not sure that that's the case. I'm not sure we've actually looked at the quality outcomes of what happened when you have vertical integration that allows there to be the direct clinical coordination and ties to an elite situation doesn't result in what kind of outcomes for the panel of patients.

I do want to say that we're talking about ACOs as though doctors are just in the ACO or just in a PHO, but in certain parts of the country, there's a physician health organization, whereby physicians who are also in an ACO may be participants in both. And so you might have a small collection of 12 doctors who are formulating an ACO, but they also may be very engaged at a PHO at the local hospital that they admit to. So they're not separate, and so when we think about the fourth bullet about how you make people more price conscious, it might be that physicians, per se, are in an ACO and have a relationship directly with
a PHO, physician hospital organization.

The thing that I was thinking about after reading this chapter -- and thank you, Jeff; I think you did a phenomenal job dealing with some very hard areas -- was that is it possible that we can look at, the Secretary -- have the Secretary look at some of the things, culture of excellence with an ACO provider in terms of physician engagement, provider-driven initiatives, look at what is a successful -- what looks like success, and also to look at what looks like poor performance, because I think so many times, we're geared up at MedPAC to take the top five and say this is the poster child for good works.

But I think at some point, we have to begin to say let's look at the low performers -- or maybe the Secretary can look at the low performers and say what's a best practice to move these people into a better performance, and I don't think we -- we talked along the lines of looking at the low performance and health care delivery systems, because if we do this, we actually improve the transparency regarding cost and quality, earlier intervention. We can focus on the mid-tier and lower-tier performers. We can move patients into
environments from some optimal care to optimal care, and we can improve cost and efficiency of the general population. And there's some robust health care delivery system, like a few that I don't need to name, but they've actually done that. They've actually looked at the sites where they had poor performance and said, "How can we move this situation to a better" -- and they're very robust health care delivery systems. Some are in the Southwest Corridor, and they've actually looked at how the low performers can move to a better situation. Then is when we really make a difference with the sea of patients that we have.

In terms of -- one other factor is the beneficiary cost sharing when you have the facility charge, and I really have a problem with that part of the facility charge, that the beneficiary having to pay that excess, so if we could actually develop some policy around the beneficiary cost-sharing piece of the facility charge.

DR. CROSSON: Okay. Moving down, Paul and then Kathy.

DR. GINSBURG: Yeah. I do hope the Commission will focus more on the site-neutral payment issue. I think the Medicare current policies have been a major contributor
to the degree to which hospitals are employing physicians, and I think it's a trend that really concerns me.

What I often hear is that physician productivity falls when they become employed by the hospital, and that when you talk to hospitals about their motivations for employing physicians, a lot of times, it's really about capturing referrals. It's not about providing higher quality care or lower cost.

I think Jeff mentioned early on in his presentation echocardiology as one of the examples of a site-neutral issue, and it's a fascinating story how all of a sudden in 2010, cardiologists wanted to be employed by hospitals. Hospitals were pleased to have them. What happened in 2010? It was an update of the Medicare Physician Fee Schedule based on a new survey, which lowered substantially the payment to cardiologists not employed by hospitals, doing it in their own facilities.

So, in a sense, which I want to point out, from payment rates based on different data sets, different approaches, I don't know which one is more accurate, but it really says it's not just a matter of a facility charge as something to defray the hospital overhead. There really
are a lot of these -- probably a lot of other areas where
the cost difference, the payment differences are
substantial and are inadvertently motivating how the old
delivery system is organized.

So I think it's a broad thing. I don't think
what Congress did late last year was really that much
compared to what the Commission had worked out before in
its policy recommendations, and I'd like to see us get back
to that.

DR. CROSSON: Thank you.

Kathy.

MS. BUTO: So I want to agree with Warner's
opening comments that it would be good for the chapter to
cover more about the drivers of consolidation.

I would add to the list the complexity of the
reporting system, the reward system, and the data system.

So, I mean, we can talk about reimbursement, but I think
there's a great deal of additional complexity that's
driving the desire by physician practices to belong to
larger organizations that can take on some of that
responsibility. And that's something in our wheelhouse in
change and we add some additional reward system or new
collection of data, whatever it is, we're adding to that
fuel, and I think, again, it's just a matter of our being
aware when we talk of some of the implications, unintended
implications of what we're talking about.

I'd like to see the chapter broadened to our
recommendations, and I agree with them for the most part,
although I agree with some of the comments on site neutral,
one, that we could do more on the one hand, but, two, we
should be careful that we're not in an unintended way
harming access to emergency or other associated services in
such a way that it's detrimental to access. So proceed
carefully but thoughtfully in that area. I think it makes
a lot of sense.

But our recommendations are mostly aimed at
mitigating what I guess I'd call bad consolidation or bad
integration, and I'd like to see the chapter at least touch
on or open up the question of promoting good consolidation.
What is it we think is desirable? We've said it in other
ways, ACOs, potentially alternative payment models.
Bundling, I agree with Dave. There's some opportunities
there for efficiencies, better management. What are some
of the good consolidation that we'd like to see promoted, made easier, not more difficult, not cumbersome, but actually something that can be done, and try to touch on that as well? And just be aware again that our recommendations have at every turn some implication for either driving more consolidation or promoting a greater fragmentation. So just that awareness, I think, would be helpful.

DR. CROSSON: Jack.

DR. HOADLEY: So I thank you really for this analysis. It really leaves me pretty convinced that consolidation -- we have to think of consolidation as a fact of life at this point in the health system, whether we're talking at the specific provider areas you talked about or some of the other aspects of the broader market level. And I think our goal is to try to address the downstream effects of that.

And it is discouraging, I think, that as your literature review shows that market forces are not creating some of the kinds of good results that we might have expected or hoped for.

On the specific sort of items here, I think I
totally agree with we don't want to follow commercial prices, and as we go into our update discussions next month, I think that's just something that will be important to keep in mind as we think about the Medicare update.

I very much want to see us continue to address the site-neutral. We've done it well, I think. In the earlier discussion, it referenced what we've done in trying to identify services where there should not be a negative consequence has been well framed, and I don't know whether in terms of this year's report whether there's a value in kind of just -- as we often do, just referencing our old recommendations, reprinting them, or whether there's actually a case to be made for restating them more affirmatively, reframing them, maybe somehow in the light of what Congress did, which clearly is pretty limited, but something that will call attention, because I think that's -- I think dealing with this issue of site-neutral pricing is pretty important.

I'll stop at those.

DR. CROSSON: Thank you, Jack.

Rita.

DR. REDBERG: I'll be brief because I think my
colleagues have made a lot of good points already. I think, for example, Paul's point and also in the mailing materials, the example of Idaho, I think the reasons for consolidation were not always to improve quality and lower cost. And for that reason, on Slide 10, I think we should be thinking more about paying for outcomes and not so much for structures.

So, in terms of our policy responses, I also agree we should not be following commercial prices. I do support site-neutral pricing. As Jon said, I'm not clear on how the premium support plays out.

And when we talk about ACOs, I think two-sided risk ACOs, as we have stated before, offer the best possibilities for being consistent with our other goals of paying for outcomes.

DR. CROSSON: Thank you, Rita.

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

Brian.

DR. DeBUSK: I, too, feel that you shouldn't chase the commercial rates. I think there are a number of issues there, should we choose to go down that route. It does concern me that I think, ultimately, that commercial
rate escalation does become a problem, and I'd like to see a systematic way to find those issues when they occur market by market. But I do think their problems become our problems.

What I'd also like to do is hope that we can separate the concept of financial integration and clinical integration, and maybe this is just wishful thinking, but not necessarily give financial integration a free pass to collectively bargain and negotiation for payer rates. And I think we can separate those two concepts in how organizations engage payers.

And then, finally, I'd like to ask that we really double down on our site-neutral payment policy. I think providing ongoing estimates of what it costs to not implement site-neutral payments would be very powerful because I think that attaches a number to a problem.

And I'm concerned about it because it creates a payment issue, but I'm also concerned at how it misdirects the flow of capital. And even if we fix the immediate payment issue, this will misdirect flows of capital that can last for, in some cases, decades. So I think the sooner we engage and the sooner we address this, I think
the shorter the time that we'll have to live with this mis-
deployment of capital.

DR. CROSSON: Craig.

DR. SAMITT: So I would echo several of my

colleagues' endorsement of each of these responses.

Certainly, we should not be following commercial prices.

It was very disconcerting for me to read the

report about a site-neutral pricing and how the watered-
down adoption of our prior recommendations really has

created a gaming phenomenon. That the most concerning part

is that we may be incenting the construction of new

hospital capacity or facilities when we feel that actually

we should be moving in the exact opposite direction. So we

certainly should at least resubmit our prior

recommendations and find a way to double down on it.

In terms of the provider insurance integration,

as you know, this is the world that I've predominantly

lived in, and I still believe that we're going to see

further development and improvement and results that come

from this form of integration. To touch on Kathy's

comments about sort of good integration versus bad

integration or good consolidation versus bad consolidation,
it feels that we need to go deeper to understand what good consolidation or healthy consolidation looks like, and so I would argue that we should redo that analysis that compares MA performance.

And I would say that I'd like to see it in three categories. One are MA plans that pay provider's fee-for-service. The second would be MA plans that pay risk-based or global payment to providers, and the third would be integrated, truly integrated plan provider. And I'd be interested in knowing for those three different categories, how does the quality differ, how do the bids differ, which you describe, but even more importantly, how does the encounter data suggest that practice patterns may be different between those three dimensions? And my hope is that what we would see is some of the more consolidated or integrated solutions would truly show a quality improvement in cost reduction.

And then, finally, it hasn't been touched on yet is I think one of the unhealthy forms of consolidation has been primary care practice acquisition, and it goes back to our prior discussions about reinforcing primary care. If primary care sort of feels unsafe, financially unstable,
then primary care will be one of the first groups that actually gets absorbed in this consolidation frenzy, when I think finding a way to assure primary care independence will be very important as we want to shift to population health.

So it comes back to our prior recommendations, which we may need to reiterate yet again, about finding a way to allow primary care to not have to be beholden by larger systems in the future.

DR. CROSSON: Sue.

MS. THOMPSON: I'll be brief. I know we're running over time. Jeff, thank you for the chapter.

I want to just underscore the comments made by Warner, agreeing entirely with taking a look at a broader geography around other types of consolidation, additionally around site-neutral payments for reasons already well stated.

I also want to just comment on transparency, and obviously it's moving hospitals and other providers to move toward a common denominator. I'm wondering in terms of keeping the focus on that what additional impact a focus on transparency will make, so just want to call out
transparency.

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

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

So those would be my comments.

MR. PYENSON: Yeah, thank you very much, Jeff, for a terrific report. I would echo most of the comments of my fellow Commissioners. There's one point that I'd like to have considered, which is the emergence of --
potential emergence of new systems of care such as telehealth which are not geographically constrained, and the potential for those to contract in different ways with physicians or other organizations that are not beholden to a local market power; and that as we think about the unintended consequences of our recommendations, that we think about that emerging possibility.

DR. HALL: I am very much in concurrence with what's been said here, and I just want to make one additional point, if I may, very briefly, that we haven't talked about, and that is that we're kind of in a crisis in terms of providers of health care, I think, that's very ubiquitous, and that is that most providers think that they have no control over the system that's taking place and there's a lot of bewilderment about it.

One of my observations after 30 or 40 years in this business is that we are not able to really feel that we are as close to our patients as we once thought we were. At the same time, as has been mentioned, there are other ways of communicating with patients.

I think that the only way we can take advantage of all of the advances that have come along in medicine,
relieve some of the angst that physicians have, is to have a more integrated system, period. It's the only way we can go, and so I hope that we will track, as we go through this, very carefully a variety of quality indicators, not necessarily physician satisfaction but things that represent more the population health of a community. And I don't think there's any other way of achieving this.

An expression that has come into medicine now is that, as providers, we are strangers taking care of strangers, and it's getting worse and worse and worse. And I don't think, unfortunately, that the fee-for-service system can be fixed in a way to improve that.

DR. CROSSON: Thank you, Bill. I'd just like to make one point with respect to the last bullet point, and it is duplication, because I think Warner brought this up in the beginning. I heard it from Craig, I heard it from Sue, I just heard it from Bill. And this is personal perspective. To me, an ACO is a delivery system structure, and there's nothing about that structure, honestly, that by itself is going to produce the changes that we're looking for. It's that structure or the best of those structures combined with the appropriate payment that is the secret...
sauce, if you will. And I think one of the problems we face is that the construction of various ACO-like structures and forms of integration and perhaps even consolidation have raced far ahead of reform of payment.

And, you know, my own thought is, you know, whatever we can do, if we believe in this delivery system and payment reform approach to solving our problems, is to accelerate -- in our recommendations at any rate, try to accelerate payment reform. Then I think maybe we'll see some of the changes that we've all hoped for.

Thank you very much, Jeff, for excellent work, and we'll move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. Now we are going to turn to the topic of stand-alone emergency departments, and Zach and Sydney are going to take us through this deliberation.

MR. GAUMER: Okay. Thank you. Good morning.

Today we return to the topic of stand-alone emergency departments, a topic we talked about last at our September 2015 meeting. Stand-alone EDs are facilities located off of hospital campuses and may or may not be affiliated with a hospital. Before we dive in, I'd like to
first thank Jeff Stensland for his work. He's been helping us out all the way along here.

We first looked at stand-alone EDs about a year ago, and at that time, we were evaluating whether stand-alone EDs could be a possible solution for isolated rural areas with concerns about access to care. In our June 2016 report to Congress, the Commission suggested, yes, stand-alone EDs might be a solution for these rural areas.

The context for today's discussion is a little different. Today we're focused on the urban and suburban versions of these facilities or those in areas that largely do not have access to care concerns.

There are a few specific items driving us to revisit stand-alone EDs. In the last year, the number of these facilities has continued to increase. In fact, their growth has been significant enough that the industry has organized a national association. We also have seen a few new academic studies on the subject. In addition, contained within the site-neutral law is a provision that exempts off-campus stand-alone EDs, and we've been talking a little bit about that already today.

There are two types of stand-alone EDs, just to
remind you. The first is off-campus emergency departments, and I'll just refer to these as "off-campus EDs." These facilities are owned and operated by hospitals, and in the fall of 2016 we counted approximately 363 off-campus EDs. These facilities offer a limited set of services amounting to ED, imaging, and lab services. They do not provide trauma care, largely, and they do not have operating rooms, so high-acuity cases get transferred to the affiliated hospital. They also tend to be located 5 to 10 miles from their affiliated hospital, in suburban areas. Off-campus EDs tend to not have many patients arrive by ambulance. However, they range in size, and some of the larger facilities do take some ambulance patients.

The important thing to remember here about off-campus EDs is that they are permitted to bill Medicare and Medicaid because CMS has deemed provider-based entities, and they bill under both the hospital outpatient system and the physician fee schedule.

Payments they receive from private payers are often in-network rates, but some also charge out-of-network rates to some patients.

Then there are independent freestanding emergency
centers. This is the second type of stand-alone ED. These are not affiliated with a hospital. I will refer to these just as the "independent EDs." There are about 200 independent EDs; most of these are in Texas. Similar to off-campus EDs, the independents offer ED services, imaging, and labs, and they take few patients by ambulance. They also tend to locate in urban areas and tend to have low patient volumes per day.

Independent EDs differ from off-campus EDs in that they are not deemed provider-based entities and, therefore, cannot bill Medicare.

Independent EDs are typically paid out-of-network rates by insurers, which data from Colorado have shown to be at least 10 times higher than payments made to urgent care centers for the same conditions. Anecdotally, we have heard that some insurers have begun negotiating lower payment rates with some independent EDs.

As you would expect, the patient payer mix of the independent EDs is heavily dependent on privately insured patients.

State law plays a significant role in regulating stand-alone EDs because states control the licensing of
these facilities. However, the licensure of these facilities is highly variable across states in terms of where they locate, the services they must offer, and the ownership of the facility. For the sake of simplicity, we can summarize this variation by saying that most states permit only the off-campus ED variety. Ohio is a good example of that. A few states permit both types, the independents and the off-campus, and Texas is the best example of that. And only one state, California, prohibits both types of stand-alone EDs.

Medicare’s regulation of these facilities is largely indirect. In order to bill Medicare, like I said, off-campus EDs must be deemed provider-based, and to gain this status facilities must meet several requirements, including that they are within 35 miles of the affiliated hospital.

As a part of the recent site-neutral legislation, off-campus EDs are exempt from the law’s prohibition on off-campus facilities billing under the higher-paying hospital outpatient payment system. This includes the ED services and the non-ED services provided in these facilities.
It is also important to note that CMS does not separately identify claims provided in stand-alone EDs. These claims are subsumed into the claims of the affiliated hospital, making it difficult for us to identify these facilities.

MS. McCLENDON: So between 2008 and 2016, the number of off-campus EDs increased by approximately 97 percent. During the same period, all of the more than 200 independent EDs were developed.

We believe more stand-alone EDs are about to begin billing Medicare. Like Zach mentioned earlier, there are currently 363 off-campus EDs. These off-campus EDs can bill Medicare if deemed provider-based, but the 203 independent EDs cannot. In the last two years, though, independent EDs have found ways to bill Medicare for ED services, which will likely increase the number of facilities billing Medicare in the coming years.

One of the most common ways that independent EDs are trying to bill Medicare is through affiliation with hospitals and hospital systems.

There are multiple ways that independent EDs have created these affiliations, the first of which is by
partnering existing hospitals with existing independent EDs in order to turn these into off-campus EDs.

In other instances, hospitals and independent EDs partner by building an entirely new hospital near preexisting independent EDs. The independent EDs then affiliate with the new hospital, turning them into provider-based entities. This has happened in places like Colorado.

We have also observed independent ED companies partnering with existing hospitals. This means that when new stand-alone EDs are built, they then become off-campus EDs instead of independent ones, which has happened in states like Arizona and Ohio.

In addition to finding ways to affiliate with hospitals, some groups have changed the model of the stand-alone ED. One type of these facilities' main focus is ED services and imaging, but they also have inpatient beds, which allows some of them to bill Medicare.

In sum, we expect to see more providers billing Medicare for ED services in the coming years.

MR. GAUMER: There are at least four reasons stand-alone EDs have grown and may continue to grow. The
first couple of these may be quite obvious.

First, stand-alone EDs can be used as a mechanism for affiliated hospitals to capture patient market share from their competitors. These facilities are small and they require less capital to develop than a full-sized hospital. Therefore, in a sense, they can be dropped into competitors' service areas on the other side of town.

Second, stand-alone EDs can extract higher payment rates from private payer when they bill as an out-of-network provider. In effect, stand-alone EDs can charge insurers top dollar when they do not have pricing contracts in place with insurers. For the independent EDs, this appears to be the primary strategy. However, we believe off-campus EDs may also engage in this to some degree.

Third, under Medicare and other insurance, providers have the incentive to serve lower-acuity patients in an emergency department setting because payment rates for ED services are higher than at urgent care centers or physician offices. For example, a hospital system will be paid more by the Medicare program when a beneficiary with a relatively low-severity condition is served in one of the system's EDs rather than in their urgent care centers.
Now, the most important reason might be the last one. This is the main takeaway from this slide. The new site-neutral law, which prohibits off-campus departments from billing Medicare at higher hospital outpatient payment rates, does not apply to stand-alone EDs. These facilities are specifically exempted within the site-neutral law. You could think of this as a loophole to the site-neutral law. As a result, off-campus EDs can continue to receive higher hospital outpatient payment rates for the ED services they provide. In addition, they can continue to receive higher outpatient rates for the non-ED services provided in their facilities. This means that off-campus EDs can continue to develop and expand ED and non-ED services under the site-neutral law.

The stand-alone ED industry asserts their aim is to fill the void in the community health care delivery system and offer convenience to patients.

What we observe is that a few stand-alone EDs are located in areas that have recently lost a hospital emergency department or are in rural areas. But many stand-alone EDs have opened in urban and suburban areas where they are in close proximity to competitors or in
suburban areas with rapid population growth.

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

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

In a study comparing the top ten most common conditions of patients served at hospital EDs, stand-alone EDs, and urgent care centers in Colorado, researchers found that seven of the ten most common conditions treated at hospital EDs in Colorado were for life-threatening conditions. At the other end of the spectrum, researchers found that none of the top ten conditions at urgent care centers were for life-threatening conditions. Both of these are in line with what we might assume here. However, at the nine stand-alone EDs which data were available for,
the researchers found that three of the top ten most common conditions of patients served at stand-alone EDs were for life-threatening conditions. Because only three of the top ten most common conditions at stand-alone EDs were categorized as life-threatening, it suggests patients served at these facilities are generally lower-acuity patients than those served at hospital emergency departments.

A separate analysis evaluated the severity level of ED patients served at three stand-alone EDs in Maryland and the nearest three hospital emergency departments. These researchers found that between 46 and 64 percent of the patients served at hospital EDs were classified by the facilities as being in one of the three lowest-severity categories of ED services. By contrast, at the three stand-alone EDs, between 68 and 80 percent of the patients were in one of the three lowest-severity categories for ED services. Therefore, a larger share of patients fell into one of the three lowest-severity ED categories at stand-alone emergency departments.

We've put together a couple initial ideas to guide your discussion on this topic.
First, the Commission could consider if CMS could begin tracking off-campus EDs in Medicare claims data. Administrators and researchers now are largely unable to see what services are being conducted in facilities.

Second, the Commission could consider examining incentives which encourage providers to serve patients in the emergency department setting.

And third, the Commission could consider reexamining the off-campus emergency department exemption included in the site-neutral law.

Thanks for your time, and we look forward to your guidance and your questions.

DR. CROSSON: Thank you, Zach and Sydney. We'll take clarifying questions. We'll start over here with Amy, Bruce, Bill, Rita, and Jack.

DR. BAICKER: I know that States are licensing these facilities, but generally speaking, what designates a facility as an ED versus urgent care? Are there minimum services offered?

MR. GAUMER: So it does vary in each State. I think there are some consistent things that kind of have to be there. Capacity to take certain levels of trauma
patients usually are one of the thresholds used by State
governments to do this.

To designate yourself as an emergency department,
often people have to take ambulance visitors, those types
of things. Yeah. But it does vary quite a lot from State
to State.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Just to follow up on Amy's
question, I think most States have a certificate of need
process that an applicant has to go through. My question
is in the regulatory infrastructure. Does the Medicare
program have standing within the certificate of need
process, or do you think it should?

DR. MILLER: It does not, and in a general sense,
I mean, to be -- you have to meet EMTALA requirements in
order to get Medicare reimbursement, but Medicare doesn't
have direct input into certificate of needs, either at a
federal or State level.

The second part of your question, should it,
would be a question for you, not for Zach, although we
could ask Sydney and see what she thinks.

[Laughter.]
DR. MILLER: It would be a significant shift in policy in the sense that, generally, the way Medicare works is if you license your doctors, if you license your hospitals, and if you license your emergency rooms at the State level, there's certain conditions of participation, Medicare pays. So it would be a real shift in sort of where supply policy sits. That's mostly at the State level.

DR. CROSSON: Yes. On this point, Kathy?

MS. BUTO: Just a point of clarification on this, Medicare does certify things like heart transplant facilities, bariatric centers, and so on, so there is a basis. It's tended to be based on not medical necessity so much as a specialized center designed to meet certain clinical needs of beneficiaries. But the way it's done this is to say in order to be covered for services, you need to meet certain criteria. So there is a way that if Medicare wanted to limit the number of these, they could proceed down that route or modify conditions of participation to accommodate any additional out-station facilities. It's a pretty cumbersome process, but there is a way, not through certificate of need, but other
mechanism.

DR. CROSSON: Sue, did you want to come in on this point or just on the list?

MS. THOMPSON: I'll wait.

DR. CROSSON: Okay. Bill.

MR. GRADISON: I'd be interested, as you pursue this issue, if you'd take a look, particularly at Texas, where there are quite a few off-campus EDs, to see what effect, if any, they have had with regard to utilization and particularly waiting times at the normal hospital EDs or urgent care centers, to see what kind of interplay there might be.

One other rather specific question -- I know it varies from State to State, but are there States where an independent ED could add three or four beds and then that makes them a hospital? There are a lot of States that don't have CON laws anymore.

MR. GAUMER: Yeah. And we've seen some of that. There are some examples. I think we read about one in Kansas the other day where -- I think it was a rural facility that was essentially a stand-alone ED, added a couple of beds, once they established themselves in the
community, and they were responding to demand in the community.

This has happened also in Ohio, I think I read recently, where a small stand-alone ED added four more ED ports, essentially, to their facility. So there is kind of initial setup as a stand-alone ED, and then they become a hospital, small hospital, something Sydney and I have been talking about as micro hospitals that you've maybe read about.

MR. GRADISON: I guess the other final question has to do with a 35-mile rule. I understand it applies. I have occasionally had questions about the wisdom of a 35-mile rule on its own if we're talking about telemedicine and trying to break down geographic barriers.

I once was working with a children's hospital that was asked to develop a children's facility and run it in a hospital which was in a town just a little over the 35-mile rule, and they were told, "You can't do it because you won't get any reimbursement for certain programs."

In this instance, I think it might just be interesting to see. This isn't for or against EDs that aren't attached to big hospitals, but I just wonder whether
the -- from the point of view of -- particularly the rural
issue, whether the 35-mile rule might be an impediment to
substituting facilities like this to hospitals in rural
areas which might otherwise close.

DR. CROSSON: Yeah. Mark.

DR. MILLER: Yeah. I'm going to intervene here
for just a second because I think there's also a
clarification I want in your minds and in the minds of the
public who have may have been listening to us over multiple
meetings.

So we're talking today about the growth in
emergency departments, the relationship to site-neutral
payment, and all that stuff that's been happening in front
of you, and a concern of growth, particularly as it relates
to kind of urban areas or suburban areas, if you want to
think about it that way.

New thought. Don't forget we had conversations
about -- you know, a freestanding emergency room in an
isolated rural area may make a lot of sense. It may be
hard for an isolated rural area to maintain a hospital,
inpatient hospital operation. Admissions are declining,
all that data that you guys are well aware of. So there
has been some talk in a separate way around reconfiguring rural subsidies to support rural emergency room, freestanding emergency rooms, and what triggered it is Bill's comment, this sort of question of how isolated you want that, the concern being that if you allowed just anybody to do it, then you get a bunch of freestanding emergency rooms that don't have enough volume to kind of support themselves.

But there is something of a distinction in the conversation here between what's going on in a rural and a suburban area versus an urban area. A freestanding emergency room may make a lot of sense in a situation where you can't maintain an inpatient hospital.

I just wanted to do that little commercial before we went on.

MR. GRADISON: But what I was really getting to was the ability -- I've been in politics. I can project my voice. What I was really getting to was the possibility of a major hospital overseeing, running these things, as part of their operation, which they often can't do because of the 35-mile rule, rather than just having the option in the small town, this hospital, of having to have a whole
structure entirely de novo, so to speak.

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

Did you want --

DR. MILLER: No. You should go on. I just want to talk to Jeff for a second.


DR. REDBERG: Thanks for an excellent chapter on an important topic.

Just actually, in your response, I guess, to Amy, it struck me when you were defining the ED law, you said they should have trauma patients, be able to take trauma patients and ambulance visitors, but it seems like most of the new off-campus EDs don't actually take trauma patients or get a lot of patients by ambulance, so that is of concern, I would say.

Maybe we're coming back to this in Round 2, but I was curious if you could enlighten us on why there was an exemption in Section 603 of the BBA for off-campus emergencies and non-emergencies.

MR. GRADISON: They have a new association.

[Laughter.]
DR. REDBERG: Just have it now.

MR. GAUMER: Well, actually, the exemption has been there. In defining what a dedicated ED is and in defining off campus, this has been out there a little while, and so this didn't happen in just the latest rulemaking process. But why this exists, I can only assume that this is to protect emergency department access in certain areas, but I'm not sure of the original intent.

DR. REDBERG: A few more clarifying questions. I would be interested in another time if you have data on sort of use of services at these off-campus services, because they seem to have a lot of imaging services, and I think most -- a lot of EDs now have a lot of CT scans associated. And I'd be interested in the volume because we've seen a big growth in imaging that hasn't correlated with any improvement in outcomes, and it's of concern again.

MR. GAUMER: I, too, would love to see the volume in these facilities, but it's not something that we can look at in Medicate data and in most private data because there's no identifier on claims that says that these are happening in an off-campus ED.
This is something that we have brought up in the rulemaking process. In our comment letter, we made a point about this, with this recent site-neutral outpatient rule. Just this week, CMS finalized that rule and in doing so said that they weren't going to. They responded directly to us and said, "We're not going to make a modifier on the claim so that we can identify this." They were a little short on their explanation for why.

So I guess I can only assume it's to protect access, but I'm not sure.

DR. REDBERG: That's very disappointing because it's a lot of data and important data that would be helpful for us to analyze.

I also had a question on page 20 of the mailing materials. When you were talking about differences in different MSAs on ED visits, there seemed to be a few like Richmond, Virginia, that dropped in ED visits, and I was wondering in others, in Texas and other places, that increase. Do you have any insight into what was going on, then, that would drive that?

MR. GAUMER: So this is referring, I think, the private payer emergency department data, and speaking to
that -- so we looked at Medicare data, and we looked at private payer data for emergency department visits to try to see if there were any obvious volume changes in markets with and without stand-alone EDs. And there were slight differences between markets with and without freestanding or stand-alone EDs.

One of the complexities of this analysis is there is a lot of possible noise about what's causing these trends, and we went into this fully acknowledging that a lot of factors could have influenced emergency department use, up or down.

With regard to the private payer emergency department data on page 20, I think, in my mind, there's even more noise on this, and so, in a market where the emergency department visits went down, even where they had stand-alone EDs, I don't have a good explanation. I think that's why we tried to take an aggregated approach.

So there were outliers on both sides of things, but in aggregate, the volume was slightly higher -- or the growth in volume was slightly higher in these markets that had stand-alone EDs, so that's also another reason why we 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
facilities, any mileage restriction that can't be closer
than X number of miles to an existing ED?

MR. GAUMER: No. So there's really -- that would
be a State decision, and the States that have independent
EDs or the freestandings, such as Texas, they don't have
zoning restrictions like that, largely.

I think we heard anecdotally that in Houston,
there are no zoning restrictions, and I think someone said
to us it's like the Wild West. They can go out and start
these facilities wherever they'd like to, and we have seen
that they do open up across the street from a hospital
emergency department.

So, yeah, there are very few restrictions is the
answer.

DR. CROSSON: Jon.

DR. CHRISTIANSON: Okay. This is really a
clarifying question for me. So there are these two kinds
of EDs. There's those affiliated with hospitals and those
that are independent. So the exemption applies to the ones
affiliated with hospitals, and so they're able to build a
new emergency department and then have two doors. One
doctor, you come in and you can have a primary care practice
located there. Another door, you come in; you go to the
emergency department. And if you go in the door to the
primary care practice, you get the higher hospital billing
rate. Is that what the exemption is?

MR. GAUMER: What we've seen mostly to date is
that the off-campus EDs are emergency departments. The
have imaging. They have an imaging department. They have
a lab department, and that's largely it. Sometimes they'll
have maybe other medical offices in the building, if it's a
large variety.

DR. CHRISTIANSON: So, if they come into an
emergency, freestanding emergency, and it happens to be
that the service is primary care that's provided, then it
gets billed at the higher rate, or is it --

MR. GAUMER: Well, the way this works with the
site-neutral exemption is if the stand-alone ED wanted to
have or did actually have the medical office building in
the walls of the facility and billed with the same billing
IDs, then they could use the higher hospital outpatient
department rates. But I think largely what we've seen so
far is that the medical office part of this is not a
central component of this business model, but with the --
kind of the final rule set out by CMS this week, which
states specifically that the non-emergency department
services provided in those facilities can be billed the
hospital outpatient department rates, it would make sense
that --

DR. CHRISTIANSON: So this is a concern about the
future --

MR. GAUMER: It's almost a future concern, more
than anything.

DR. CHRISTIANSON: And another quick question,
the ownership of the independent ones, I mean, we've seen
some large health plans buy urgent care centers now. Have
you seen any ownership by large health plans of these
freestanding emergency setups?

MR. GAUMER: I have not seen any insurers buying
freestanding emergency departments.

DR. HOADLEY: A couple of quick, simple
questions. One, the exchange you were having with Mark or
the point Mark raised about the rural kinds of things where
maybe a hospital has converted to an ED, does that get
counted in your definition of an off-campus ED?

MR. GAUMER: Where the hospital goes out of
business and becomes an emergency department? Yeah, that would get picked up in ours. Those are probably the hardest ones to track, but they pop up on our radar as a result of the closure analyses that we do. And that's actually how this began. In our world, we kind of said, "There's a lot of these going on." And so yes.

DR. HOADLEY: And when you talked, I think it was on Slide 7, the term "partner," I'm wondering what that really constituted. I assume that's something less than ownership, but how high a bar or how low a bar is it? Can you just write a memorandum of understanding and now we're partnering?

MR. GAUMER: So the way I've seen it happen, anyway, is you have a freestanding emergency department company that gets together with a hospital or hospital system and says, "Let's build a new facility," and it will be under the hospital's brand, but the freestanding emergency department company will essentially be a part owner and will do a lot of the work to, you know, implement their model. And, you know, maybe they staff it. Maybe they run it. That's unclear to me. And it may vary. But there is -- it's almost like a joint venture, so partnering
and joint venture in my mind is kind of the same thing in this regard.

DR. HOADLEY: I guess I wonder whether at some point whether partnering could be used in a less connected level than that. That might be something to keep an eye on.

Do we have any information on whether Medicare Advantage plans are sort of following the same policies in terms of how they might be paying either the freestanding - I mean, the off-campus or the independent EDs?

MR. GAUMER: That's a really good question. I'm going to look into that and get back to you.

DR. HOADLEY: And the last question is: Payment for urgent care centers, is that all paid under physician fee schedule, or is there a facility fee involved for an urgent care center? Or does it simply depend on ownership again?

MR. GAUMER: It is complicated, also, and it depends on ownership. And so if there's an urgent care center that's owned by a hospital, they receive both the hospital outpatient and the physician fee schedule rates. And if they are a freestanding urgent care not owned by a
hospital, then they get the physician fee schedule rates.
And I'm going to look at Kate -- who just gave me the
thumbs up, so I didn't like to you. Thank you.
DR. HOADLEY: Okay. Thank you.
DR. MILLER: Yeah, and I think the general
thought is we've been thinking of the urgent care stuff as
kind of running through the physician side of things. And
to the extent that you kind of build one of these and then
urgent care people start running through one of these
things, then you're going to get that rate shift that you
saw, you know, in other circumstances. What he said, which
was confirmed by Kate, was correct.
DR. CROSSON: Okay. So we're going to -- sorry, Brian.
DR. DeBUSK: So knowing that we can't separate
out these claims from these off-campus departments, as we
develop new quality measures like the potentially
preventable emergency department visit, this new business
model could completely contaminate that parameter.
MR. GAUMER: It would complicate the measure, I
think. Yeah, it could. But I would want to ask Ledia
about that, too, which you'll get a chance to do.
DR. MILLER: And, remember, I think what we're about to shift to in this second round -- right? We're moving into --

DR. CROSSON: Moving into it, yeah.

DR. MILLER: I mean, one recommendation you could end up with here is to direct the Secretary to start tracking these claims separately so it isn't such a blind spot.

DR. CROSSON: As a matter of fact, let's move to Slide 11. So I'm going to have a general discussion here, and I'm going to ask for hands in a minute. But first I'm going to point out that we're tight again on time.

So there are good points to be made here, and please make them. But I would emphasize also the potential -- because I'm thinking about the tenor of the discussion so far, which is generally in support here. So I would also ask you if you want to make a comment and you disagree with either one of these three directions, to make that point. Otherwise, we'll assume -- I'm going to assume general agreement. Okay. So hands for discussion. Okay. Let's start with Jon -- I did it the last time.

DR. CHRISTIANSON: Yes.
DR. CROSSON: Start with who? All right. Let's start with Rita.

DR. REDBERG: Thank you. So I wanted to talk a little bit about the role of primary care and emergency department visits, because as I was alluding to, I think a lot of these conditions are not clearly emergencies and could be handled with perhaps more or better incentives to keep them in primary care. And, again, I don't imagine we have this data, but I would be interested in how many of the patients who go to the freestanding emergency departments or, whatever, emergency -- off-campus EDs, have talked first to their primary care doctor, because as I said, certainly a lot of these issues could better, for the patient and I think for the overall system, be handled in a primary care office. It's always better to be seeing somebody who knows you and more efficient and less unnecessary testing and less time. Most patients -- at least my patients don't really enjoy going -- a lot of our emergency rooms have waits. There are some sick people there. It's just not that pleasant an experience.

And so along that line, I'm just wondering also when we talk about primary care whether, you know, we could
favor groups that had perhaps incentives to keep those
visits, because when I admit some patients, you know, from
the emergency room, they say they tried calling their
primary care doctor first but nobody was available. They
were told -- you know, sometimes there's not capacity for
extra visits, and it's a lot simpler to refer someone. And
I think if we kind of reoriented the incentives for primary
care at the same time we're addressing the emergencies, it
would be better overall for beneficiaries and for the
program.

    DR. CROSSON: Thank you. It appears I've done it
again and forgot the individuals who had volunteered to
begin. Those were Rita and Alice. I'm going to take Alice
next.

    DR. COOMBS: Thank you very much. A couple of
things I wanted to address.

    In my area, a for-profit group came in, took over
a bunch of hospitals. One of the hospitals involuted and
became an ED, a freestanding ED. So what now happens is
that in that ED the capacity to actually take care of true
emergencies in that region has become basically attrited
and there's a referral process where they refer to other
emergency rooms, even though they formerly were able to take care of those patients.

One of the issues I have is what does the workforce look like in those different entities, either the off-campus ED versus the independent EDs, because this is really a concern of mine in terms of even if, say, the independent EDs did want to eventually take care of those Medicare beneficiaries, are they really able to on a workforce basis? So that would be one concern.

So I support one, two, and three, and even for three I thought of this, and I thought it was very interesting that, going forward, if even we would consider an exemption -- a revocation of the exemption of the independent EDs, because that's something we could recommend to Congress going forward in terms of this growing trend, just as there was a moratorium on LTCH development at some point in the past because of the development of LTCH in regions that were income-associated and seemed to be more of a business plan kind of arrangement, so that the demographics here kind of speak to a similar type of pattern.

For the rural, Sue brought up the rule with the
rurals, and I think that's one issue that we should probably be really squeaky clean on. With the independent EDs developing in close proximity to urban areas, it might be that with those situations, if they said, oh, these are needed, that you might have a different -- an anti-distant kind of requirement in thinking about that.

And so the one thing I want to talk about is, you know, the conditions of participation and what that looks like, and the role of all the accrediting agencies with these independent EDs. What role does the Joint Commission play and all of the things that a typical hospital kind of abides by, and how does CMS interface with making sure that those standards are being upheld?

And the conditions of need is such a difficult area to get your arms around because of state mandates. Those accrediting agencies might be a secondary window where we could actually ensure proper certification and accreditation.

And someone brought up that there are floating EDs, where the ED opens today and tomorrow it closes, I think that presents a problem for Medicare beneficiaries if they were ever to be involved in that system in that they
may come to rely on something that may not have the assurance -- you know, they may say that we can actually open and close as we see fit based on capacity. So that they can be open 24/7 and they have the capacity to be open 24/7, but can they actually handle emergency?

And I agree with Rita about the diagnosis. All those diagnoses are clearly able to be treated in a doctor setting, but some of them, if they're accompanied by hypotension, a fever with hypotension, acute influenza type syndromes, those are very different kind of natures in terms of the presentation. And that in and of itself speaks to some kind of site neutrality intervention. And so I would be in favor of that arrangement.

DR. CROSSON: Yeah, I'd just like to make one point here myself, which is, with respect to the loophole that you referred to and Zach described, I mean, one approach would be to say we should just close that. But then we have, as Mark pointed out, this other set of ideas, which is that we may want to promote the use of hospital-affiliated or even independent emergency rooms in certain rural situations. And it might well be that we would find out that in order for those to be financially viable and to
respect genuine needs for support services, we would have
to be paying some additional funds.

So I think it may turn out--

DR. COOMBS: I agree with that. I agree that
rurals, as its market is alluded to, the discussion we had
with rurals, very separate. This discussion with
independent EDs, very separate. And so that we can
actually put a menu, there's veal marsala and then there's
chicken cordon bleu, and this is veal marsala and that's
it.

DR. CROSSON: Just to be clear, the ERs that
serve ham, they're over on this side, those that don't --
[Laughter.]

DR. CROSSON: Sorry. On that note, we're moving
up this way.

DR. GINSBURG: You know, this was a very good
presentation, very informative for me. I wasn't familiar
with it. Actually, as I started thinking about it, I
realized that I'm quite familiar with a situation in Ohio
which might be representative of a lot of others where a
hospital system acquired a failing low-volume hospital and
made a commitment to the community that it would expand
outpatient services and have an ED. So this, you know, seemed to be something that's probably useful for the community. But let me get to my point.

I think what we're grappling with is that we're setting the payment on the basis of the structural characteristics of a provider, and the freestanding EDs are a case where, as we saw the data, most of the services are way below those structural requirements, but the payment is still high.

So I started to think about what we could do, and maybe it could be that for Medicare to continue paying in a freestanding ED, it would have to see evidence that the acuity of the patients treated is high enough to be worth the higher rates. So in a sense, the facility could lose its Medicare designation and then just be paid as an urgent care center if too small a proportion of its cases are acute.

Another thing which would be more complicated to administer is you could even try to vary the payments.

DR. CROSSON: By diagnosis.

DR. GINSBURG: By diagnosis or some way. But whatever you want to do, we really need that data that CMS
decided not to collect.

DR. CROSSON: Okay.

MS. WANG: I agree with all of the recommendations on page 11. I think that there are -- I view this as a continuum. There's primary care, there's urgent care, there's emergency departments. The analysis that is presented here is basically demonstrating that the freestanding emergency departments that you've examined are urgent care centers who are getting paid at a higher rate because of varying state licensure laws. They're not providing the same services, they're not meeting the same life safety codes, but just because they are licensed as something called an ED, they are getting a higher payment rate for something that an urgent care center is treating and getting lower payment rate, and urgent care centers, you know, are also treating things that could be in a primary care setting. So we've got to continuum here of the same conditions being provided in different settings that, because of the different status label, are being paid at different payment rates.

I think that Medicare should -- needs to early on sort of have a position on this, and that's why I agree
with all three bullet-point recommendations here. I think that in the issue of the menu, rural access is clearly a situation that needs to be treated as kind of its own -- I think from a policy perspective, people want to see access improved through approaches like this.

I think another area is also the hospital closure. There are communities where hospitals do need to close, and the way that you can sort of support the needs of the community and make them okay with taking that costly overcapacity out of the system is by replacing it with a freestanding emergency department.

But other than those two circumstances, I think that what you've presented is kind of edge of the wedge dangerous. And so I think that tracking Medicare claims is very implement, and maybe ultimately moving towards -- I mean, the site neutrality doesn't help; if you're licensed as an emergency department, you're an emergency department. I think you're getting paid that way.

I think that what I'd like to suggest is that there's some sort of tracking and further analysis and maybe even for a hospital-based off-site emergency room, that there maybe be some critical mass of emergency room --
real emergency department services that are being provided. The table that you compiled shown on page 16 to me would not cut it. I would not view a freestanding, hospital-based or otherwise, providing this menu of services as being worthy of being treated as a true emergency department.

So, you know, that's a little murkier. That's not a bright-line thing there. But I think that there needs to be some sort of judgment, I guess, about whether something that is off site, that is, you know, really within a hospital infrastructure, particularly, is really more of an urgent care center or is truly an emergency department. You know, it seems that the study group of facilities, the business model as Brian described it, that you've examined here is motivated maybe more on the private payer side, but I think it's very important for Medicare not to -- to be clear about whether it's going to encourage or discourage or try to shape the development of these organizations.

DR. CROSSON: Thank you.

DR. CHRISTIANSON: Yeah. Just a quick comment on the third bullet point. I think this exemption is clearly
contrary to our -- or principle is contrary to what we've recommended. It's unfortunate. I would like to see us take a strong position and reexamine on this.

DR. CROSSON: Bill.

DR. HALL: I agree with Jon that this is sort of the antithesis of what we talked about this morning about the desirability of integration of health care services across a spectrum. They're referring to the freestanding emergency rooms. This would seem to be a curious exemption to that rational approach to integration.

On the other hand, they probably do provide a community service, but we don't really know that. But I think a few additional things might be looked at. For example, do we know much about staffing patterns in these freestanding? On any given day, would you see a physician? Would you see an advance practice provider or none of the above? It just makes me very nervous that there don't seem to be any clear regulations in that direction.

What I find at least in our community where we do have these things that we call "doc in a box" -- that's sort of the general term for these freestanding programs -- is that if they make a mistake or potentially an error and
not recognizing the severity of something, the mechanism
for following up on that is completely nonexistent.
They're told to go to the emergency room of some hospital.
    So maybe that's rare or maybe it's common. We
don't know. But if it's truly an emergency and that's the
sequelae, it probably requires another one or two hours to
get to a place that actually can handle an emergency. So I
think we need to have some kind of scrutiny of at least
manpower and the ability of these institutions, depending
on the staffing levels, to refer promptly and properly.
That's the definition of emergency medicine.

DR. CROSSON: Thank you.

Amy.

DR. BAICKER: So the clarifying question I asked
around really the minimum standards for ED, I, too, found
that chapter enlightening, and it had me thinking along the
lines of what Paul had suggested around either
prospectively these facilities really vetting their role in
the community, expecting to care for trauma patients where
there is a need or having arrangements with ambulance
facilities to understand that they would be a source of
care for patients in the community. It obviously seems
quite opportunistic, given the laws it's outlined here.

I wonder if there is an opportunity for us to
look further at urgent care as well as -- you referenced
briefly the retail clinic sort of models. I just know from
my personal experience, retail, like referenced Minute
Clinics in CVS or Walgreens has these, they're actually
very unprofitable by themselves.

So the fact that you mentioned the urgent care
centers, if they're affiliated with the hospital, they're
able to get the hospital fee and also then the physician
fees, if we could just better understand the role of those
entities and what we believe to be the motivating factors
for establishing ED versus urgent care versus clinic, these
sorts of things would be helpful to further the discussion.

DR. CROSSON: Sue.

MS. THOMPSON: I'll be quick.

I really did appreciate this chapter, Zach.

Thank you.

Additionally, I like the point that -- I'm not
sure if it was Jon -- thinking about emergency urgent care
-- primary care, emergency urgent care, and now these
freestanding in some sort of a continuum, but even in a
broader context of how we're working to clinically integrate and trying to understand where do these patients end up and who are they handed off to and who is overseeing the broader care in terms of our Medicare beneficiaries.

And then one last comment, as we think about policy here, to be cognizant of the potential for unintended consequences as we think about the issues we have previously raised around rural, so just a last call.

DR. CROSSON: Craig.

DR. SAMITT: So I'm in support of all three recommendations as well. What I also like about them is it doesn't compromise the establishment of freestanding EDs, where the true need exists. So, if there really is need for a high-acuity ED care in a certain community, I don't think there's anything that's been recommended here that would compromise that, which is why we would allow those to happen. We would want those to happen.

I also agree with the notion about the rural exceptions that we need to -- as we have in other circumstances, assure that there's a rural exception in this case.

The only one modification and then one question
that I would have pertains to the second one. We talk about examining incentives that may be encouraging providers to serve patients in the ED. I would supplement that by saying should we have incentives for primary care and other providers to preserve care that is lower acuity within their practices or in urgent care settings.

So, for example, are the ACO incentives sufficient to encourage ACOs to really keep urgent care and non-emergent care within practices, and should that even be a separate quality variable that is measured with ACOs?

And my question is about beneficiaries. So, if I'm a beneficiary -- and let me take a diagnosis. I simply have pharyngitis. I have a sore throat. Is there differential implications to me if I go to my primary care doctor, an urgent care facility, or a freestanding ED? And I'd love to understand as well to see, because beyond just provider incentives, if it's otherwise neutral to me as a beneficiary, then I may just go to the freestanding ED that may be right next door. But the question is, Is that the right incentive that we should have?

MR. GAUMER: So I can answer that in part here. If the patient goes to any of those facilities -- the
physician's office, the urgent care, or the ED of any type -- it's 20 percent copay or thereabouts. So, if the payment in the ED is higher, that 20 percent results in a larger out-of-pocket expense.

DR. SAMITT: Unless I have Medigap.

MR. GAUMER: Unless you have Medigap.

DR. MILLER: And that's the big deal is that if there was a signal there, "Gosh, did you know that the 20 percent in this setting was higher than that setting?" with a wraparound, employer, Medigap, or a supp from Medicaid, you're not feeling any of that.

DR. CROSSON: Hold on.

DR. COOMBS: I just want to respond quickly, but there is as nonfinancial piece of it, and it's the fact that it's a disruptive innovation that allows a much more efficient handling of a pharyngitis. That's why it works. That's why it's successful. You can get in and get out. That time factor is really important.

DR. CROSSON: Kathy, do you have a point on this, or are you just getting in line?

MS. BUTO: Separate.

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

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

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

Mark expressed a concern earlier about, say, rural locations. Well, couldn't we do that through a site of service through the physician fee schedule, and would
some of these things correct themselves, then? If you had
a suburban -- an allegedly off-campus emergency department
in a suburban shopping center in the middle of an affluent
neighborhood handling sniffles and sneezes, it would be and
look and act like a clinic, irrespective of the corporate
structure. And I just wonder if this is one of the few
situations where the granularity of the physician fee
schedule might actually work to our advantage and be able
to cover a broader hose of these services and not get into
splitting hairs about how sick or how ill is this patient
coming into this facility and who owns it.

DR. MILLER: Well, the ones, without buying into
they're all clinics and they're all through the physician
fee schedule, just with two seconds of thought, I want to
think about that. But what principle I would take from
that and would ask you all to think about is there is a
couple of times people have said, well, maybe we should --
I think Alice said maybe there's as moratorium. You can
take approaches like that, but what the Commission has
tried to do more traditionally in these areas is set a
uniform payment and then say if this is a viable model --
or a more rational payment -- if this is a viable model,
then it will continue to deliver, so, in a sense, take out
the revenue-generating opportunity and say this is a fair
price for this, whether it comes off the fee schedule or
whether it comes off the OPD or wherever it comes from and
says now you all can play whatever structure you want, but
this is the payment.

And I just don't know -- well, I'll stop there.

DR. DeBUSK: Well, the comments earlier about
rural emergency departments were very well made. I mean, I
think that's a legitimate concern and a separate topic.

I'm thinking more along, again, these very
suburban, very clinic-looking -- again, it would be nice to
be able to peel back all that and maybe address it with
something that's a little more granular.

DR. CROSSON: I mean, that's my sense of where
we're going is if we're going to solve the problem we have
identified before, which is as Pat elucidated, giving rural
communities the option of moving down from a hospital to
something else, call it a freestanding emergency room --
and that's a legitimate effort, and I think we all sensed
that that was -- then somehow we have to do that but not
have it contaminated with this other problem. And so we're
going to have to have some sort of a nuanced approach, which will be kind of hard to get it right, but that's probably the direction we need to take, or we take Paul's suggestion and we do it through paying differently, which is another way of doing it, because then you wouldn't be paying extra funds for a cold, but you wouldn't be paying it in that rural setting for the legitimate purposes that the thing was established for.

So there's a couple of, I think, ways that we could split this, and hopefully, we'll come back at some point with those teased out better.

DR. DeBUSK: Well, in theory, rural could be a site of service.

DR. CROSSON: We could make it a separate site of service. Yeah.

Okay. Warner.

MR. THOMAS: Just two quick comments. I think tracking the data would be important to kind of see what is the trend on this.

On examining the incentives, the only comment I would make there is I agree with Sue and all the comments on looking at the rurals because I think, certainly, being
able to provide an opportunity for hospitals to transition to being a freestanding ED or an ED only with ambulatory is a great opportunity.

On the urban setting, the only comment I would have is there are areas where we see five-, six-, seven-, eight-, nine-, ten-hour ED waits, and to me, that is not okay from a beneficiary perspective. And in those markets, perhaps some of these -- not that they've got to be hundreds of them, but perhaps there should be some of these as an alternative to a patient waiting five to ten hours for an ED visit.

So I just think getting back to the incentives, that's probably one of the incentives you see here, and I think that ought to be studied at the same time that we're just looking at visits. I think we ought to be looking at how many people are getting up and walking out of EDs and things like that. So I just think it's another comment to consider in the paper.

DR. REDBERG: Just to comment on that, Warner, as you know, ED patients get triaged. So, if someone is waiting five to ten hours, to me that suggests they were a lower acuity, and it goes back to the discussion we were
having about perhaps they should be better treated in urgent care or physician office.

DR. CROSSON: Pat, same point or different point?

MS. WANG: Yeah. It was just urgent care centers have really sprung up, develop relationships with hospitals, ambulances waiting outside of them to relieve the bottleneck that you described. I think what we're talking about here, from my perspective, keeping beneficiaries out of the emergency department should be a high priority, no matter what. So if there are step-down kinds of settings, urgent care, primary care -- but urgent care, I think, is filling a tremendous need right now for the points that you just mentioned.

But what alarms me about this is this is an urgent care center wearing a cloak of an emergency department. I think you have to be really careful about sort of recognizing it as that, but maintaining the urgent care sort of capacity, I think is important.

MR. THOMAS: So I totally agree. I'm a big fan of urgent care, and I think they play a very, very important role. I just think as we look at the situation, I think we ought to look at the wait time situation as
well.

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

DR. CROSSON: Okay. Kathy, last comment.

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

So I think we might be able to -- and I don't think it would take much to reframe this as more than CMS tracking the claims data and looking at incentives, but really taking a much more proactive role in trying to, first of all, collect the data, then develop criteria and use whatever approaches they have, whether it's conditions of participation, conditions of coverage, site-neutral payments, a number of other mechanisms at their disposal to try to get a handle on this, because if they -- all of these are great, but if they do this, I guarantee we're
going to see a ballooning of these facilities, and it will be too late to really pull them back. So the question is, Can we suggest a course of action that's a little more proactive where we urge the agency to get on top of this through a variety of mechanisms that we could talk about later, but including incentives, criteria, conditions, even some certification maybe, if necessary?

DR. CROSSON: Okay, Paul. Paul, last comment.

DR. GINSBURG: Yeah. Kathy, I also think that we should be aggressive in this area, and I'm wondering if we should consider going one step further, which would be recommending to Congress or maybe to CMS that there be a moratorium on additional hospital freestanding ED facilities.

MS. BUTO: While they do all this other stuff.

DR. GINSBURG: Yeah.

DR. CROSSON: Okay. Good discussion. Good discussion.

We're now at an end. Zach and Sydney, thank you very much.

We have the opportunity for public comment. If 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.]
DR. CROSSON: We're actually missing a few people who were fascinated with the tiramisu, so I think, nevertheless, to stay on schedule we need to start. Okay. So we're going to take on the question again about payments from drug companies and this time also device companies to physicians and teaching hospitals. And we have Ariel and Amy, and it looks Ariel is going to start off.

MR. WINTER: Good afternoon. Amy and I will be discussing payments from drug and device manufacturers to physicians and teaching hospitals that were reported under the Open Payments program. And we intend for this work to appear in an appendix to the physician update chapter in the upcoming March report.

Before we begin, I want to thank Sydney McClendon for her help with this project.

So here are the points we'll be covering today. I'll start with some background on this issue. Then I'll describe the Open Payments public reporting program. We'll present results from our analysis of new data from 2015.
And, finally, we'll talk about potential changes to Open Payments program and future analytical work.

In 2009, the Commission recommended that Congress mandate public reporting of financial relationships between drug and device manufacturers and providers and other health care organizations.

The goal is to help Medicare, other payers, and the general public better understand the scope of these financial ties and the relationship between drug and device company payments and physician practice patterns.

In PPACA, in 2010, Congress created a public reporting system. CMS implemented this program in 2013 and called it Open Payments. As we expected, the media and researchers have been using this database to shed light on physician-industry ties.

There is a growing literature describing the relationship between drug and device industry payments and physicians' prescribing behavior.

For example, a recent study published in JAMA Internal Medicine used data from the Open Payments program on meals provided by drug companies to physicians. They looked at meals that were related to brand-name
medications, such as Crestor, in one of four drug classes. The authors found that physicians who received such meals prescribed brand-name drugs within each class at a higher rate than other physicians. Another recent article used data from the Massachusetts public reporting program and found that physicians who received industry payments prescribed brand-name statins at a higher rate than other physicians. Earlier studies also found that physicians' financial interactions with manufacturers are associated with prescribing of newer and more expensive drugs. Under the Open Payments program, manufacturers and group purchasing organizations must report certain payments and transfers of value to physicians and teaching hospitals. The law applies to manufacturers of drugs, devices, biologics, and medical supplies. The category of physicians includes medical doctors, osteopaths, dentists, optometrists, podiatrists, and chiropractors. But the law excludes other health professionals, such as advanced practice nurses and physician assistants; it also excludes professional organizations such as medical societies and patient
advocacy organizations.

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

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

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

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

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

And now Amy will provide more detail about the
MS. PHILLIPS: The Open Payments database contains three main files:

First, the research file, which contains payments for basic research, applied research, and product development. These payments go to teaching hospitals, directly to physicians, or to research institutions that list physicians as principal investigators on a project. Research payments may cover costs associated with patient care, time spent managing the research, or the drugs or devices that are studied.

Second, the ownership file contains information about physicians with ownership or investment interests in a manufacturer or GPO. This could include information about a physician's stake in his or her own company.

Third, the general payments file includes payments that are not in the other categories, such as payments for promotional speaking, royalties, and consulting.

Last year, we analyzed 2014 data and published results in our March 2016 report. After we published our analysis, CMS released additional payment records for 2014.
that were worth about $1 billion.

This table compares total payments from 2014, including the newly released records, with 2015. Overall, total payments only increased by about 0.4 percent from 2014 to 2015 -- the bottom row.

There were small decreases in general payments and ownership interests and a small increase in research payments. But we have not yet examined the new 2014 data in detail. Today's presentation is focused on 2015 data, which I will discuss next.

This chart shows the proportion of payments in 2015 that fall into each category. The total payments sum to about $7.5 billion.

If you look to the orange sections on the right, you'll see that research payments make up about half of the total value of payments. Please note that values are displayed in millions. Within the research payments category, $3.2 billion went to physicians and $724 million went to teaching hospitals. It's important to note that these payments exclude those that are subject to delay in publication, and we do not yet know the value of those payments.
The green sections on the left show the general payments category, which makes up 40 percent of the total value of payments. Among general payments, about $2 billion went to physicians and $605 million went to teaching hospitals.

The light blue section shows physician ownership or investment interests, which, at around $1 billion, make up the remaining 10 percent of the total value.

Around 80 percent of the payments went to physicians, while the other 20 percent went to teaching hospitals.

Across all three payment files, about 618,000 physicians received payments. Eighty percent of physicians receiving payments were MDs and DOs, 20 percent were dentists, optometrists, podiatrists, or chiropractors.

Of those physicians who received a general payment, the average payment per physician was $3,242 dollars, and the median payment was $157. This means the distribution of payments is highly skewed with a few physicians receiving a high proportion of the dollars.

Of those physicians with ownership or investment interest in a drug or device company, the average value of
interest per physician was about $265,000 and the median value was $4,651.

We did not calculate the average research payment per physician because research institutions may list multiple physicians as principal investigators, so we are not able to attribute these payments to specific physicians.

In 2015, across all three payment files, 1,110 teaching hospitals received payments. Among the payments made to teaching hospitals in the general payments file, one hospital accounted for half of all payments.

Payments to hospitals were mostly via royalties or licenses which accounted for 70 percent of general payments made to hospitals.

Gifts were the most prevalent type of payment with 78 percent of hospitals receiving them, despite only accounting for 2 percent of general payments to hospitals.

For the next four slides, we will be focusing on general payments.

The distribution of general payments among physicians is highly concentrated at the top. The top 5 percent of physicians who received payments account for 86
percent of total payments.

Looking at the demographics of these physicians, we found that five specialties -- internal medicine, cardiology, orthopedic surgery, psychiatry/neurology, and oncology/hematology -- account for half of the physicians in the top 5 percent, and we found that 10 states account for 60 percent of these physicians.

MR. WINTER: Okay. Next we examined general payments to physicians by the type of payment. So the first row shows that royalty or license payments accounted for about one-quarter of general payments and had the highest average amount per physician -- about $233,000. Only about 2,300 physicians received one of these payments.

Next, going down the list, is compensation for services other than consulting -- which includes promotional speaking fees. This also accounted for about one-quarter of general payments to physicians.

About 31,000 physicians received one of these payments, which is 5 percent of all physicians who received at least one general payment. And the mean payment per physician in this category was about $16,000.

Then moving on down, we'll look at food and
beverage, which accounted for 12 percent of the total payment amount but was received by about 589,000 physicians, or 96 percent of all the physicians who received at least one general payment. And this reflects the widespread prevalence of industry-provided meals to physicians. The mean value of food and beverage per physician was $400.

We also examined the distribution of general payments to physicians by physician specialty, and this table shows the top ten specialties by total payments. Since we mailed out the paper, we have refined our analysis by dividing internal medicine into smaller specialty categories, so this table is different than what's in your paper.

Orthopedic surgery accounted for the highest share of payments: 21 percent, or $410 million. The average payment received by orthopedic surgeons was relatively high: over $19,000, with a median of $418. The large difference between the mean and the median indicates that the distribution is skewed towards physicians who received very high payment amounts. Internal medicine is second on the list,
accounting for 15 percent of the total, with a per physician mean of $2,400.

And cardiology was third, accounting for 8 percent of the total, with a per physician mean of almost $8,000.

Next, we look at the distribution of general payments to physicians by the type of company that made the payment. Because the data list the company's name but not the type of company that made the payment, we had to look at each company name and decide how to categorize it. To do this, we used company websites and other sources.

We found that device manufacturers accounted for 48 percent of general payments to physicians and drug manufacturers accounted for 46 percent. The category that includes manufacturers of both drugs and devices was third, accounting for 5 percent of the total.

So for the last four slides, we've been focusing on the general payments files, but now I'm going to switch gears and look at the physician ownership or investment interest file.

This table looks at physician ownership interest by type of company. Device manufacturers accounted for
almost $900 million in physician ownership interests, or 86 percent of the total. Drug manufacturers accounted for only 7 percent.

As noted on the slide, POD stands for physician-owned distributor, which is an entity owned by physicians that sells implantable medical devices used by the physician owners in surgeries. We broke out these companies separately because they have been criticized by the OIG and the Senate Finance Committee for potentially creating a conflict of interest.

I'll conclude by discussing potential changes to the Open Payments program, as well as future analytical work. The potential changes listed on this slide and the next were part of our March 2009 recommendations on public reporting.

First, we could reiterate our recommendation that manufacturers should be required to report payments to advanced practice nurses and physician assistants.

Currently, the law requires reporting of payments to physicians but not APNs or PAs, and this creates an incentive to shift payments to these clinicians because they are not subject to reporting.
The number of APNs and PAs billing Medicare has been growing steadily. According to ProPublica, these clinicians wrote about 10 percent of all Part D prescriptions in 2013.

Second, we could reiterate our recommendation that manufacturers should be required to report payments to patient advocacy organizations. There was a recent news story about funding from drug companies to patient advocacy groups.

For example, the story noted that half of the top donors to a large patient organization were drug companies; each one contributed at least $1 million.

Third, we could reiterate our recommendation from 2009 that manufacturers and distributors should be required to report information about drug samples to the Secretary. This information would include: each recipient's name and address; the name, dosage, and number of units of each sample; and the date of distribution.

The rationale for this recommendation is that the drug industry provides free samples to providers worth billions of dollars every year.

Although these samples offer benefits to many
patients, they may also lead physicians to rely on more expensive drugs when cheaper drugs may be equally effective.

Requiring manufacturers to report this information would enable researchers to examine the impact of samples on physicians' prescribing patterns.

According to this recommendation, the data on samples would be available through data use agreements for research purposes but would not be available on a public website.

So here are some ideas for future work:

We plan to examine the relationship between payments from manufacturers and physicians' use of drugs and devices.

We plan to link Open Payments data to Part D and Part B drug data.

One question we could explore with this is whether the top prescribers of new drugs are more likely to receive industry payments. We also hope to explore trends in payments to physicians as more years of data are released.

This concludes our presentation, and we'll be
happy to take any questions.

DR. CROSSON: Thank you, Ariel and Amy.

We're now doing clarifying questions.

MR. GRADISON: Okay. I noted and you pointed out that after the initial disclosure of 2014 data, an additional $1 billion was reported. What was that all about? It just seemed, frankly, a little bit strange that they would put out something incomplete or that it would be that much that they'd pick up later. What happened?

MR. WINTER: We're not sure

MR. GRADISON: Okay.

MR. WINTER: That's the short answer. We did our analysis using data that was released in January 2016 for 2014, and that totaled about $6.44 billion. And then when they released the 2015 data, they also released a fuller data set from 2014 that summed to $7.5 billion. But we have not been able to get into that database, the 2014 database, in more detail to figure out, you know, where these additional -- what these additional -- we know what these additional payments were for in terms of research -- most of them were for research. About $300 million were physician ownership, and about $120 million were for
general payments, but we don't know distribution by specialty or type of general payments.

DR. CROSSON: It reminds me of Senator Dirksen years ago saying, "A billion here, a billion there. After a while it adds up to real money."

MR. PYENSON: Thank you very much. A great report. A couple of questions.

It seems as though pharmacy benefit managers are not required to report. Is that correct?

MR. WINTER: That's right. But that was part of our recommendation, that they should be required to report.

MR. PYENSON: Okay. Thank you. And it seems as though rebates being paid associated with Part B drugs are also not reported. Is that right?

MR. WINTER: That's correct. They are excluded by statute.

MR. PYENSON: Okay. And then the third question on the stock ownership. I assume that doesn't mean a physician buys common stock on the market. It means a gift of common stock?

MR. WINTER: So the physician ownership file excludes -- I believe it excludes stocks owned in publicly
traded companies, but not -- but it would include stock
ownership or other investments in privately held companies.
If a manufacturer gives common stock to a physician in a
publicly held company, that would probably appear in the
general payments files, and there's a category called
"Ownership Interests." It's about the fourth row from the
bottom. And that reflects when the manufacturer gives an
ownership interest in a company to a physician, and that
could include common stock, but I could look into that and
get back to you.

MR. PYENSON: Thank you.

DR. HOADLEY: So one follow-up on Bill's
question, is there any indication or any way to know if
additional dollars that -- the additional billion dollars
could reflect some of the delayed payments for research?

MR. WINTER: That's a good question.

DR. HOADLEY: Or we don't know?

MR. WINTER: We don't know, and I'm not sure if
we'd be able to figure that out because I don't think
there's a variable that indicates whether a payment that is
now being disclosed was originally subject to the late
publication. We can take a look at the file in more detail
and see, but that is certainly a possibility.

I think what's more likely is that there were payments that were disputed or that CMS had questions about. For example, they couldn't always match the physician identifier that was reported by the manufacturer with the physician identifier in CMS's own systems, and so they had to go through the process of cleaning the data, and that could reflect some of the missing records that were eventually added. But we don't know for sure.

DR. HOADLEY: It seems like those are questions that CMS ought to be willing to answer in general.

My other question, my original question was about the reporting delay for the research and development. Was that something that we had anticipated in the Commission's recommendation?

MR. WINTER: Yes. Our recommendation was to allow for a delayed publication for up to two years or until the product was approved or cleared by the FDA, whichever came first, and in the statute, the statute said they could delay publication for up to four years or until the product was approved, whichever came first. So they have a longer period in the statute than we recommended.
DR. HOADLEY: I mean, I'm sort of curious about the rationale because it seems like the -- it wouldn't be a lot of identification of exactly what product is being tested in the research. Obviously, you would know that a particular cardiologist was linked to Merck or whatever company, but it wouldn't be identifying that it was to develop this particular new product.

MR. WINTER: If the payment is related to a specific product, they are required to report that.

DR. HOADLEY: Okay.

MR. WINTER: But if it's sort of general research and they don't have a product yet, then they can't report it, and they wouldn't.

According to CMS, the purpose of this provision was to balance the manufacturer's interest in keeping its research efforts proprietary and balance that with the public's interest in having access to this information, so --

DR. HOADLEY: And we appreciate the broad rationale. It seems like you could accomplish that by maybe suppressing the identity of the drug being studied but not the fact that payments were made, and then there
should be a clear way, it seems like, to identify later on why that was added or something like that.

DR. CROSSON: Brian --

DR. REDBERG: Just related to that, have any of those been -- the delayed been announced yet?

MR. WINTER: I don't know. They have not been publicly announced. CMS has not said the release for 2015 includes X amount of dollars that were delayed for 2013. We can ask them if they have this information, but I don't think the file includes a variable that identifies whether --

MS. PHILLIPS: There is a delay in publication variable.

MR. WINTER: Okay. There is a delay in publication variable, but I'm not sure if that would tell you that a payment that's being reported now was originally delayed for publication. We'd have to look at that some more and talk to CMS.

DR. CROSSON: We have Brian, Bruce, Craig.

DR. DeBUSK: Regarding payments to academic medical centers, if say an implantable medical device company made a payment to do research on a very specific
device, obviously that would fall under open payments.

What if instead they funded, say, three fellowship positions, didn't specify what the research was to be, but basically, those three fellows chose to do research in that area? For purposes of open payments, how would that be treated?

MR. WINTER: If it's a payment to a teaching hospital -- you said academic medical center, so --

DR. DeBUSK: I apologize. As a teaching hospital.

MR. WINTER: If it's a teaching hospital, right, and they're often the same but not always. So, if it's an teaching hospital from a drug or device manufacturer, that has to be reported, even if it's not related to a specific drug or device. And so if it's for a fellowship, that would probably be reported under the education category, and they would not report a name of a drug or device because it was not linked to a specific drug or device, but they would have to report the payment itself.

DR. DeBUSK: And then I had one other question.

I noticed you showed 21 PODs. Just from your own intuition -- physician on distributors. I apologize. For your own
intuition, do you sense that that number is underreported?
I don't feel like there are only 21 PODs in the entire
country.,

MR. WINTER: That's a very good question. So we
identify PODs through looking at companies' websites, which
were often -- and you could talk about this in more detail.
They were often very vague about what the company did or
produced or sold.

But we also got names of some PODs through OIG
report and a Senate Finance Committee report, and then Amy
can talk more about how they identified some of the other
ones.

But the Senate Finance Committee report did say
they have anecdotal evidence that these pods are
structuring their financial relationships with physicians
to obscure the relationships. So they don't have to report
it under open payments or report it to the physician's
hospital. So there's certainly a possibility of
underreporting.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Just a follow-up question on the
research funding. Much research is conducted through
contract research organizations, and those organizations perhaps pay physicians. Is that captured through open -- this process?

MR. WINTER: If the research agreement that's being run by the CRO lists a physician as a principal investigator, that has to be reported, and that would appear in the research file. And the name of the organization would be there. So if it's a CRO, we could see the name of that organization, and we'd also see the name of the physicians who are listed as PIs.

MR. PYENSON: So is that the entire payment? Not all of the funds go to physicians, but is it the entire payment?

MR. WINTER: It's the entire research grant or funding. It's not broken down by the payment to the physician for their time managing the trial. It includes the cost of managing the trial. It includes the cost of the drugs or devices. It includes patient care as well as compensation to the physician, so it includes everything.

MR. PYENSON: Do you think this is a good estimate of industry spending on research and development or a portion of it, except for the time lag?
MR. WINTER: I'm not sure I could answer that immediately. I'd have to think about that some more because there certainly could be research grants that don't have physicians as PIs. They could be PhDs and not be MDs or DOs and so they would not have to report that information. So I'd have to think about that some more. That's a good question.

DR. CROSSON: Craig.

DR. SAMITT: Back to Slide 13. You had talked about the ownership interest category, and I think you had mentioned that personally purchased stock interests are not included. Why would they not be considered --

MR. WINTER: This would be stock in a publicly traded company.

DR. SAMITT: Stock in a publicly traded company.

MR. WINTER: Right.

DR. SAMITT: So why would that --

MR. WINTER: I'm not sure if they were excluded by statute or by regulation. I'd have to go back and check. I think the notion there is that -- I'd have to think. I don't know. I don't know why that might be excluded, but my sense is that it is. And we can go back...
and look into what the rationale is.

DR. CROSSON: Okay. I think we're ready to move on to the discussion. I would just point out that we kind of have two things on the table at the same time. One is a proposal to --

Thank you. I'm just being reminded to remember to call on Alice and Rita. Thank you.

We have got the notion here on page 17 and 18 that we have prior recommendations, and one is from 2009, and the other two are more recent. The idea here is we're looking for support because we'd like to reissue those recommendations.

And then the second part, which is on the last slide, is thoughts about future work, particularly the issue of linking open payments data to Part D and Part B drug data or other ideas for future work.

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

DR. COOMBS: Thank you very much.

So, for starters, for future work, I agree with our former recommendations about pursuing reporting of the other advance nurse practitioners and PAs, and also the requirement for payments to patient advocacy organizations.
Several areas that I am particularly interested in, Ariel, based on my own personal experiences, the validity of the data that's recorded. So I personally went to the website. I looked up my data, and on the website, way over in the corner on the right-hand side is dispute. So there's an opportunity for a physician to actually dispute the findings that are within the content of the report, and just my personal interview with multiple physicians, they're not even aware, first of all, of the information on the website that's concerning them, so that to actually talk about whether or not this has been validated with the provider, that doesn't happen.

And I was thinking of what way in which MedPAC -- if we're going to have these robust recommendations that are on page 18, that we first should probably go through some process whereby we validate those providers, and with our interviewing of what we're going to do for physicians, it might be an easy climb to do a pilot of, say, maybe 40 or 50 physicians to say, "Have you looked at the website? Have you disputed what was found there? If not, are you aware that you have the capacity" -- or some kind of discovery where we actually look at reinforcement
because manufacturers are just reporting one-sided. I think that if manufacturers were reporting to both the physicians that they're reporting as well as to the public reporting, so that there would be disputes on -- and I'm sure -- this is not 100 percent -- there might be disputes of what is actually seen there before we draw some of the conclusions that we are.

And one of the issues is, for the research, do we think that the research funds for patient recruitment, patient participation, all of those things should be attributed to physicians? And I think that's a problem for me if we lump it all together, and then all of a sudden, it's sitting in the house of physicians. So I don't know if you've had a chance to kind of consider that in particular.

MR. WINTER: It's not something that we have thought about much in detail yet but something we can certainly talk about.

The issue is that the statute requires reporting of payments made to physicians but not other entities, and in our original recommendation, it included other entities, like academic medical centers, CME organizations. And if
you could report it in the name of other entities, then it would not necessarily show up as the name of a physician. It could show up in the name of an academic medical center or the research institution or the specialty society, but I think because the legislation is limited to physicians and teaching hospitals that the files and the data are structured around the individual physicians and individual teaching hospitals. But under our original recommendation and our original concept, it could have been reported under the name of entities and not necessarily under the name of physicians.

Does that help?

DR. COOMBS: Right. So should it be broken out as to this dollar amount is attributed to physicians and the rest of it is for the operation of the research protocol?

MR. WINTER: Are you suggesting that you'd break it down by the amount that is physician compensation for their time managing the trial versus the amount that's spent on patient care and the --

DR. COOMBS: Right. And patient --

MR. WINTER: -- cost of the drugs and devices?
Yeah. It's certainly something to think about.

DR. COOMBS: Yeah. And then lastly --

MR. WINTER: We can make that suggestion to CMS.

DR. COOMBS: And lastly, in terms of royalties, there are other industries that we look at in terms of other disciplines, that royalties are kind of assessed at, okay, this is an appropriate amount for, say, engineering discovery, something in biomedical engineering.

What we see here, is that comparable to those other industries? I'm thinking about how in the GIPC, we considered what's a cost of doing business for -- we talked about this with MEI -- for a physician versus what does is the cost of doing business for an accounting. Is there a way to do comparable kind of comparison of this is an appropriate amount? Or it might be over. It might be under what you would have expected if you compared it to other professions.

MR. WINTER: I'm not aware of a database that would -- public database that has royalty payments to other professions that we could use as a benchmark, but it's something we can think about.

One thing that complicates this is that the
patent -- one patent may be much more valuable than another
patent, and if you're comparing -- even within the drug and
device world, patents have vastly different values. Then
if you're comparing between drug and device patents and
other kinds of patents, I'd be concerned about whether
those are really comparable worlds.

DR. COOMBS: Right.

And then lastly, for samples, I think if we do
samples, we definitely have to have some bidirectional kind
of commitment on -- the manufacturers, pharma is reporting
that these samples were given, that there should be some
kind of way of attesting that physicians actually receive
the samples, and it shouldn't be unilateral as the website
appears to be currently.

MR. WINTER: Just one point about the role of
physicians and teaching hospitals and validating the data,
they do have an opportunity to review and validate the data
and dispute it if they discover there's an error.

Physicians and the AMA have raised lots of
questions and concerns about how cumbersome this process is
and whether physicians are aware that this process exists,
and so CMS has taken some steps. They have said to
simplify the process, make it easier for physicians to
review and dispute the data, and also to educate physicians
that the data are out there and that they should be
reviewed. But, certainly, this is an important area.

DR. COOMBS: My only thing is that you can't
dispute it if you don't know that you're one of those
618,000.

DR. CROSSON: So just on that point, Alice,
you're saying the concern is that the company might report
providing samples to a physician and the physician never
received them.

Ariel, I think the proposal is that this database
would be available to researchers and not the general
public. So, if that were the case, how would the physician
-- in the event of concern that Alice has raised, how would
the physician know to dispute that?

MR. WINTER: I think you probably want to include
a process as exists for open payments that would allow
physicians to review the data that are being reported about
them in terms of samples and dispute any data that they
disagree with or that is inaccurate.

DR. CROSSON: I'm sorry. I interrupted you.
Sorry.

MR. WINTER: So you may want a process where whoever is administering this database, whoever in HHS is administering the database, reaches out to physicians who are included in the database, to alert them to the fact that they've been reported as having received samples, and they should go in and review the information to confirm its accuracy.

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

MR. WINTER: Currently, CMS does not reach out to the 618,000 physicians who have been reported in open payments, not individually, but as a group, they try. They have efforts reach out to physicians as a profession but not individual physicians.

DR. CROSSON: Okay. Rita is up.

I'm sorry. On this point?

DR. BAICKER: Yeah, on that point. So I do believe it's quite widespread practice for pharmaceutical manufacturers to collect signature form physicians as they're handing out samples. So I believe the data absolutely exists. I don't know about 100 percent of 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
going downtown to some nice restaurant for a pharmaceutical industry-sponsored dinner, and then I kind of put that together with this exclusion thing.

And the same with patient advocacy organizations. I mean, when I worked in the Senate back in 2004, and took a lot of meetings as part of that work with patient advocacy organizations, you know, I was on leave from medical -- from my cardiology job. So, you know, and they would say things that didn't sound really quite right to me, certainly not at all with the evidence, so I started always asking about the funding of these advocacy, and every one of them was funded by a drug company that often was making whatever it was.

And, you know, it just changes, to me -- it's not a patient advocacy. It's industry-sponsored, you know, voice, and that's very different than, I think -- and it's not that we're talking about it but I think relevant to PCORI too, because I'm not sure that we're really hearing from patients in that patient center, when -- so I certainly think the reporting of funding for a patient advocacy is very important.

I wanted to also comment on the devices and the
drugs. You know, I think it's a good idea, for future work, to link open payments to Part B and Part D, but as you noted, a lot of the payments, even more than drugs, are from device manufacturers which would not be covered by Part B and Part D. I don't know if the unique device identifier, which still has not been implemented, would allow tracking of those payments, but I think it's important to think about how to track device payments, and, in particular, I think that's a lot of what I think is going on in orthopedic surgery, and we saw the very lucrative royalties and a lot of surgeons may develop their own devices, develop their own companies, have royalty agreements. And I think it's an important issue for beneficiaries because I don't think there is consistent disclosure when doctors are implanting a device that they actually are profiting from, and I do think that should be part of informed consent, which is sort of related.

And the last -- oh, and for drug samples, I also think that's a good idea to track. I would say, at UCSF, at least 5, maybe 10 years ago, we banned drug samples, and it -- which, by that time, you know, I've been there 26 years -- when I started I didn't really question it. But
then I started noticing that the only drug samples we ever had in cardiology were the very expensive new ones, you know, the sort of ones that, of course, you start your patient on these new, expensive ones and then they want to keep refilling it, and they were never, you know, the low-cost, you know, multiple drugs for every -- most cardiology categories. And so I thought it was a good idea when UCSF decided to ban them system-wide, because it wasn't really increasing access to all medications. It was just the very new and expensive ones.

And the last thing I was going to say, you know, on the research -- because I've heard some discussion, at least in medical meetings, about should research payments be considered the same as general payments, and I do think, you know, there's all kinds of industry-sponsored research. But there certainly -- and you cited some of the data, is data to suggest that industry-sponsored studies are more likely to find a positive result. I mean, there's a lot of ways to influence how you ask the question, how you choose your inclusion and exclusion criteria. And then the other problems with the failure to report negative results, which we know is a big problem because then we don't learn when
things don't work, which are all more likely to happen with a biased funding source.

So I think that was it. Thank you.

MR. WINTER: In terms of the device -- I'm sorry. In terms of the device, linking devices to individual physicians, device payments to individual physicians, one thing you could do is look at surgeons who get payments, high payments from device manufacturers that maybe make implants, and look at whether there's a correlation between the payments they -- those surgeons and their -- the rate at which they do certain implant procedures. So even if you -- you couldn't link the specific device company to a specific device that was used, but you could look at it more generally, in terms of physicians who received a lot of device company payments.

DR. REDBERG: I think that would be a great area for future work.

DR. CROSSON: Brian, on this point.

DR. DeBUSK: If you did -- if we did follow the recommendation of including UDI information on the CMS claims form, you would then be able, at the practitioner level, to be able to tie individual devices and individual
cases. If I'm not mistaken, I believe the open payments
and GUI ID databases actually mesh, using the same Dun and
Bradstreet identifier for the manufacturer. I believe that
data would actually mesh right out of the box.

DR. CROSSON: Okay. Very helpful.

Okay. Can I see, roughly, hands for discussion
here? Okay. So we have -- let's start here with Bill Hall
and go this way and then come around here.

DR. HALL: I think this is very informative work,
and I just want to make sure that we have a little bit of
historical perspective on this. When I graduated from
medical school, every medical student got a fancy bag from
one of the companies that I think is out of existence now.
I don't even remember which it was.

DR. CROSSON: It was Lilly.

DR. HALL: Lilly. That's right. Thank you.

[Laughter.]

DR. HALL: You're dating yourself.

Also, it would have a reflex hammer which is a
sort of medieval device you use to test reflexes.

[Laughter.]

DR. HALL: Also good if you're mugged sometimes
in the street.

And it was assumed that you would be showered with gifts at every medical meeting, including dinners, silly tee-shirts, pens, pencils, candy. I mean, it was a terrible situation, and study after study after study showed that no matter how people denied it, it influenced their patterns, sometimes for a lifetime. So the problem was real.

That's -- it's a total difference now. It's a completely different kind of system now, and I bet you that if we wanted to have efficiency of inquiry it would be the 5 percent and 90 percent rule, and some of that data was in your report, that it's probably 5 percent of the physician workforce that are perhaps -- need to explain why these payments are so high. So do you penalize everybody because of this -- the -- what might be called the 5 percent? So I think it might be helpful to do a little more analysis on that and see if we pick some cutoff arbitrarily, say does this kind of quote not sort of solve the problem.

At my own institution, which is no different than many others, we have to have a declaration as part of our faculty appointment. We have to list these things
separately. So the idea is you keep track of all of this.

As I'm sure Rita could speak to more informatively than I can, an article -- a research article that is submitted to a journal is almost automatically devalued if it looks like pharmaceutical support was there. So at -- evidence-based medicine says we don't know whether there was any problem here but the study would not be considered quite as worthwhile.

On the other hand, there are a lot of advances in medicine, a lot of information that needs to be distributed that might not otherwise be distributed. So I don't think we should throw the baby out with the bath water, but we took a serious look at this, was once a serious problem, but -- because the implication is that if you're on that list that you must be kind of crooked or something. I think the vast majority of people probably -- as was pointed out, probably had no clue that they were on that.

DR. CROSSON: Okay. Amy.

MS. BRICKER: So generally speaking a support the recommendations for changes to the open payments that have been outlined.

I wanted to take one of Rita's comments maybe a
step further, and I would be interested in further
discussion with my colleagues around the value of samples
with respect to the Medicare population. We know that
coupons, for example, are not permitted to be given to, you
know, Medicare beneficiaries, supplementing their out-of-
pockets associated with drug expense, and should we take
that a step further with samples for the very reason that,
Rita, you pointed out? Less about helping folks afford or
have access to very crucial therapies but more about
starting people on high-expense, new products, for them to
just be -- you know, need to continue or really not started
on what is, you know, in the best interest, potentially, of
the patient at the time.

So I'm interested in maybe looking at that in the
future. But, yes, support of tracking of that information
in the least. I don't know about the recipient's name and
address, and how far we have to necessarily go identifying
the patient, but if there's a way for us to track that back
to a Medicare patient, at a minimum I'm in support of that.

DR. CROSSON: You know, I'd just like to
emphasize support for what you said, because -- and Rita,
as well -- because it's been a while now but some number of
years ago, when I was working on the issue of drug use, and
we looked in a very large group practice, among all the
things that appeared -- this is not scientific, but based
on discussions -- that appeared to be influencing
prescribing patterns, you know, it was much less the free
pizzas -- and we didn't have very many of them, and they
couldn't have any pepperoni -- but it was the provision of
samples, and its impact both on the physician but
particularly on the patient who got used to taking a brand-
name drug when, in fact, in many cases, if not all, there
was a generic available.

It's a difficult issue because, to some degree, I
think it can speed up medical practice -- I mean if you can
just -- as a physician, if you can reach in the drawer
behind you and give the patient something very quickly and
easily, I can understand that, and I think from the
patient's perspective sometimes they view this as a net
gain. And yet I think, in the end, the Medicare program's
interest and the beneficiary's interest is not in this
direction. So I think it's -- anyway, my own experience
bears out what you said.

Going down, coming up. Jack.
DR. HOADLEY: So again, thank you for this paper.

It's really very helpful.

I mean, I think one of the things to keep in mind as we think about this, and this goes a little bit to what Alice and some others have said, is the purpose of this exercise is about transparency. We're not taking any action step in terms of saying, okay, based on the amount of money you get, something else happens to your payments.

So, I mean, that's the advantage of, you know -- people can go in, like you're doing, and analyze and see whether there are patterns that emerge, and if, in the example of the research costs, it does seem like it would be worth making sure we have the appropriate breakdowns of the amounts that go directly to the physician in question versus the expenses of actually running the trial, they could all be there and simply labeled in appropriate ways, or in the scenario you said, where the institutional payments could be pulled out differently. You've already got the issue where there's a PI but it's a whole team of people, and who do you attribute it to.

So the more of those details that are there it allows people like yourselves, who are going in and digging
into these data, to sort of understand. But again, the
point is transparency.

I'm supportive, I think, of the various things
you've identified on Slides 17 and 18, in terms of items
from our original recommendations. You know, we might want
to go back and think about payments from other entities.
PBMAs was mentioned. I mean, you could think about health
plan payments. Some of those might get farther afield and
doesn't really belong in this box, but somewhere along the
line that might be worth thinking about.

I do think maybe there's -- worth thinking more
about, from the question I asked in the previous round,
about the delay and whether we should recommend going back
to just a two-year delay or a notion of reporting the
amounts but not the purpose of particular things. So yes,
it's a payment from this particular company but not what
it's for. I mean, I think those would be things to at
least consider for other refinements.

I think on the research area, I think, you know,
there's a lot of good ideas here, and I can imagine -- and
I'm happy to offer more thoughts offline -- but, I mean, I
can imagine targeted studies for certain drugs, or certain
drug classes, such as some of the studies that you've referenced from the literature, where you're looking at brands in a class that has a lot of generic availability, or where there are several competing brands, and does it influence choices on the Part B side.

You know, we've talked, in our other discussions about classes, where there really are competing products, maybe at different price points for treating a particular thing, and by targeting into some of those particular cases, and the previous discussion about devices, even without the identifier you ought to be able to look at, as Brian was suggesting, at things in that same light. And I think trying to look at the high people -- the 5 percent or whatever percent of people with the highest amounts, and trying to figure out what's going on, it may turn out some of those are because they're PIs from much larger studies that go on, and it's not really money to them, that might look different than somebody else who's just had a lot of travel and a lot of straight-out gifts.

But trying to understand a little more of what's going on, and in your case, in your example of one hospital that had some enormous share of all the hospital payments,
again, there may be a perfectly legitimate story behind that, or not. I think trying to understand that would be useful as well.

And I do think -- I was going to add on the question of samples and things -- I mean, there are sampling -- sample kinds of programs that operate not at the level of the sort of traditional way of giving samples to individual docs, but there are organizations, particularly working with clinics and things. Virginia has a whole program where they collect samples from manufacturers -- there's still some of that issue of bias towards the brand products -- and then, in turn, those are made available to clinics that are working with poor patients, but without kind of that same, right, that same sort of direct relationship. And obviously that could be done in a way that encourages samples for generic products as well, operating through that process, you know, that can improve.

And then, you know, it would be also interesting since copay coupons, as Amy said, are not allowed in Medicare, but again, some of the aggregated programs or the ones within the IG's rules -- again, I'm getting a little
farther afield from where we started here -- but sort of looking what's going on and seeing if there's any issues in those. I don't know that it's a high-priority item for us, but something that we could consider looking further into.

MR. WINTER: Jack, can I just address two things that you mentioned? I just wanted to clarify that the analysis we did of the top 5 percent of physicians only included the general payments. We were excluding research payments. This is only things like consulting, promotional speaking fees, royalties, that sort of thing. So we left out research payments from that -- this analysis that's on that slide.

And then the hospital that we referenced that accounts for half of the payments to all teaching hospitals, they hold patents related to three costly cancer drugs, and so there's a manufacturer that's paying them for the right to use that patent -- those patents.

DR. HOADLEY: That may be a legitimate -- but again, that's where transparency --

MR. WINTER: Yeah.

DR. HOADLEY: -- if we say, okay, there's one but there's a perfectly understandable reason for it.
MR. WINTER: Right.

DR. HOADLEY: People can judge -- you know, people -- you can talk about that and people can judge if that's something we should worry about or not.

DR. CROSSON: Kathy.

MS. BUTO: It just occurred to me, Ariel. I don't know if you all have looked at the ACE demonstration, the orthopedic demonstration. You're probably aware of this. And the reason I ask is that I think underneath this whole issue is the concern that physicians are obviously going to be prescribing or using either devices or drugs based on their relationships, and not based on an overall management fee or ability to manage the care of the patient over time, including how well did they do after surgery, kind of thing.

And I guess I just wonder if one thing we can think about in the next iteration of this is, you know, what are -- aside from the reporting part, and getting greater transparency, what are the approaches that we might take as a commission to look at de-linking, or taking the relationship part out of this to a greater extent, and making it, whether it's a bundled payment or some kind of
other approach, that would give greater assurance that choices are being looked at, that there isn't steering going on based on personal investment or interest or compensation. So let's get underneath that and figure out sort of what are the kind of positive things that could be done to promote that kind of behavior, as maybe our next version or generation of this work.

Because I think, you know, the reporting always feels to me like you're chasing something, and that -- will you ever catch it? And my own instinct is it's really hard to catch once it's gotten going, but if we could figure out, to sort of get underneath that and move more toward how do you break that underlying strong tie, that would be useful. And I thought of the ACE demonstration because I know that that was part of the underlying rationale.

MR. WINTER: Right. And one important element of bundled payments, such as the ACE demonstration, is the ability for physicians and hospitals to gain share, for surgeons, other physicians to share in savings when they reduce device and supply costs, as long as patient quality is protected, and safety.

DR. CROSSON: Okay. Coming down this way. Did I
hear something?

MS. BUTO: Brian.

DR. DeBUSK: Regarding Kathy's comment, too, something like ACE or BPCI or CJR, when there is a gain-sharing component in place with that, you actually open yourself up to both ends of that, which is now not only do you have the potentially improper relationship but now you have potential stinting of the device, for example, going only to a low-demand hip across the board, where before maybe I used 50-50. And to the point that Rita made earlier, I think that's where having some of that UDI information available on a CMS claims form allows us to track patterns of use in both directions.

MS. BUTO: I wasn't -- I mean, I think you're right, there can be issues on both sides of it, but I do think, ultimately, what we want to do is inject more sort of, I guess, objective choice based on the patient need, and that's why reporting on outcomes is so important to that, I think.

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

DR. CROSSON: David.
DR. NERENZ: Just one friendly amendment point with regard to everything on 17, 18, 19. I would think that maybe in terms of sequencing we might focus first on Slide 19, about the analysis, in order, then, to prioritize the actions on 17 and 18. All the reporting things have some level of cost and burden associated with them that's going to be incurred by somebody, somewhere, and I think that we'd want to be thoughtful about where we ask that burden to be taken up, and just make sure they're aligned with the greatest priorities.

And by priority I mean how much evil is there in any of these areas? I presume it's not all the same, that there's some more evil some ways and some less evil other ways, and whatever burden of reporting we recommend to take on is just organized in that way. I suspect there's a little more we can learn through some additional analysis about the relationship between any kind of payment and some subsequent behavior change. So just a thought about that.

And then the last one is just, you know, we have to be careful what we wish for, if we play this chess game all the way out. And so all this reporting occurs and then less payments occur, or some change in payment occurs, and
then less bad behavior occurs. One of the consequences
maybe just more direct-to-consumer advertising, and that
has its own downside, and none of us can watch TV anymore
because there's nothing but ads on there that we don't want
to see.

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

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

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

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

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

DR. NERENZ: No, or actually make it part of the
reiterated recommendation, say whatever agency is going to
take this up, to actually mandate the reporting, might want to do that in priority order based on some things learned in addition --

DR. CROSSON: I see. I thought you meant --

okay.

DR. MILLER: That was one of my questions. And the other was -- and I think everybody gets this, but I just want to say it out loud. So the burden falls on the actor who's providing the money. So in a sense, the drug company and the device company have to decide that it's worth giving a meal or worth giving, you know, travel or something because they know they have to support it.

Now, that's not to say it's zero burden on the physician, because the physician does have to look in and say, okay, do I want to dispute this? But the large burden, you know, tends to fall on the actor who has decided to distribute the dollar here. I think, if I'm following your point.

DR. NERENZ: Oh, and I don't claim to know the ins and outs of corporate accounting. But then if those become tax-deductible business expenses, then somebody else picks it up. So it falls on us all somewhere somehow.
MR. THOMAS: Just on this page 17, it doesn't mention -- we mention PAs and MPs, but we don't mention pharmacists. I know in the chapter it was indicating that pharmacists are not part of the disclosure at this point. Is that something that -- is it a change that's being considered or would they still be excluded under your recommendations?

MR. WINTER: So our original recommendation included pharmacists. I think there's a full list somewhere in the paper. So here we were trying to highlight entities or people that were excluded that we thought were high priorities to include in open payments. So we're not saying we're backing -- I don't think we're saying we're backing away from saying that payments to pharmacists should not be reported. I don't think we're saying that. But I think we're trying to highlight which categories that were excluded are high priorities to be included, and this is really for your discussion. So we're not --

MR. THOMAS: Just getting back to Rita's point around nurses and pharmacists, I mean, I think it's important to understand if there's funding being done there
that we understand what that looks like, just like we would
a physician, because they're all involved in the care
decisions. And so I think it's important to organizations
that are involved with this and also for patients. I would
courage us to make sure it's a broad enough list or put
some materiality factor on it or whatnot. But if it's
above a certain materiality threshold, then I think it
ought to be recorded.

DR. CROSSON: And, Amy, on this?

MS. BRICKER: Just I would support that, Warner.

I think what we're finding is likely nurse practitioners
and PAs, you know, the prevalence of them was more limited
when this was a requirement, and while pharmacists today
don't have broad prescribing authority, they are advocating
and hoping to, you know, have that ability at some point.

So I think it's wise of us to, you know, require that
pharmacists also be included or any other practitioner, for
that matter, even if today it's quite limited, just so that
we're not back here having this discussion in five years.

MR. THOMAS: I think more like PharmDs or folks
that are involved in, you know, really helping to think
through what drug regimens will be, especially in the
inpatient world. I mean, they play a much, much bigger role now of kind of what the drug regimens are going to be in treatment.

DR. CROSSON: Okay. Thanks, Ariel. Thank you very much, and Amy as well. Thank you for a good discussion to the Commissioners, and we'll move ahead with the next presentation.

[Pause.]

DR. CROSSON: Okay. We are going to come back to a continuing discussion that we've had about what at the moment we're using the term "premium support" for, and our directive here, our goal, is to try to determine what design elements we might recommend if and when the Congress decided to pursue this rather substantial change in the Medicare program for the future.

Eric is going to take us through this discussion.

MR. ROLLINS: Good afternoon. Today I'm going to discuss how benchmarks and beneficiary premiums could be determined if Medicare used a premium support model for Part A and B services. This presentation is part of a broader exploration of premium support that we are undertaking during this meeting cycle.
We first discussed premium support at last month's meeting, where Ledia and Carlos examined the issue of rewarding high-quality care, and we anticipate presenting additional topics related to premium support in the spring. The Commission plans to include a chapter on premium support in its June 2017 report to the Congress, but this chapter will not make any recommendations. Your discussion on today's presentation will be reflected in the chapter.

I'd like to start by giving you a quick overview of the presentation. I'll first provide some background on the concept of premium support and then move on to discuss three key issues that would need to be addressed if premium support were going to be used in Medicare: the role of the fee-for-service program, the use of competitive bidding to determine benchmarks, and options for mitigating large increases in beneficiary premiums. I'll then raise some possible topics for discussion.

Moving now to Slide 3, the Commission has been examining premium support for a number of years as a way to encourage beneficiaries to use care in a more efficient manner. Under premium support, beneficiaries would choose
to enroll in the fee-for-service program or a managed care
plan, much as they do now. However, Medicare would make a
fixed payment for each beneficiary's coverage, and this
payment would remain the same no matter which coverage
option the beneficiary chose. The beneficiary premium for
each coverage option would then equal the difference
between its total cost and the Medicare contribution. This
means that higher-cost plans would have higher premiums,
while lower-cost plans would have lower premiums. As a
result, beneficiaries would have an incentive to use a
lower-cost plan.

If policymakers decided to use premium support in
Medicare, the role of the fee-for-service program is a key
issue that would need to be addressed. Premium support
proposals have taken a variety of approaches on this topic.
Some proposals would only use premium support to change how
Medicare pays managed care plans and would leave the fee-
for-service program untouched. Other proposals would treat
fee-for-service as a competing plan under premium support,
and some proposals would phase out the fee-for-service
program and rely entirely on managed care plans to provide
Medicare benefits.
There are strong arguments for treating the fee-for-service program as a competing plan in a premium support environment. Under this approach, fee-for-service would operate much as it does now, except that CMS would prepare a bid that reflects the cost of providing coverage through the fee-for-service program, and this bid would be compared to bids submitted by managed care plans to determine beneficiary premiums.

Treating the fee-for-service program as a competing plan would ensure that beneficiary premiums accurately reflect the difference between the cost of fee-for-service and managed care in an area. The fee-for-service program would also help limit Medicare spending because it would be the low-cost option in some areas of the country, and its presence would help keep the rates that managed care plans use to pay providers close to fee-for-service levels. Fee-for-service would also provide coverage in areas where no managed care plans are available. Finally, some beneficiaries will continue to prefer fee-for-service coverage, even if they might have to pay a higher premium for it in some areas.

Moving on now to Slide 5, in a premium support
system, Medicare would establish a benchmark that would serve as a reference point for the cost of providing Part A and B benefits. The method used to calculate the benchmark would be very important because the benchmark would be used to determine how much Medicare pays for coverage and how much beneficiaries pay in premiums. Higher benchmarks would lead to higher Medicare spending, as well as lower beneficiary premiums, since the difference between a plan's bid and the Medicare contribution would be smaller. Conversely, a lower benchmark would mean lower Medicare spending and higher beneficiary premiums.

The benchmark could be established through competitive bidding, as in the Part D program, or through some form of administered pricing, as in the MA program. The use of competitive bidding would likely give policymakers more accurate information about the relative price of fee-for-service and managed care plans, and thus result in beneficiary premiums that better identify the lower-cost plans in an area, particularly if the fee-for-service program is treated as a competing plan. One way to use competitive bidding would be to compare the fee-for-service bid to a representative measure of the managed care


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bids in a market area, such as the median or average bid, and use the lower of the two as the benchmark. This method would reduce Medicare spending by basing the amount it pays for coverage on the lower-cost delivery system in each area.

As I noted a minute ago, the benchmark in a premium support system would be used to determine how much Medicare pays for coverage and how much beneficiaries pay in premiums. This would be done by splitting the benchmark into two pieces: a base premium and the Medicare contribution. Once the Medicare contribution had been established, it would be the same for every plan in an area, including the fee-for-service program. The premium for a plan would then equal the base premium, plus any difference between the plan's bid and the benchmark. Plans that bid below the benchmark would have premiums that are lower than the base premium, while plans that bid above the benchmark would have premiums that are higher than the base premium.

Policymakers could set the base premium using one of two basic approaches. They could have the base premium equal a standard dollar amount that would apply throughout
the country, like the Part B premium. Alternatively, the base premium could equal a standard percentage of the benchmark. For example, in Part D, the base premium equals 25.5 percent of the national average bid.

One area of controversy in the debate over premium support has been the issue of limiting the annual growth of the Medicare contribution as a way to reduce program spending. Some premium support proposals would limit the annual growth based on a formula that is usually linked in some fashion to the overall growth of the U.S. economy, which historically has grown more slowly than Medicare spending. If this trend continued under premium support, the Medicare contribution would grow more slowly than the benchmark, and the difference would be made up by higher base premiums.

I'm now going to walk through two examples that illustrate how the bidding process under premium support could work. But before I do, I'd like to briefly review the key steps in the bidding process.

Step 1 is determining the benchmark. In the following examples, we assume that the benchmark would be set at the lower of the fee-for-service bid or the median
bid from a managed care plan, but this is a policy choice. Under this approach, the benchmark in some areas would equal the fee-for-service bid, and in other areas would equal the median plan bid.

Step 2 is determining the base premium. In these examples, we assume that there would be a standard base premium of $125 in every area, similar to the current Part B premium, but this is also a policy choice.

Then in Step 3, you would subtract the base premium from the benchmark to determine the Medicare contribution. As I mentioned earlier, the Medicare contribution would be the same for every plan in an area.

Finally, in Step 4, you add the base premium and the difference between the plan's bid and the benchmark to determine the premium for each plan.

In the first example on Slide 8, there are a total of six bids in an area: the fee-for-service bid, which is the column on the left, and five bids from managed care plans, which are the columns on the right. The bids from the managed care plans are sorted from the low bid, which is Plan A at $680, to the high bid, which is Plan E at $800. Each bid shows the cost of providing a standard
package of Medicare benefits to a beneficiary of average health, which allows bids to be compared on an apples-to-apples basis.

This example shows how premiums would be determined in an area where the fee-for-service bid is $700, which is a relatively low amount. CMS would determine the benchmark by comparing the fee-for-service bid to the median plan bid of $740 from Plan C. Since the fee-for-service bid is lower, the benchmark in this area would be $700. The standard base premium of $125 would then be subtracted from the benchmark, resulting in a Medicare contribution of $575 for every plan in the area.

This is the gray portion of each column.

The beneficiary premiums for each plan are shown in green. Since the fee-for-service bid equals the benchmark, the premium for fee-for-service coverage in this area equals the base premium of $125. The bid for Plan A is $20 lower than the benchmark, so its premium would be $20 lower than the base premium. Since the bids for Plans B through E are higher than the benchmark, their premiums would be higher than the base premium and would range from $135 to $225 per month. So beneficiaries in Plan E would
face a premium that is $100 higher than the premium for the benchmark plan in the area. They could choose to either stay in the plan and pay the higher premium or switch to a lower-cost plan.

The second example shows how premiums would be determined in an area where the managed care bids are the same as in the first example, but the fee-for-service bid is $800 per month instead of $700. Since the fee-for-service bid is higher than the median plan bid of $740 from Plan C, the benchmark in this area would equal the median plan bid of $740. The base premium would still be the standard amount of $125, but it would now buy coverage from Plan C instead of fee-for-service. The Medicare contribution for every plan in this area would be $615, which is the difference between the benchmark of $740 and the base premium. The bids from Plan A and Plan B are lower than the benchmark, so their premiums would be lower than the base premium. The bids for the fee-for-service program, Plan D, and Plan E are all higher than the benchmark, so their premiums would be higher than the base premium. In this area, beneficiaries in fee-for-service and Plan E would face premiums that are $60 higher than the
benchmark plan in their area. As in the first example, they could choose to either stay in the plan and pay the higher premium or switch to a lower-cost plan.

Turning now to Slide 10, it is well known that Medicare spending varies significantly across the country due to regional differences in payment rates, beneficiaries' health status, and service use. The Commission has found that variation in service use accounts for about half of the overall variation in spending. Some variation in spending remains even after spending has been risk-adjusted to account for geographic differences in beneficiaries' health, and much of this remaining variation appears to reflect regional differences in physician practice patterns. In a premium support environment, policymakers would need to decide who should pay for this remaining variation. When this issue has been raised in previous presentations, the discussion among the Commissioners suggested that beneficiaries living in high-cost areas should not be expected to pay for this remaining variation because there is little that they can do to control it. Two components of the bidding process would be particularly important in this regard: the bidding areas
This slide uses three simplified examples to illustrate why the bidding areas and the method used to set the base premium would be important. In these examples, Area 1 has average per capita spending of $850 per month, and Area 2 has average spending of $1,000 per month. The same number of beneficiaries live in each area, so average spending for the entire country just equals the average of the two regional figures, or $925.

These three examples show base premiums and Medicare payments under three different bidding processes. Note that the sum of the premiums and the sum of the Medicare payments are the same in each example. The only thing that changes is how premiums and Medicare payments are allocated between the two areas.

The first and second examples show the impact of using local bidding areas. In the first example, the benchmark is set nationally at $925. The Medicare contribution equals 86.5 percent of that, or $800, and is the same in both areas.

The base premium equals the difference between
the average cost in each area and the Medicare payment. As a result, beneficiaries in Area 1 pay $50, and those in Area 2 pay $200. Under this approach, much of the cost of the additional spending in the high-cost area is borne by the beneficiaries who live there, in the form of higher base premiums.

In the second example, the Medicare contribution still equals 86.5 percent of the benchmark, but there are now separate benchmarks for each area. Compared to the first example, the Medicare contribution in the high-cost area is higher and the base premium is lower. For the low-cost area, the reverse is true. The use of local bidding areas, thus, shifts more of the Medicare spending to high-cost areas.

The second and third examples show the impact of setting the base premium as a standard percentage versus a standard dollar amount.

In the second example, the base premium equals 13.5 percent of the area's benchmark, while in the third example, it equals $125 in both areas. If the base premium equals a standard dollar amount, premiums in the high-cost area are lower than they would be if the base premium
equals a standard percentage of the benchmark. The reverse is true in the low-cost area. The use of a standard base premium, thus, also shifts more of the Medicare spending to high-cost areas.

Moving now to Slide 12, the illustrative examples that I discussed earlier would give beneficiaries an incentive to enroll in the lower-cost delivery model. That incentive would be provided through beneficiary premiums that vary based on the relative costs of fee-for-service and the median plan bid in each market, although I would like to reiterate that those are policy choices. As a result, the extent to which those two figures differ would be a key factor in determining how much premiums might increase or decrease.

This slide shows the distribution of the difference between fee-for-service spending and the median MA bid for 2016. The values on the horizontal axis show local average fee-for-service spending minus the median MA bid in each market. As you can see, there are areas where MA is more expensive and areas where fee-for-service is more expensive.

The two biggest columns in the slide indicate
that about 45 percent of beneficiaries live in areas where local average fee-for-service spending and the median MA plan bid are within $50 of each other. Under our illustrative examples, the change in premiums for these beneficiaries would be relatively small.

On the other hand, about a third of beneficiaries live in areas where local average fee-for-service spending and the median MA plan bid differ by $100 or more. Most of these beneficiaries live in areas where fee-for-service is much more expensive than MA. That's the right-hand tail of the distribution. But there are also some beneficiaries who live in areas where MA is much more expensive than fee-for-service. That's the left-hand tail of the distribution.

Tables 4 and 5 in the mailing materials list the biggest markets where MA and fee-for-service premiums would see significant increases, if benchmarks were set at the lower of fee-for-service costs or the median plan bid.

Given the magnitude of the potential increase in premiums in some areas, many of you have expressed interest in exploring how policymakers could mitigate the impact of large increases on beneficiaries. We will turn to that
There are a number of ways that policymakers could mitigate the impact of higher premiums, and this slide lays out just some of the options. As we go through these, keep in mind that premium support is meant to give beneficiaries a financial incentive to use a more efficient delivery model for receiving their Medicare benefits, and that beneficiaries could avoid paying higher premiums by switching to a lower-cost plan. Mitigating the impact of higher premiums would reduce the effectiveness of that incentive.

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

Second, policymakers could limit how much premiums increase from year to year, using either a dollar or percentage limit. Under this approach, the transition to the new system would take longer in areas where the...
difference between fee-for-service and the median plan bid is larger.

Third, in areas where fee-for-service premiums rose significantly, new Medicare beneficiaries who are now enrolled automatically in fee-for-service could be enrolled instead in lower-cost managed care plans.

Fourth, policymakers could provide subsidies that would pay some or all of the premium for low-income beneficiaries. As part of this, policymakers would need to decide which beneficiaries would be eligible for a subsidy, what kind of subsidy they would receive, and how the subsidies would be financed by the federal government and the States.

This next slide demonstrates how different approaches could be used to mitigate premium increases. The figures here are based on an analysis of MA plan bids and projected fee-for-service spending for 2016.

Like the illustrative examples that we discussed earlier, we assumed that there would be a standard base premium and that the benchmark would equal the lower of the fee-for-service bid or the median plan bid.

This time, we used the Chicago area as an example.
because it is one of the largest markets where the cost of fee-for-service exceeds the median MA plan bid by $100 or more. Given the data that we used for this analysis, the base premium for 2016 would be $106. Here, we roughly project premiums for 2016 through 2021, using growth rates from the latest Medicare Trustees' Report, and assume that the transition to the new system starts in 2017.

The green line at the bottom of the graph, marked D, shows fee-for-service premiums under current law. The yellow line at the top, marked A, shows how fee-for-service premiums would increase if Medicare switched immediately in 2017 to the new system for calculating premiums.

The two lines in between, marked B and C, illustrate two options for mitigating the increase in premiums. Under Option B, the higher premiums are phased in over a five-year period and take full effect in 2021. Under Option C, fee-for-service premiums could not increase by more than $20 annually during the transition to the new system. Given the size of the difference between local average fee-for-service spending and the median MA bid, the transition to the new system would still be under way in 2021 and would likely take more than a decade to fully
Again, these options are for illustration only, but they demonstrate how policymakers could substantially mitigate the impact of higher premiums under a premium support-type model. Obviously, though, mitigating premium increases would also weaken the impact of using premium support.

Moving now to the last slide, I'd like to close with some potential topics for discussion. From our earlier presentations on premium support, the discussion among Commissioners has suggested that there are arguments for setting benchmarks and beneficiary premiums using a method that has five key elements: one, treat the fee-for-service program as a competing plan; two, use competitive bidding to set benchmarks; three, use local health care markets as bidding areas; four, set the benchmark in each area at the lower of fee-for-service or managed care; and five, use a standard dollar amount as the base premium.

We would like to hear your views on these elements, keeping in mind that the chapter on premium support that we are planning to include in the June 2017 report will not contain any recommendations.
In addition, we would also like to hear your views on whether, how, and to what extent policymakers should mitigate the higher premiums that some beneficiaries would face under premium support, given that it is designed to encourage beneficiaries to use lower-cost ways of receiving their Medicare benefits.

That concludes my presentation. I will now be happy to take your questions.

DR. CROSSON: Thank you, Eric. Nice, clear presentation of a very complicated area.

So we're going to do clarifying questions. I see Kathy, Paul, Bruce, Jack -- Kathy, Paul, Jack, Amy, Bruce.

Kathy?

MS. BUTO: Thanks, Eric. This was very clear on a very complex issue.

My question is about those areas where we found fee-for-service spending is high and the MA -- I guess the median MA plan cost is relatively low in comparison. Did you take into account in thinking about the out-years the issue of managed care penetration? In other words, fee-for-service spending might be high, but let's say 80 percent or 95 percent of the population is in fee-for-
service. So, if you then use the median cost plan, MA
plan, as kind of your benchmark, you're really basing it on
a fairly small number of beneficiaries compared to the
total. I didn't know if you took any of that into account.

MR. ROLLINS: For the purpose of this example, no. It was just here's what the premium would look like.

MS. BUTO: So is that something we should look at? Because it strikes me that we base the benchmark on
the lowest cost or the median low-cost plan or whether it's fee-for-service or MA, but most beneficiaries in the area or in the other were really then going to create some real dislocation. And you can mitigate that, but I'm just wondering if it's something we ought to look at.

MR. ROLLINS: I think that's collectively your decision and something you're going to have to grapple with. You can make the argument that to the extent that you want to encourage or provide an incentive for people to go to managed care plans, do you want to have some -- are there some hurdles that need to be cleared before you can say the managed care plans in this area are well established and they have the capacity to serve a much larger number of beneficiaries?
There have been proposals from other organizations where premium support would only sort of kick in once managed care penetration in a particular area had hit a certain threshold. That's an option you could consider.

DR. MILLER: I hate to do these kinds of conversations on the fly, but the other way, does some of that get mitigated if you go to more of a straight average of the premiums between fee-for-service and MA instead of taking a lower of? Is that another way?

MR. ROLLINS: You could do that because, if you did an overall weighted average across fee-for-service and managed care, those benchmarks would generally be higher than the example I was walking through in this presentation, so that the impact on premiums would be smaller.

DR. MILLER: [Speaking off microphone.]

DR. CROSSON: Okay. I have Pat, Paul, Jack, and Bruce.

MS. WANG: You may have had this -- I have a for example questions. Is it okay if I just rattle them out?

MR. ROLLINS: Can I take them one at a time?
MS. WANG: One at a time. Okay.

[Laughter.]

MS. WANG: It's probably in the paper, but can you remind -- there are a lot of beneficiaries who only purchase Part A and who don't pay any Part B premium today. Does the premium support analysis assume that everybody will have A and B? Because for somebody, obviously, who is only A today and is paying no premium, this would be a big change, much less like what the premium would be.

MR. ROLLINS: The analyses that are in the paper are sort of agnostic on that question. That's definitely an issue that policymakers would need to grapple with is we still going to allow people to be Part A only or to be Part B only, or would this be sort of a new model where sort of if you're in Medicare, you're getting A and B.

MS. WANG: Yeah. Okay. That's something to --

DR. MILLER: That's a really good question because it really does force that issue.

MS. WANG: Yeah, yeah.

MR. ROLLINS: And with the baby boomers now, the number of people who are Part A only is going up pretty rapidly.
MS. WANG: Right. Partly because the premium for Part B is becoming unaffordable, so some big implications here.

When you looked at identifying a median MA bid, is there a consideration around narrow network plans that really do not look comparable to fee-for-service? So, if you're going to make fee-for-service compete against MA plans, should there be consideration about creating a bit of a level playing field about the benefit that somebody is getting? I mean, narrow network products are definitely cheaper, but I think consumers have to be quite educated about what they're buying before they do. And if you set the benchmark premium or Medicare contribution based on the low-cost option, which is driven by something that is a much skinnier network than fee-for-service, is that an unfair competition?

MR. ROLLINS: I'm not going to characterize it as fair or unfair.

Certainly, I think you would want to have some sort of minimum standards, like they have now in the Medicare Advantage program about network adequacy. That being said, I think an environment like premium support,
you're not going to get away from this notion of one way
you can deliver the Medicare benefit package in a lower-
cost fashion is to use a narrower network or restrictions
on which providers beneficiaries can use.

MS. WANG: I suppose you could also -- assuming
there were enough MA bids, you could drop the lowest and
the highest or something like that to maybe try to adjust
for something like that?

MR. ROLLINS: You could do that, and that's one
reason the examples that are in the paper sort of focus on
the median bid or the average bid and sort of not putting
too much weight on the bid from sort of one end of the
distribution of the managed care sector, sort of taking the
middle of the distribution.

MS. WANG: Now, this also --

DR. GINSBURG: Can I ask a follow-up on that

question?

DR. CROSSON: Okay. Pat, Paul would like to make
a point on that point; is that all right?

MS. WANG: Of course. Sure.

DR. CROSSON: Go ahead.

DR. MILLER: That's the one that Warner is
supposed to have.

[Laughter.]

MS. WANG: Turn your mic off, Jay.

DR. GINSBURG: Okay. Just on the narrow network plans, I don't think that we will see in Medicare Advantage anything to the degree that we're seeing narrow network plans and marketplace plans because of the fact that, for various reasons that we don't have to go through now, what Medicare Advantage plans pay hospitals and physicians are very similar to Medicare rates. So, in a sense, there's not the usual, let's say, privately insured reason for having a narrow network to keep your enrollees away from some very high-priced providers and to be able to get -- restrict the networks to get lower prices.

So I think that to the degree that we're going to see narrower networks in Medicare Advantage, it's probably going to be driven by plan assessments as to which providers are more efficient using some of the tools, like looking at bundled payments -- not using a bundled payment, but assessing cost per episode of care or this physician's rate of -- to what degree do this physician's patients use the emergency room. I think that's what we are more likely
to see in Medicare Advantage than we're seeing in the
marketplace.

DR. CROSSON: Go ahead.

MS. WANG: Okay. Can you explain a little bit
more about -- so the bids are based on the average, which
sort of suggest like a risk score-neutral beneficiary. Is
there a risk adjustment in the program after a beneficiary
joins and has eight chronic conditions and is polypharmacy
and has got all of these needs? How does that run through
this kind of model, and what happens to the beneficiary
premium in particular?

MR. ROLLINS: So risk adjustment would be used in
sort of two stages of the process and would very much be a
key part of it. The first would be when you are comparing
the bids from different plans in a particular area. You
would need the average risk score for each plan to then
adjust their scores -- use the scores to adjust their bids
to reflect a beneficiary of comparable health across all
the different options.

The examples that are in this presentation sort
of assume that the bids have already been risk-adjusted, so
that it's, as in the MA program, the risk score is 1.0, and
so they can kind of be compared sort of apples to apples.

So that's sort of the first part.

The second part would be, as we do now in the MA program, if you have beneficiaries who said, "I want to enroll in a managed care plan," you would need to risk-adjust the payments that go to the plan to reflect the additional costs that are due to the differences in their health status, so something at least at the outset of the premium support that would be fairly similar to the HCC risk adjustment methodology that we now have.

MS. WANG: So the policy decisions around whether the beneficiary contribution is a fixed-dollar amount or some percentage of premium could affect the beneficiary portion if it were a percentage, for example, of a higher per cost?

MR. ROLLINS: Under these examples, the premium would not vary based on the differences in your health status.

MS. WANG: Okay.

MR. ROLLINS: The amount that Medicare pays to your plan would vary based on your health status.

MS. WANG: Okay. I got it. Thank you.
Inside the study, there was a -- in the
description of local areas and local markets, there was a
statement based on your analysis that -- I mean, I think
you took plans that served at least half of beneficiaries
in a local market area, and a lot made the cut. Can you
say how many fell off? I mean, the question is about local
plans and what the definition of local market areas might
do. I think, as we talk about SNP plans and so forth,
which would tend to be much smaller -- the bigger the
market area, the more we are pushing towards plans of a
different model with maybe regional plans, national plans,
as opposed to local plans. So I was curious about that.

MR. ROLLINS: So a couple of things. The first
is you were talking specifically about special needs plans.
For the table in the mailing materials that talked about
plan availability in each area, we set aside the special
needs plans and the employer-sponsored plans because
they're not sort of broadly available to the Medicare
beneficiaries who live in a particular area. And that's
another set of issues that would need to be addressed under
premium support as sort of what's the role of those plans
under a premium support model.
In terms of, I think, the first part of your question, how many plans did we exclude because they only served a portion of the service area, I don't have that sort of at my fingertips. It's knowable. My recollection is it didn't make a huge impact. But as I said, we can look into that.

MS. WANG: Thank you.

DR. CROSSON: Okay. Just to clarify, I've got Paul, Jack, Bruce, and Bill Gradison just for clarifying questions.

DR. GINSBURG: Yes, I wanted to clarify the role of policy recommendations in the chapter in June. I mean, it's clear that we are not going to recommend for or against premium supports, but as we go through these issues, are we going to take the stance, well, if Congress decides to do premium support, it would be better if they treated the fee-for-service program like a competing plan, et cetera?

So are we just going to run through -- analyze these issues, not come to a conclusion, but just have Congress benefit from our analysis?

DR. CROSSON: Sometimes we throw the term
"recommendations" around loosely, but for the most part, when we make a recommendation, we vote up or down, and it's in bold type and it's delivered specifically to someone, usually the Secretary or Congress. We are not doing that.

DR. MILLER: That's right, and so the way I think about is what we've tried to do in these conversations is capture the drift where people tended to think about things. And something that Jay said at the outset or earlier, if I'm remembering right, is the Commissioners tended to be concerned about, you know -- think of the consolidation conversation we had this morning -- runaway prices, and so that kind of drove them into the fee-for-service should be part of the mix argument. And then a lot of the other design issues were about how much risk does the beneficiary bear relative to the program, and that drove a lot of the other decisions.

So what I was thinking -- and, you know, this is to be worked out -- is there's no recommendation, but the writing in the chapter would be you could do this different ways, but there are strong sets of arguments for doing it this way. And so that, you know, the astute reader, and perhaps even the less astute reader, should be able --
[Laughter.]

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

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

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

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

DR. COOMBS: I had a question about that, and I don't know if I'm getting into Round 2. I don't think so.
But would there be -- as I read the chapter, a constant theme was is there a role for us to be issuing some kind of element of prognostication in terms of how well it would work and which setting we would be concerned about certain barriers for this to be a successful plan.

That kind of information for Congress would be valuable in terms of how this thing would grow legs and walk out the door and work. And so that kept being a recurring theme for me, is how likely is this to work in all sectors of Medicare with all of the contingencies that we're dealing with today. And maybe the next round we can kind of talk about that.

DR. CROSSON: So I might say in part, yes, to the extent that these design discussions are focused in on, you know, if you do it this way, you get a better competitive dynamic than if you do it some other way. Now, that presumably leads to long-term success as opposed to failure, but it's certainly not the only other -- not the only element.

The second element is to what degree does this take into consideration and serve to protect beneficiaries, you know, and I guess to line that up with long-term
success, we'd have to be something, you know, approaching a
political public policy issue as opposed to a financial or
operational set of parameters.

But I don't think -- and please correct me -- I
don't think we have the intention to have a discussion with
takes the whole range of issues, financial and, you know,
delivery system organization and payment methodology and
all the things that would potentially lead to this model
working. Some of these we've discussed in other papers and
other chapters and at different times. But this work is
not meant to be comprehensive in that way. Is that fair?

Okay. So we go to Jack.

DR. HOADLEY: So one comment that sort of picks
up on a couple of the previous questions talking about the
use of medians and averages, I mean, I think we should
think a lot about where it should be a weighted average
versus an unweighted average. In Part D, there was the
experience that some of the parameters were initially
implemented -- obviously, in the first year they had to be
unweighted because there was no enrollment weight. But
even after the first year, there was some use of unweighted
average that ended up having some unintended consequences.
And at least in the Part D bidding, you know, the unweighted average can be a quarter to a third higher than a weighted average. So I think that is one other variant on parameters we should keep in mind.

My question is a little different. I think I've asked a version of this question before, but it was sort of triggered again by Slide 12 and the distribution of sort of where current day bids. And, obviously, all of this is using current situations to illustrate what might happen. But the question really is: Have we thought about how the bidding dynamics really change under a different set of rules? So these are bids that come in under a system that has fixed benchmarks that plans bid to, and they know -- you know, they're higher in some low fee-for-service areas, they're low or they're intended to sort of bring -- you know, have a certain effect. And if you change the bid to this kind of a more open bidding system, I don't know if there's a bidding literature or something we can go to to say, you know, what would -- how different might we expect so we're not sort of setting up this expectation that this really does reflect what the world might look like, even though we write lots of caveats and say this is only what
we -- it's obviously the right starting place, but it does seem like some discussion of sort of where the bidding dynamics could operate differently would be helpful to sort of think this through.

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

That being said, the magnitude of the change in the bid was, I think, 3 or 4 percent, so they didn't -- you know, they thought directionally they would probably go down, but they weren't willing to say that the bids would necessarily change a lot. But that is, as you note, one of the great sort of unanswered questions about how this would
DR. HOADLEY: My gut -- I don't know any -- you know, I'm not an economist, and I'm not an expert on bidding, but my gut says that if you go from the benchmarks that are, you know, 95 percent of fee-for-service or 110 percent or whatever and you've got something that says, well, fee-for-service is just going to be in the mix, that you could potentially see quite different bidding, and it wouldn't always be lower. It could be higher in areas. It just seems like it mixes things up a lot. And if there's any way to get somebody who really knows this area to, you know, help inform us on sort of what changes you might expect under some of the scenarios we're envisioning, it seems like that would be helpful.

MR. PYENSON: Just to pick up on Jack's point, I think an analogy, a historical analogy might be to see what's happened in Part D bids where the dynamics there are heavily driven by organizations going for the low-income subsidy market. But I believe some of the studies probably from CMS have identified the role of the risk corridors in letting plans bid lower than they otherwise would have. And that might be a feature of risk corridors that -- I
don't know if you've examined that as a transitional
element or permanent element for stability?

MR. ROLLINS: It's not something that we've
looked at in great detail given that the Medicare Advantage
program seems to have operated fairly well for many years
now without using them. But as you note, that would be one
option that could, in theory, give plans a little more
leeway to bid more aggressively. How much, I do not know.

MR. PYENSON: Just a couple of other questions.

I believe the paper identified advantages of looking at
regional -- bids on a regional basis compared to a county
basis.

MR. ROLLINS: So based on some work we did a few
years ago looking at the Medicare Advantage program, we did
make a recommendation to use areas that are larger than the
county-based areas that we now have in Medicare Advantage.

That being said, these would be regions that are
still very much regions and not getting up to the level of
state or something like that, which you have in Part D. In
urban areas, this would be sort of within the same MSA and
within the same state. That would be a region sort of as
you used the term. I think in the paper we used "market
area." And then for rural parts of a state that are not part of an MSA, they'd be part of a -- I'm forgetting the term. "Health service area," I think.

DR. MILLER: Yeah, it's basically the commuting pattern [off microphone].

MR. PYENSON: HRR kind of concept.

DR. MILLER: [off microphone].

[Laughter.]

MR. PYENSON: I thought it was a MedPAC area, MedPAC unit. But just a consideration on there. Provider-sponsored organizations are often more local than that, so finding a way to think about the impact on provider-sponsored organizations, I wonder if you could do that.

Another question gets at Jack's question, perhaps, and, you know, we've seen, as you know, in the history of insurance, there always seems to be insurance companies that forget and decide they're going to buy market and make it up in the next year. And it never works out well for them or for their competitors.

Now, there's a limited ability to do that under the current bids for established plans, but I think that gets at perhaps a nuance in is it the bid or some bid
adjusted for a standardized profitability or standard --

you know, that is if a plan is bidding at a loss and they

have a low bid because of that, that might not be an

appropriate contributor to the benchmark. So I'm wondering

if you've got -- if that's worth getting into that kind of
detail.

MR. ROLLINS: Obviously, that's something that we
can discuss. My off-the-top-of-my head reaction is that
might be a little sort of down in the weeds and sort of
more kind of a CMS area. I don't know, you know, to what
extent that's part of their existing bid review process.

We did sort of have that possibility in the back
of our minds, again, when we were setting the benchmarks
that we wanted to use maybe the median bid, which more
technically in our example was a weighted median bid,
weighted by the actual enrollment or enrollment-weighted
average, to give more credence to the plans that are
actually operating in the area and actually have enrollment
and guard against, you know, sort of a new plan sort of
coming into the area and pricing really aggressively
without any real proof that they can make it work.

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

I don't know. I don't mean to be pouring cold
water on this, but politically, I just don't see how you
get -- how are you going to get somebody from Miami,
Florida, to vote for this thing if it's any increase at
all? I mean, that's a rhetorical question, but it's worth
thinking about.

DR. MILLER: Well, there's a couple things. The
last thing is a rhetorical question, and, you know, we'll
go through the plan and the design issues and, you know,
this is something that you know Congress periodically comes
back and actively discusses, and the mechanics of them
getting the votes are their problem. So, you know, I just
want to make sure -- and I know you said it was a
rhetorical question for all those reasons. I just want to
reinforce it with them -- with everybody else.

But some of his answer is right here, isn't it?
The distribution of who potentially pays and who --

MR. ROLLINS: Yes, and then I was also going to
point out there's a table in the paper that sort of says if
the benchmark was based on -- if you compared fee-for-
service to either the low bid, the median bid, or the
average bid, sort of which is lower in your particular
area? And under all three of those options, at least two-
thirds of beneficiaries were living in an area where the managed care, the median bid is lower than fee-for-service.

MR. GRADISON: It's two-thirds of two-thirds [off microphone].

MR. ROLLINS: Roughly --

MR. GRADISON: Total population under Medicare [off microphone].

MR. ROLLINS: Very roughly although -- very roughly. But, again, the magnitude of how much your fee-for-service premium would go up would depend on that, sort of what's the gap between fee-for-service costs in your area and the median bid. And as that shows, there's a lot of variation.

DR. MILLER: And, Bill, the other point I wanted to make off of your point is it's not just a fee-for-service consideration, because your point -- and mine often starts here, too -- goes right to Miami and you sort of go, well, wait a minute, how is that going to work? But, remember, there's markets in other parts of the country where you're going to have to pay to stay in MA.

So, you know, your dynamic of, like, well, who is going to support this actually cuts in both of those
directions. You know, like I don't want my fee-for-service constituents to pay more, but in some markets it's going to be, but wait a second, my MA constituents are going to pay more.

So there are some real serious dynamics, and I think what this chapter, among other things, is trying to do is lay this out so that people understand what they're actually constructing.

DR. CROSSON: Warner.

MR. THOMAS: Have we done this similar analysis over a period of time, and do we have any idea what this may look like as we kind of trend the escalation of traditional Medicare costs versus MA?

MR. ROLLINS: We have not looked at it over time. I suspect at least over, you know, comparing one year to a year or so and not looking over a long period of time, I suspect this distribution looks roughly similar.

MR. THOMAS: So you don't really think that there's a -- any difference in cost control between fee-for-service Medicare and MA?

MR. ROLLINS: I will welcome input from any of my colleagues. I'm not under the impression that over the
long term, per capita cost growth would be different in Medicare Advantage than it would be in fee-for-service. The shift in Medicare Advantage, you might get some transitional changes in utilization and things like that through better management and things like that. It's very unclear, over the long term, that sort of the long run cost growth is different in a managed care setting than in fee-for-service.

There are some who argue, under premium support, that if enough people were in managed care they might collectively insert more control over that, but that is obviously somewhat speculative.

DR. MILLER: Yeah, and I was also going to draw the distinction between, you know, what you can do with static data and say, well, if you could try and straight-line project -- you know, do some straight-line projection stuff, and I think his point stands. Your point could also be, but wait a minute. Doesn't the dynamic change significantly under a bidding structure like that -- which is Jack's point -- and that is very hard for us to estimate because there's not a lot of experience with this.

But the other thing I think I would say is Eric,
the CBO report that you referred to a few minutes back, they did make some assumption about how much they thought they would get out of this, and my recollection, which is very consistent with your answer, is they got a few points but they didn't necessarily get a different trajectory of time, was sort of what I took away from it, which is a relatively aggressive group of folks who took a look at this and know things like this.

MR. ROLLINS: [Inaudible.]

DR. CROSSON: Okay. I think we are ready for the general discussion. Let's see if we can throw up Slide 15. It's going to be the basis for the discussion.

So, you know, I think comments can go where they go, but I particularly want to know if we have Commissioners who disagree with one of those five bullets, because otherwise the assumption is since this direction or these design elements have been kind of accrued over a period of time, that there's a general belief that these are the right ones, for the purposes that we're engaged in.

So we've got Paul and Jack who are going to start. Paul, we'll start with you.

DR. GINSBURG: Oh, great. I think the materials,
the presentation, Eric, were really excellent, not only clear but very sophisticated in their understanding of these issues.

I'm very interested in premium support. I've worked on it in the past. My sense is that the issue stopped being debated in Congress after the 2012 presidential campaign. In the jargon, it became toxic. I think premium support will be an important issue in the future, and I think it's really terrific that the Commission is having these discussions so that Congress will be much better prepared when the political winds shift and premium support is no longer toxic and something they're eager to support -- to consider.

I'm comfortable with all five of the points, the elements. I have comments on a couple of and I want to propose a sixth element. One is as far as using competitive bidding to set benchmarks. I think it's really important to think along the lines of weighted means in MA, rather than points in the distribution, like the second-lowest, or even the median. And the concern is about areas that have a fairly small number of MA plans, and just the potential for gaming, if we're, you know, really targeting
it on one particular point in the distribution.

I agree with using local markets as bidding areas, and the materials that were sent ahead I think suggested that it should be an entire local market that's the bidding area. And I just want to point out that particularly as we're making the local areas larger than counties, that there probably will be many considerations where provider-sponsored plans, or plans that are partnerships between a provider organization and an insurer, may have difficulty really covering the entire area.

I also could see reading it, how much more complicated it gets when you have entities bidding for only part of the local market area. So it may be that it's just too complicated to do that. That's just something to target.

And the additional elements I want to bring up is that, you know, I think one thing that was an unwise addition to many of the premium support proposals we saw a few years ago was another element, which was -- let's call it a cap, you know, that the benchmark can increase more than the CPI or GDP+1 or some other index. I believe in
having -- you know, certainly there is a mechanism in premium support that's really harnessing beneficiary choice, it's harnessing plans behaving differently as their MA market becomes more competitive, and I think that's where the savings should come from.

I think if you put in artificial limits you enormously increase the uncertainty of what this means to the public. In a sense, does this mean that Medicare will no longer -- Medicare support will no longer rise in proportion to health spending? You know, is there this possibility that it will rise less than health spending and I will be responsible for an increasing proportion of health spending over time?

You could set up a premium support without that. If the savings were disappointing, Congress could always come back to a cap. But I think building premium support with a cap, which is usually motivated to get a bigger score from CBO, is really a mistake. And, you know, we're racking up increasing examples that when Congress puts in unrealistic targets like SGR, and, you know, has a hell of a time undoing the mess it's gotten itself into.

DR. CROSSON: Thank you. Jack.
DR. HOADLEY: So I want to go back to sort of the fundamental question here of whether we think that beneficiary choice can drive efficiency, which is sort of what's really framed this discussion. And to the extent that I answer the question no, I think -- you know, I come back to the question of why risk some of the disruptions that this create. And I continue to be very concerned that some of the reasons we think beneficiary choice leads to efficiency just don't hold up. There are challenges for beneficiaries in making decisions about plans, ranging from the inadequate information available.

There's an issue this year on Plan Finder, where you can't directly look up the additional benefits that Medicare Advantage plan provides, so there are problems all along with Plan Finder in terms of comparing traditional Medicare to fee-for-service, to looking up network -- you know, whether your providers are on networks. And so that's one part of it, the confusion of trying to sort out choices in a very complex environment.

Lack of standardization, I know, we'll come back to that issue in the future. We know, in the Part D world, that beneficiaries do not shop regularly for plans and
don't switch enough to influence premiums, and one of the results of that is a lot of gaming of the system from the plan side, and we see companies that, you know, have developed strategies of letting their older plans age and the premiums go up because people don't leave the plans, and then they bring in a new product to attract new enrollment, at a lower premium, and, you know, this works to the detriment of those who are in the old plan. Obviously you can say people ought to switch, but, you know, we make it hard for people to do that by some of the things I just mentioned.

So, you know, these are the kinds of things that really concern me, that, you know, that the system, as it's designed, to try to let beneficiary choice drive efficiency will ultimately not work and we'll get the kinds of disruptions that Bill was point to, without the benefits. You know, I think you go on to talk about issues of sort of -- one of the arguments we made for keeping traditional Medicare in as a competitor, and in a lot of ways I think that's the right thing, but how are we really going to do that in a high-cost area if an area like Miami is going to cost people so much? And if we figure out how
to communicate that to people, they'll either end up paying
a lot or they'll switch out of it, and if enough people
switch out do we lose the anchoring of traditional Medicare
that we think is important to sort of maintain the provider
rates? And at some point, that notion that MA plans are
getting something close to Medicare rates for hospitals and
other providers, you know, will go away if there's not
enough of a piece in the market.

You know, the reverse is true in the low-cost
areas. We've gone through, over years, of trying to figure
out Congress trying different methods, not all of which,
you know, worked out very well. But it tried to figure out
how to keep plans in the low-cost areas. Are we
comfortable with the idea that if we widen the gap based on
current prices and current bidding, whether the MA plans in
those low-cost areas will simply go away because it will
now cost too much -- the premiums will go up substantially
and it will cost too much to do that.

So, I mean, those are some of my real concerns
about this path we're going down. Some of the more
specific things that have come up, in terms of the topics
here, you know, I think -- and we've kind of -- maybe we've
already talked this one through, but the reliance on the low-cost plans, I think, could be quite risky, and I think the notion of going to some kind, as Paul was saying, an enrollment-weighted average or enrollment-weighted median, you know, is critical, because I think there is the potential to have low-quality plans that bid low.

Yeah, I think narrow networks under this new kind of environment could be more of a possibility. I think there are lot of -- I mean, Paul's right, that under the current environment that's unlikely, but I think that potentially changes under these kind of incentives. And so we could see a lot of sort of really not very good plans entering in, and so we need to make sure that they don't get to drive the price.

Geographic variation, I think is a big issue. I know in Part D, where you don't have a geographic adjustment, we're seeing people in New Jersey pay double the average premium that they pay in New Mexico, and that's in a world where you don't even expect the kind of geographic variation that you do in other parts of health care. Right now it's a two-to-one difference between New Jersey and New Mexico in the kind of premiums, without that
kind of adjustment. Now people are living with that, obviously, but it's kind of a -- it's a real question whether that's the fair thing to do to our beneficiaries. I think on some of the, what you call the mitigation measures, I think, you know, a lot of them are important. But I do think it's important to distinguish between what are -- the way I would use the word mitigation, which is to sort of reduce the effect on somebody, sort of on a permanent basis, as opposed to transitions or things that would delay the impact. And I think we really should be careful to distinguish between things that are transitioning. Transitions are -- we've always said are important with new systems, versus things that -- and some of the examples you have there would be more what I would call mitigation, which is, you know, not having a full effect go in for certain kinds of things.

And then picking up on one of the points Paul made, I do think it's very important that we don't end up basing premiums in the Medicare contribution on some kind of an external measure or a cap. I think that is very risky, and Paul said that point well.
And the last one I'll make -- oh, one more on that, related to the transition, was you mentioned auto-enrollment as an option, and I have real serious concerns about that. I think that, you know, we've seen issues right now with the seamless conversion that exists for people who are new to Medicare, and that CMS has put a temporary stop to that program because of some of the concerns that have been raised.

Anyway, my other last point was on whether average fee-for-service spending is really the right way to set a traditional Medicare premium. I look at a lot -- you know, we think about Miami as, again, the poster child for what's out of line, and the question is, what does that higher spending really mean? We've never done a good job of figuring that out.

To the extent that it's abuse or fraud or just overuse by certain providers and the patients that see certain providers, you're essentially going to attribute that to everybody who lives in that area, and because, you know, I live in Miami but I'm not going to those providers that have driven the average up, you know, why should I end up paying as a result of what's going on there? And since
we don't really see the path to which this changes that behavior on the part of providers, I think we should think hard about sort of whether there are issues in using that as a measure to attribute a fee-for-service premium.

So I know that's a long list of things, but they're ones that I wanted to put on the table.

DR. CROSSON: So, Jack, I just want to see if you could help me square the circle on your first two comments, because what I thought I heard was, the first comment was beneficiaries are not going to switch. Right? Then the second comment was, but if they do switch, then we have a whole series of potentially untoward --

So what I'm thinking you're saying is something like this. Tell me if it's right. Where the price -- where the premium -- beneficiary premium differentials are not large, it's not likely to be enough impetus for beneficiaries to switch. On the other hand, where they are large -- Chicago, Miami, for example, are on the other side, on the MA side -- then, perhaps, they would shift but they would shift to such a great degree that we could have some of the problems that you've mentioned.

Is that sort of what you're saying?
DR. HOADLEY: I mean, in some ways what I'm doing is playing out different potential scenarios. I actually think that the degree of switching would be insufficiently great to sort of have some of the effects that even I'm making in my second point, but, you know, our switching study in Part D said that as the premium differential that you faced from Year 1 to Year 2, you know, as a result of a new open enrollment period, got larger, yeah, eventually people did start to shift.

Even then, we looked at -- I can't remember exactly numbers, but like where there was a $20-a-month shift for their Part D benefit, we still saw less than half the people make that kind of shift. But if eventually, over time, you know, if we did some of the things to make it easier for people to make choices -- which is part of the remedy I would give to my first point -- is if we really do want this to work -- and I'm not sure how much I do -- but if we want this to work, if we're going to do it and, therefore, I'm trying to mitigate it, one of the things you would need to do is make it easier for people to make choices. And then, at some point, you'll do that well enough that people will move, and then I'm worried that you
get into a different problem.

DR. CROSSON: As always, please feel free to say what you think.

[Laughter.]

DR. CHRISTIANSON: [Off microphone.]

Paul and Jack both said it. This is a very narrow thing, and it's nothing to take on any of the things that you said. So they have both criticized this indexing approach, you know, tying the federal contribution. Everybody is clear that's not what this direction that we're talking about is going in. You guys are just reinforcing that. Right. Okay.

DR. CROSSON: Okay. We are going to have a general discussion. I see a lot of hands.

DR. GINSBURG: Can I just say one thing about Miami?

DR. CROSSON: Go ahead.

DR. GINSBURG: It's -- you know, when Jack brought up Miami, I think the way to characterize Miami, which is such an outlier, is phenomenally expensive fee-for-service, perhaps much of it a result of fraud and
abuse, and we have a situation where a lot of the
beneficiaries who live in Miami have been able to pursue a
bonanza of basically enrolling in a Medicare Advantage
plan. These plans seem to be able to avoid some of the
forces that make fee-for-service so expensive in Medicare.
And it's a bonanza to them because their benchmark is based
on the fee-for-service experience. So, you know, we're
spending -- that, actually, I don't know if it compounds
it, but, you know, Medicare program isn't saving a thing,
because Medicare Advantage being important, competitive in
Miami, and reducing costs, is really all going to the
beneficiaries and the plans.

DR. CROSSON: Okay. So we've got a lot of
discussion. I'm going to start with Jon, and this time
we're going to go this way.

DR. CHRISTIANSON: Okay. With respect to the
topics for discussion, I think treat the fee-for-service
program like a competing plan I think for sure. I don't
think the Medicaid program or the taxpayers could stand a
15 percent increase in Medicare costs, which is our current
estimate of what it would be.

Using competitive bidding to set benchmarks,
Eric's argument for that is that will kind of reveal what the costs of delivering care are. And I'm in favor of using some sort of competitive bidding if we go down this route, but just based on my own work here in this area, there's four things that have to be in place for you to really come close to figuring out whether the bids, you know, relate to actual costs.

One is the design in terms of what's a winning bid, and Paul and Jack have already argued against the design that's used in the treasury bill auction and other places, which is the second lowest bid being the winning bid. That has the strongest incentives to try people to reveal their true costs, and it doesn't sound like we're interested in that.

Second, you have to have a lot of bidders, not only actual bidders but potential bidders, for this to happen.

Third, you have to be willing to -- or it increases the incentives if you're willing to throw some bids out, they're just too high. Well, we don't see a lot of interest in that. I don't think we're likely to see a lot of interest in, you know, throwing bids out.
Then the fourth thing is contract length. We haven't talked about contract length. But is it a one-year contract, or do we really want to have a bidding process like every single year? That's different than the enrollment process. So the length of the bidding process really makes a big effect on how seriously people take the bidding, not wanting to be out of the game for three years, for instance, versus one year.

So all of these things play into whether or not you actually get numbers that actually reveal something like the cost of providing care. So the justification is if you're using the bidding process to do that, then I still think it's probably a good idea to some degree. I don't think we want to go into it assume we're going to get too much more than we're actually going to get, given the way we're going to have to end up designing this bidding process. A lot of these things are not going to be part of it.

Using local areas as bidding areas, sure, I think we should. Setting the benchmark at the lower of fee-for-service or managed care, yes, some version of that.

I'm not sure what I think about the fifth point
yet, base premium should be a standard dollar amount.  

And the last one, you know, this would be the most fundamental change in the Medicare program since it started, basically changing the program from a fixed set of benefits to a dollar amount. That's philosophically a big change. It's fundamentally a big change for the beneficiaries. So we're going to say, yes, we should try to mitigate things, and we should phase it in and all that. The problem is that to make such a big change philosophically, we're probably going to have to be in a period of financial crisis for the Medicare program. And given we're in a period of financial crisis, people want savings right away, and so the notion that you're going to mitigate things by phasing it in over ten years is probably not going to fly in that kind of environment. So I think we should suggest mitigating it, but I think we should be realistic in terms of what we think actually would happen if you implemented a program like this in the real world. So those are just a few thoughts.

MS. WANG: Overall, I think this was, you know, great and sort of like very precise and very crisp. I hope that when the final chapter gets written, you know, all of
the strands around the quality discussion, et cetera, can be woven together in some way to lay out policy options to design a program like this around value as opposed to -- you know, because this was very precise about this is just focused on cost. The other presentation was focused on quality, but value has other aspects to it.

As far as the bullet points, treating fee-for-service like a competing plan, yes. Competitive bidding to set benchmarks, fine, but I would be careful because I think that, you know, to Jon's point, you do need multiple bids, and even in some markets now, that you might have a lot of sort of competing MA products. They're actually because of consolidation on the plan side, the insurance company side, they're all offered by the same carrier. And, you know, it might introduce some skewing in the way a bidding process would operate.

To that point, I am very concerned about using like the local market areas that are much bigger than the current county-based system for MA for a couple of reasons. I think that, you know, local plans, provider-sponsored plans probably have a lot of overlap. I think that there are a lot of provider-sponsored plans that are doing the
sort of work around integration of the delivery system and insurance mechanisms, value-based payment, population health that are initiatives that are valued and that we want to see promoted.

I am worried that if the local market area is defined too broadly, that those plans will not be able to expand and that you then further the difficulty of -- or the first problem about compounding that there's more consolidation and, therefore, less competition, real competition in market areas. So I'd be careful about that.

To that point also in terms of setting benchmark at lower fee-for-service or managed care, you know, from a pure cost perspective, I get it. But here, again, in areas where fee-for-service is lower than managed care and fee-for-service is the winning bid, what does that actually leave in the system? Are there ACOs in those environments because the fee-for-service benchmark is so, so low already? And are we sort of locking that in forever? Does that have some sort of ripple effect in terms of some of the other population health initiatives that, you know, we want to see introduced?

I just think these are -- I don't know the
answers, but I think that these are considerations that need to be highlighted within the context of a premium support model that focuses on value.

DR. MILLER: Just a couple of things to say in reaction to that. At least in some of the conversations in the past, the other concern on the side of going to a larger market was a county-based market created too many opportunities to pick and choose who you could avoid, if you will, and that there were certain populations you didn't want to go to, you didn't go to this county. So some people, at least Commissioners in conversations like that, were saying, no, I want you to go and you have to offer in this entire market, which is Part 1 of the reasons that kind of drove us into that direction.

And then the other thing on your -- you know, is the ACO in there? I think in this conversation, when we're using the words "fee-for-service," we're assuming the ACO is also in the fee-for-service environment. ACOs would be able to do what they do. It would just be that would be part of the calculation of the fee-for-service bid.

MS. WANG: My only point there is that I do think that in some low fee-for-service areas, given the way that
ACOs are now constructed, it's hard for them because fee-for-service spending is already so low, and when they get measured against their own performance and their own baseline, it's like, what are they cutting, you know, if they have to continually -- and so in those areas, MA plans can introduce more innovation in terms of care coordination in a different type of delivery system. So, you know, and I realize that there's a cost consideration there, but I just would be concerned about that.

As far as the first point, maybe it would be useful to do some research around identifying local plans or identifying provider-sponsored plans and understanding how large their service areas are in defining what would be an ideal market area, because I get your point there. But if they are generally, you know, covering X number of contiguous counties, maybe that can inform the definition of a local market area if we think that it's valuable to keep them in the game.

DR. MILLER: Right. I think Bruce was making the same point a couple iterations back.

DR. NERENZ: I've just been trying to think through how this plays out over multiple cycles. You know,
our examples are essentially what happens in the first
year, and I'm just trying to think about how does it play
out over and over again, particularly in the situation we
have on Slide 9. And I'm wondering if I can just run
through that a little bit, if there's a problem either I'm
seeing that's not real or if it's real.

I'm thinking mainly about a premium spiral sort
of effect, mainly on the fee-for-service side. I am making
an assumption that the people likely to stay in fee-for-
service, when this kind of thing is in place, are probably
a little sicker on average because they want to preserve
their ability to go to MD Anderson or they want to go to
the local academic medical center that's not in the network
of Plan C or something like that. So it starts with that.

But basically it says in Year 2, Year 3, Year 4,
the healthy people are gradually gravitating more than they
were at the beginning into the MA plans. The sicker people
are staying in fee-for-service. Now, the bids on the MA
side are not necessarily going down because, again, these
are pegged to the health needs of an average person. But
the actual mix of people is getting healthier. But the key
-- and that's not necessarily a problem, but on the fee-
for-service side, each year that is going up, meaning the
premium that we're going to charge people to be there keeps
going up, which then keeps multiplying the effect, because
eventually only the most desperate people who must, must go
to MD Anderson are willing to pay that higher premium. And
I just don't know where it ends.

So I know this hasn't been part of the
discussion, and there's probably a similar kind of multi-
cycle dynamic over on the size where fee-for-service is
low. I suspect what -- and that it's even harder to figure
out, because one scenario I can imagine is eventually the
MA plans just go away and there aren't any. And then the
fee-for-service bid, so to speak, is just set on the
historical experience there.

So is there any way to actually model through how
this plays out over time and if there's a train crash
somewhere down the road?

DR. MILLER: I mean, I think what we could bring
-- I mean, just to try and always be as direct as possible,
on the modeling exercise, no.

[Laughter.]

DR. MILLER: And I'm being facetious to some
extent. This is extremely difficult to do the behavioral stuff because, in addition to what you just said, what does the beneficiary do for economic reasons, what does the beneficiary do for clinical reasons, what's the benefit package that's offered, there's a whole other set of dynamics of does the plan play, does the plan leave, which plans -- that type of stuff. It's extremely complex.

But there have been studies and analysis where other people have tried to talk about some of those dynamics, and we can try and capture some of that and bring it into it. But I really can't commit to do the analysis directly because I just don't think there's the wherewithal.

The other thing I want to say is the same -- I think, you know, what you're expressing is a real-life concern. In theory, you could be seeing some of that right now in the current environment, right?

DR. NERENZ: Yes.

DR. MILLER: Because we have an MA plan and all the rest of it. And so, you know, how much of that have we seen? But then, of course, there's what's happening in the exchanges, which -- right. And so, yes, this is decidedly
one of the risks when you go into a direction like this.  
Hopefully risk adjustment tries to capture that, but it's  
imperfect, and you might have to have mitigation effects on  
top of that if you wanted to try and control the spiral.  
But it is decidedly a risk.  

DR. NERENZ: And if we just say, look, it's just  
too complicated to model out, that's probably a fair thing.  

DR. MILLER: [off microphone] bring into this.  

Maybe there are things we can get from other people's  
analysis to at least inform your point.  

DR. NERENZ: But even if we thought that some  
general trend like the one I described could happen, aside  
from any real formal modeling, you know, risk adjustment  
has certain protective effects in the MA side, but there  

isn't anything like that on the fee-for-service side, and  
the question is: Well, could any such thing be created and  
what would it look like? Or is maybe there some kind of a  
cap phenomenon over on that side?  

And, again, I don't know what the answer is. My  
first thought is: Am I just imagining ghosts that don't  
exist? But maybe the ghosts do exist.  

MR. ROLLINS: Well, I think in the bidding
process we sketched out here, again, reiterating Mark's point that risk adjustment is imperfect, but to the extent that you had a sicker group of beneficiaries who were sticking around in the fee-for-service program, their risk scores would go up over time, and you would be making a bigger adjustment to the fee-for-service bid to try and capture that.

Now, again, that may not be perfect, but there would be at least some mechanism there to help do that.

DR. NERENZ: Well, but then let me just clarify on that, because that might help. But I thought the bid here was pegged to the services of an average-risk beneficiary, so that's not really --

DR. MILLER: It is [off microphone].

DR. NERENZ: The bid is, but you just -- okay.

So the bid wouldn't change, actually.

MS. WANG: But then the contribution [off microphone] --

MR. ROLLINS: So if fee-for-service --

DR. NERENZ: Okay. That's what I wanted to clarify.

DR. GINSBURG: Yeah, I just want to say that I
think David's scenario is a risk for the current system. I think that, you know, where we just a fee-for-service benchmark without risk-adjusting it. So in the premium support that Eric sketched out, we would risk-adjust the fee-for-service number as well as each of the MA bids.

DR. NERENZ: But then -- and I'll give up on this because it's a long enough time. But, yes, the fee-for-service system, so to speak, would be protected, but I think the beneficiary part of the premium would not be protected if the bid doesn't move. So that's just --

MR. ROLLINS: The premiums would be based for a beneficiary of average health. So, again, to the extent risk adjustment works, your premium in a fee-for-service sector would take into account the fact that the people who are still in fee-for-service are on average sicker. Now, as multiple people have said, that's a real area of concern.

DR. CROSSON: Okay. So we're going down here, and I think we're arriving at Kathy.

MS. BUTO: Okay. My thoughts have gotten more complicated as time has gone on. But so one of my underlying concerns is that the structure of premium
support could actually accelerate the opting out of Medicare Part B by those who might have other options, because depending on how it's structured, you were mentioning, Eric, that we're already seeing for some baby boomers the not taking up of Part B and staying on employer retiree insurance or whatever else.

My concern is if the costs go up and there are subsidies for low income, then there are people who can't afford or might have other options who will actually opt out of the Medicare benefit. I'm really worried about the social insurance nature of the program, fundamentally that we don't kind of accelerate that movement. So I just put that out there.

The issue of the limit that both Paul and jack mentioned I know is not our preferred option, but we do mention it on page 22 and talk about an alternative kind of limit tied to the benchmark. Any limit we put on there I think is by necessity going to shift more cost to beneficiaries or to the beneficiary's share. So I'm concerned about that.

Back to the point that David was just making, I think we maybe ought to think about an escape valve. So
what happens if for whatever reason Congress decides to adopt this approach and we start to see some kind of a spiral, whether it's more and more people leaving Medicare, whether it's we're in a conundrum of fee-for-service gets more and more expensive and we can't figure out how to deal with that, risk adjustment isn't doing it?

So one concern is when you do a major change like this, that if you make a mistake, there ought to be a way to either adjust or to back out of it. With the SGR, we couldn't figure out how to back out of it. It took us forever. And so just something to think about. It might be that if we think Congress is going to do this, they ought to try it first, either regionally or they ought to try it for a certain number of years, phase it in, something. But there ought to be design issues that say after so many years the authority might even expire and would have to be renewed, which would give you another opportunity to take the savings from anything that's done and redesign parts of it.

So I don't know what that is. I'm just thinking ahead to the fact that any dramatic change like this really needs to have some ability to make adjustments, because
this is not anything that really exists in Medicare now.

DR. CROSSON: Jack.

DR. HOADLEY: One quick follow-up to the question that Dave started raising. I mean, obviously, as I think somebody said, you know, if risk adjustment really, really worked, you really just shouldn't have as much of that particular kind of problem, but what we're seeing is -- I think we're just putting more reliance on the risk adjustment where the consequences of its failure or its inadequacy gets accentuated in some of this. And again, the example I used in Part D, where we see these two-to-one ratios, you know, it's unlikely that a lot of that is due to simple prescribing differences in a couple of different states around the country.

It seems more likely -- although, you know, I can't show it, empirically, that a lot of that has to do with unmeasured risk adjustment. We do risk adjustment in Part D. Differences between, you know, plans out there that charge $70 for the identical benefit that somebody else charges $20 for in the same part of the country, almost has to be risk-driven.

So, I mean, that's just a way to kind of see how
far away you can get when risk adjustment doesn't work as well as it should.

DR. CROSSON: Okay. Warner.

MR. THOMAS: So a couple of comments I had, and I think going back to Jack's comment, one of my concerns on this -- I don't disagree with the key elements up there, really. I think -- the big concern I have is whether a beneficiary can really -- or will really make the choice between, you know, the best option or a cost-effective option. I think we see this in fee-for-service versus MA today, where we have MA program which are more cost-effective. They actually have, in some cases, better benefits and yet people select fee-for-service consistently.

So I just get worried that we think that the market and the selection of the plans is going to play out in the right fashion. So that's a concern I have.

I think the second piece -- and this is, I believe, related, although on a slightly different topic, is that on the auto-assignment, I think one of the things that ought to be considered if we're going to write this chapter is just the whole idea of how we auto-assign today,
because essentially, everybody automatically assigns in
fee-for-service. So we're auto-assigning people into the
option that in many markets is more expensive.

And I guess part of the question is, should
people be auto-assigned into the most cost-effective
option, with clarity around what's being done, and they
could opt into a different option but, in many markets,
especially the more expensive markets, we auto-assign
people into the most expensive option, and I think that's
something that ought to be thought about and considered.

The last comment I would make is around the ACOs,
and if folks are going to go into the fee-for-service
option perhaps we ought to think about how they get
assigned into an ACO model. And I think this is a benefit
to the ACOs, in areas where fee-for-service is the cheapest
option. You know, this would be a benefit to be in an ACO,
that you would potentially be able to gain more members,
you know, kind of selecting into your model, which I think
may encourage more organizations to embrace the ACO model.
And if ACOs work the way we would hope, which is better
coordination, obviously we would like folks to select into
models that have the ACOs.
So, you know, I know that we're not making a recommendation around premium support, but if we -- if we went in that direction I think these are key elements that would make sense.

I think the other comments are just important, regardless of premium support. I think they're items that ought to be highlighted or brought up in the chapter, I think, aside from the premium support model.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, I wanted to mention that the chapter is laid out as a really exciting path for premium support, and I think the models and the analytics that were done were very well-done. Mark, I think the word we were looking for was it's a "gist" that we're going to -

DR. MILLER: Oh, not the drift.

DR. DeBUSK: Not the drift. It's the gist of what we're trying to convey.

But I loved the gist of where it took us, because, you know, this concept of area-specific benchmarks obviously I support. As far as the competitive, or the bidding model, really any competent method that does price
discovery, I'm somewhat indifferent to. I mean, I understand the merits of second-lowest bids and medians and weighted medians. I think, really, anything that helps us discover that price, I think, is going to get us there.

The one thing I wanted to comment on, or two things in particular, though, the base contribution for Medicare. I think that should be set at a fixed percentage, not necessary a fixed amount. And the thinking there was that that would allow -- there would be some geographic variation -- well, there is going to be geographic variation -- but some of that, presumably, would be tied, or at least hopefully would be tied to the cost of living anyway. So the thought was that some of the variation you would see in premium -- because, again, you're setting -- it's a percentage contribution -- would be on the -- reflect the cost of living.

And then the final thing I wanted to mention, how much should be done to mitigate those -- the potentially large premium increases. Is this an opportunity to introduce some type of means testing into how we do that? I mean, is that the third rail? Jack is shaking his head at me already. You know, I mean --
DR. HOADLEY: It destroys Medicare, basically.

It's a social insurance program, and if we go to a full means-tested Medicare it will become Medicaid.

DR. DeBUSK: I didn't use the word full.

DR. HOADLEY: We're already there, with the income-related premiums and we're starting to see the effects of people dropping out.

DR. DeBUSK: Well, I did notice -- in the -- there are now some Part B -- I figure up to $200 or $300 premiums, once you hit certain income levels. So we have means testing now. The question is, is this a chance to refine or introduce it? And I'm seeing enough heads -- well, I'm seeing enough heads shaking to know that it may be a dead-on-arrival idea.

That's all.

DR. CROSSON: Okay. Bill.

MR. GRADISON: I think there's a connection between this general package we're discussing and the idea of benefit design, which we've been over before. I think this kind of a program, if adopted, would work a lot better if there were a change in premium design first, which is to combine A and B and have a catastrophic benefit -- I mean,
not that that's a new idea. But in terms of -- I at least
want to suggest that perhaps we should be referring to that
in some manner, in whatever we present.

Most of my thinking about this is how to package
it. At one point I -- and I'm not sure this wouldn't work
-- at one point I thought of it as an actual decision tree,
because there are a lot of things you're going to have to
work through that lead to other branches. And I'm not
trying to be formalistic or look too far ahead. But
fundamentally, I think the main contribution we can make to
intelligent discussion of this issue, from people who like
it or don't like it, is to pinpoint the key decisions. I
may be way off on this but I think there are probably about
-- I can't number them all, but about a dozen, maybe. I
mean, it isn't that -- you can put it on one page.

I mean, I would think that would be an objective
to have a one-page. What are they decisions you've got to
make? And then there are subsidiary decisions, of course,
that are very important, because I think this could
contribute to -- the presentation, I think, would
contribute to trying to keep this on a basis that you never
can say it -- objective is -- nothing about this is
objective. It's all subjective. But at least maybe some degree of facts-based thinking.

DR. CROSSON: Craig.

DR. SAMITT: I have a macro comment and then a couple of micro comments here. The macro comment really stems from a comment that Pat made, that I would hope that as we derive the chapter for June that we not think about the pieces of premium support in isolation, that I think, Pat put it, is we need to weave this together into a common fabric. I think it's dangerous to talk about each part in isolation without continuing to tie it back.

So, for example, these topics for discussion, we really need to talk about the fact that the bidding and the benchmarks would need to be tied to a quality metric, so that this isn't about cost; it's about value. And so I know that the reason we've done it this way is it's a complex discussion, and so we've broken it into parts, but I think at some point soon we're going to want to pull the pieces back together, so it's not viewed as an either-or; it's always viewed as an "and."

I am in support of the elements here. I'm a little bit uncomfortable given some of the conversation
about competitive bidding versus benchmarks and how to set
the benchmarks, and really would love to learn more about
the enrollment-weighted bidding, and whether enrollment-
weighted bidding actually can serve as a mitigation
strategy in and of itself, because it would blend or smooth
the transition and the curve so that it wouldn't be as
striking if it's kind of an either-or or second-lowest or
what have you, that it's more of a blended approach to
benchmark development, which could smooth the potential
disruption here.

I also, to Warner's comment, I don't want to lose
sight of the -- sort of the default enrollment issues here
as well, that if we believe that this program will work,
and we work through the mechanics to align the incentives
to choose the highest-value options, that default should
also default to highest-value options as opposed to the way
things work today.

And then, finally, and you mentioned doing some
work on this, I would be interested in knowing and
understanding how duals and special needs plans kind of fit
into all of this, and how that will work. And I know that
adds another layer of complexity but it would be important
to understand that too.

DR. CROSSON: Sue.

MS. THOMPSON: At a very macro level, I can't help but reflect on conversations and previous lives where, in organizations, we have been faced with problems of funding pension, and the whole question of defined contribution versus a defined benefit. And I'm worried about the employee and whether or not they could manage their own retirement planning. And in that context, I just think it's important that we have an opportunity here to pull the beneficiary into this discussion and make them a part of the decision-making here, in terms of their managing not only their health but their health plan.

So I think there's an opportunity here we shouldn't miss.

DR. CROSSON: Sue, I just want to be sure. When you said "in previous lives," I think you mean in previous aspects in your own life program.

[Laughter.]

DR. CROSSON: We generally don't deal in the supernatural here, although it might seem that way sometimes.
[Overlapping speakers.]

[Laughter.]

DR. CROSSON: Bruce.

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

So what we have -- what we're going through, I think, is a series of issues to fix the problem that Warner addressed, to fix a series of other problems that we have with, you know, the one-third, two-thirds issue -- Medicare Advantage and fee-for-service -- and to do that in a reasonable way, tackling a series of problems and identifying ways to do that.
So I don't see this as, you know, hugely dramatic or, you know, might be fundamental change, but I see it as a series of steps that can be taken in a reasoned way. And certainly none of it is going to be perfect. You know, risk adjustment is not perfect. That's -- it's not called risk elimination. There's still risk. Right? And a series of other kinds of issues of how the bids are constructed.

But one element I would urge that we put into this is to make the system simpler. The burden of annual bids on Medicare Advantage, the other structures, everything from the star system, the risk adjustment system, and so forth and so on, to the extent we can, in the course of our gist, identify elements that can be simplified in the whole process, I think would be very helpful. And in that context, what we're creating, I think, is a guidebook for fixing the system, whether it's called premium support or something else.

So that's my overall view. So I support the issues, the five issues there.

On the last one, the sixth -- how much should be done to mitigate large premium increases -- I think it's important
to consider beneficiary spending on Medigap as a real spending. It's not inexpensive. A lot of people buy it, and often that spending is offset by the kinds of extra benefits that Medicare Advantage provides. So if we're concerned about the actual out-of-pocket, how much an individual has to pay, it's not just the premium for Part B. And I think that gets to some of Bill's comments about, well, you know, in fact if we create a catastrophic and some other changes like that, then maybe we would address that issue.

So from an overall, you know, technical standpoint of let's go ahead, let's figure this out, then I think there will be a lot of valuable things that come out of it.

DR. CROSSON: Thank you. Bill.

DR. HALL: So going around the room, I'm impressed with the complexity of this issue, even if we're -- some people in the room here who have tremendous life experience with this, and also a little reflected by the annual Medicare enrollment period, where a lot of patients come in, and I don't know the right answer to some of the questions.
I'm wondering about timing. This will be for the June report -- is that right? So what about a scenario where we find out, in a week or two, that there might be some substantial changes in priorities in Washington and in the states, or not?

[Laughter.]

DR. HALL: On every list that I've seen --

DR. CROSSON: I said we don't deal in the supernatural.

[Laughter.]

DR. HALL: All the lists that I've seen is that the Affordable Care Act has to be eliminated, day one. I think change to Medicare through the House might be something that comes up.

So I'm wondering, do we need to do even more work and emphasis on this, in some sort of very rapid fashion? Where are people going to get -- the responsible people who are making decisions, going to get the information? Are there lots of different ways, or is this -- is the Commission the major vehicle where people would look for reliable information? Does that speed up or change our timeline?
DR. MILLER: Well, my first reaction is, you know, in all honesty, I don't know how it can deliver it faster than June. You know, we'll have to go through all our update process stuff. All that gets into the March report, by law, and you know, and that's what's going to be in the March report. Meanwhile, we'll be working with this kind of information, gathering the other non-update stuff into the June report. So I don't know how it can move much faster than that.

However, the other thing I would say is as it turns out we have been talking about this for a couple of years, and it's kind of in bits and pieces all over the place. And what we're trying to do in June is saying, this is really what everyone thinks, you know, and write it down. And so there is information out there and obviously, if we were to get urgent calls, we can take people through it in bits and pieces.

The thing, I think -- and I've said this a couple of times but I'm just going to say it again -- is I think the point of this is to have a reasonably thought-out, at least at a principled and general policy direction, guide to what you have to think through if you're going to take
on a policy like this. But the other objective is, I think a lot of people come to this and think there is -- it's simple. It's much more straightforward. And as you can see, it does involve some serious issues that can cut in one direction or another, and I think part of having it available at the time that, you know, we have March and June, is that if people want to have a serious conversation, they have to be able to answer these questions in how they design it.

So I don't think we can deliver it much faster than June, but the whole intention is, is if there was a shift and people were to talk about this seriously, have some place where they could go for at least a first-level take on what -- you know, you have to be able to answer these five questions if you're going to start having this conversation.

DR. CROSSON: Okay. Alice and John.

DR. COOMBS: Thank you very much. This has been a learning session for me, and I think I've learned a lot. One of the things I think impressed me most in listening around the table was the whole notion that if we provide this, we are actually functioning as choice
architects for beneficiaries. And in that, I think Jack pointed out some issues with beneficiary choosing for the Part D plan. I think Craig something about the quality piece. If you are a choice architect, you're supposed to provide the patient with the ability to choose as they see fit and also give them a tool set or create an environment whereby they choose the right thing. And so the right thing is judged by whom?

And so one of my issues is this whole notion of setting the premium in the absence of the quality, and so that you might have a patient who chooses solely based on the premium, and the risk adjustment is not perfect, no matter how much we say it is. There's one renal failure patient that is much more advanced than another, and I think that systems can kind of triage patients the way they see fit, panels will fill up. There might be capacity issues with different plans.

I would like for us to be able to say somewhere along the line that the challenges in this area have to do with patients' capacity to choose, and on the opposite side of the spectrum is our ability to be the best choice architect because we are functioning in that manner because
we provide the patient with some tool sets that say this is going to help you to make the right decision. Even if you don't have exposure to it, there's something out there for you.

And so the quality piece is something that's going to be a harder thing to really kind of tease out, but it needs to be ever present within the decisionmaking environment for the patients.

DR. CHRISTIANSON: Having the last word is -- a quick comment on what you just said. I think one way in competitive bidding and other kinds of programs you deal in a very crude way with quality is you have to meet some quality benchmark to bid. It's either a historical benchmark to bid, or your bid is thrown out if your quality rating isn't, you know, satisfactory. So there's a crude way of dealing with that, not perfect.

I was struck with the conversation here, going back to what Warner said this morning, and I was often -- things that we talk about feed into each other, interlinked, and he was saying, well, maybe we should look at consolidation that's more things than just provider. Maybe we should look at health plan consolidation. Then
Pat brings up, oh, are there really enough organizations here? Got a lot of plans, but how many organizations? So we know that work that Kaiser Family Foundation has done that's very interesting, it shows a relatively small number of organizations in the MA program enroll a relatively large number of bidders. So that would maybe discourage us from, you know, the notion of competitive bidding and how that's going to work. But we do this work over with ACOs, right?

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

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

DR. CROSSON: Okay. Eric, thank you so much for taking on so ably such a complicated topic for us.

Now we turn to the last presentation and discussion today, the Medicare outlier payments to hospitals, and Craig and Jeff are going to -- it looks like, Craig, you're starting.

MR. LISK: Yes, I am. All right. Good afternoon. Today we are going to go to review some research we have done on the relationship between Medicare outlier payments and hospital charging practices.

I want to first discuss our motivation for this analysis.

Going back more than a decade, well over a decade ago, some hospitals were gaming the outlier payment system by inflating their charges to take advantage of some loopholes that were in the outlier -- with how outlier payments were being -- costs were being determined for the outlier payment system. But CMS, in I think 2003, made some modifications to the outlier policy to close those loopholes.

In 2013, the Office of Inspector General
conducted a study of Medicare outlier payments in which they examined hospitals with a high share of outlier payments and found that these hospitals charged substantially more for services in the same MS-DRG, even though the patients had similar lengths of stay, raising concerns about why charges for similar cases vary substantially across hospitals.

In addition, three recent articles in Health Affairs by Ge Bai and Gerry Anderson have looked at the relationship between hospitals' financial performance and hospitals' charge markups, finding that hospitals appear to be using the charge-master to maximize revenues, raising questions as to whether hospital markup practices might also be affecting Medicare outlier payments.

So in our presentation today, we are going to review the policy rationale for outlier payments and review how Medicare pays for outlier cases and examine the type of cases and hospitals that receive these outliers. We'll then focus on two issues in Medicare outlier policies: the influence of charge markups on outlier payments and the calculation of outlier costs. We'll finish with a discussion of potential changes that could be made to
Medicare outlier policy.

So, first, why have an outlier policy?

Well, under Medicare in the PPS, hospitals receive a fixed payment for a case, giving hospitals a strong incentives to provide care efficiently, as they keep any gains when their costs are less than payments, but must absorb losses when costs are greater than payments.

Some patients, however, are very high cost, either because of adverse outcomes or patients are extremely sick with multiple conditions; the basic DRG payment was not intended to offset the losses on this set of cases, particularly since outlier cases are not randomly distributed across hospitals.

The outlier policy, therefore, acts as a stop loss insurance for these high-cost cases, with a deductible and coinsurance. Hospitals have to first cover a fixed loss on a case before outlier payments kick in and then share in the cost of the case for covered costs above that amount. Thus, outlier cases are not meant to be profitable. The policy is intend to limit the losses hospitals incur on extraordinarily high cost cases.

The program sets aside a fixed amount of funds to
support the outlier program by reducing all the DRG weights uniformly. It's a fixed pool of dollars, so any changes in the outlier program are basically done budget neutral.

This next slide shows the outlier payment formula.

Hospitals can receive outlier payments once total costs of a case are greater than the DRG payment plus the fixed loss cost threshold of $23,573 in 2017. Then Medicare pays 80 percent of covered costs above this amount.

To calculate costs, Medicare takes total Medicare-covered charges for the case and multiplies this amount by the hospital's Medicare inpatient cost-to-charge ratio.

So please note, Medicare is using total covered charges for the case and multiplying it by a single cost-to-charge ratio to come up with an estimate of costs.

So we know that outlier cases need to be high cost, but how do they compare to the typical case in a hospital? So we can see here in this chart they have much longer inpatient stays, they have a higher average DRG weight, they have higher average costs per day, and that is
generally from greater use of special care units, and higher daily expenses for pharmaceuticals, supplies, lab services, and therapy, reflecting the more complexity of those cases. Altogether this leads to an average case cost of over $64,500 in 2014, more than five times the average of a regular case.

Payments per case are also higher, but because hospitals need to cover the fixed-loss cost threshold before they start receiving outlier payments, payments for outlier cases are generally much lower than their costs. So how does the incidence of outlier cases fall across MS-DRGs given that we see that outlier cases generally have a higher DRG weight?

Well, we find that there is wide variance in the distribution of outlier cases across MS-DRGs. But we do find a higher incidence of outlier cases in MS-DRGs with high weights, long lengths -- longer lengths of average stays, and with major complication and comorbidities. So the more complex higher-weighted DRGs tend to have much more outlier cases. These include transplants, major cardiac procedures, and major spinal procedures that are some that have incidence of outliers of over 20 percent.
Conversely, the low-incidence outlier DRGs are the opposite -- generally in lower-weighted DRGs, with relatively short lengths of stay, and no major complications or comorbidities. These cases will include COPD, heart failure, simple pneumonia, and major joint replacements.

So the implication is really the mix of cases a hospital has can affect its incidence of outlier cases. So in the next chart we see how the incidence of outlier cases varies across hospitals, and as you can see here, the distribution is uneven across hospitals.

For over half of all hospitals, less than 2 percent of their cases become outliers, and 7 percent have no outlier cases at all. But 13 percent have outlier shares of over 5 percent. And we found that at the very top distribution here, 50 hospitals were over 15 percent of their cases became outliers, and this very high outlier group is different from the typical hospital.

What we find is that a majority of these 50 hospitals with the highest outlier shares are small surgical subspecialty hospitals. The outlier cases for this group do not look like the slide I showed you just
back on Slide 5. The average length of stay for these cases was much shorter than average for the typical outlier cases, just 5.2 days.

The high incidence of outlier cases in the surgical specialty hospitals appears to come from three sources: high charge markups in the operating room, very high charge markups in the operating room; high device costs; and high per diem costs, in part probably because of their small size.

A case becomes an outlier because of high relative costs. In determining costs, Medicare uses a simplified method to determine costs by multiplying total covered charges for a case by the hospital's overall Medicare inpatient hospital cost-to-charge ratio.

One of our concerns is how markups potentially affect outlier payments here, and one way is through the mix of services used. More service use from departments with higher markups will result in higher outlier cost estimates and vice versa.

Second is the difference in markups within a department or cost center. Thus, a higher than average markup for a particular service or device in a cost center
will also increase outlier cost estimates.

So, remember, in determining costs for outlier cases, current policy is to use Medicare's inpatient overall cost-to-charge ratio to calculate cost. But as you can see here in this slide, markups vary substantially across hospital departments or cost centers, with routine and special care services having lower than average markups, but drugs, operating room, lab, and radiology services having much higher markups. Please note what I'm showing you here is the ratio -- when I'm talking about markups, I'm talking about the ratio of charges to costs.

It is this difference in the mix of services used for a case that potentially could affect the hospitals' overall cost estimate for outlier cases.

If we look across hospitals, we see wide variation in the overall average markups. In this chart the level of the markup is shown across the bottom of the chart (as the ratio of charges to costs) with the share of hospitals with those markups on the left.

As you can see here, most hospitals' charges are two to four times the cost of care, with the median being 3.2. But many hospitals, over 17 percent, have charge
markups over five times the cost of care, and a few even
have markups over ten times the cost of care.

So do we see any relationship between these
markups and the incidence of outliers?

Well, in this slide we do see potentially a
slight weak relationship if we look at the heart of the
distribution where outlier cases lie in terms of those
share from two to five -- markups of two to five times the
cost of care.

But then when we have the very high markups, the
incidence of outliers drops down. So we kind of have this
weak relationship. It's hard to say what is going on, and
it's a relatively small difference. There's some
relationship there, but it appears to be relatively weak.

So how well does the total CCR work in estimating
costs for outlier cases?

To examine this, we compare outlier case costs
using the total cost-to-charge region and departmental CCRs
at the individual hospital. Departmental CCRs should
provide a more accurate picture of hospitals' claim costs
as it will reflect better the mix of services used and the
differential markups across departments.
Neither method, though, will capture differential markups within a department, such as a higher markup for a particular high-cost device. But in aggregate, we find both the total CCR and departmental CCRs give similar estimates of total outlier costs. But at the case level, the mix of services used will affect the estimated cost, and here we have a simplified example of how cost estimates can vary between the departmental CCR and total CCR.

In this example we have a case that uses services from three departments with different cost-to-charge ratios or different markups: CCR 0.5 for routine, 0.1 for operating room, and 0.3 for supplies and devices.

In the next line we show the total charges for services in each of these three departments. We then show estimated costs using the two approaches for calculating outlier costs -- departmental CCR and total CCR. The total CCR for this hospital is 0.32. And what we find between these two calculations is a very different estimate of costs?

If we look at the total -- and you can see the differences between what happens with routine and operating room for each of these services. But the total comes out
to be $37,000 with the departmental CCR, and the total CCR produces a cost estimate of $48,000 when a single CCR is used like in the current outlier policy.

Thus, if the service mix is weighted to services with higher markups, the total CCR will give a higher estimate of costs. But if service mix is weighted to more routine services -- such as for long stay patients -- the total CCR potentially will underestimate costs.

And if we look across MS-DRGs, we see large differences in the average outlier cost estimates between the two approaches, reflecting the fact that the mix of services used varies by DRG.

We find, for example, that the total CCR tends to underestimate costs of outlier cases in MS-DRGs with a high incidence of outlier cases and overestimate outlier costs in MS-DRGs with a lower incidence of outlier cases.

So our findings from this analysis lead us to two potential policy changes for you to discuss. These policy options are not mutually exclusive.

As we just showed, the total CCR at the case level does not provide an accurate estimate of outlier case costs, tending to overstate costs for cases with more high
charge markup services and understating costs for cases with more routine costs that might be the result of long inpatient stays.

So one option would be to use hospital-specific CCRs to calculate cases costs for determining outlier payments. This option would potentially increase the complexity of calculating outlier payments since instead of using a single CCR, multiple departmental CCRs would need to be used to calculate costs. This potential increasing complexity would need to be weighed against the improvement that would be made in payment accuracy at the case and hospital level to determine whether this option is worth pursuing.

The second change would address the phenomenon of the large share of outlier cases in surgical subspecialty hospitals. We find that the length of stay for outlier cases in these hospitals was much shorter than the typical outlier case, 5 days compared to 19. so it is puzzling why these hospitals should have so many outlier cases with such short stays, unless they are taking advantage of the way costs are determined or they are extremely inefficient or it's somehow in their markup practices.
In this policy, CMS would establish a two-part test to qualify for outlier payments. First, the case must stay a set number of days over the average for the DRG, such as 5 days; and, second, the case must exceed a fixed loss cost threshold, such as is the case with current policy. If a patient died, there might be an exception to the length of stay rule.

This option would reduce the number of cases identified as outliers in many of the small surgical subspecialty hospitals and other hospitals that tend to have much shorter than average stays for outlier cases. It will not affect the traditional longer-stay outlier cases and, in fact, may result in some redistribution of outlier payments as the fixed loss cost threshold potentially might be reduced. This policy also should be relatively straightforward to implement. Both of these policies would be budget neutral. We're just redistributing outlier payments to cases that have truly higher costs -- or that we suspect have truly hard costs.

And so with that I'll be happy to answer any questions you might have about our analysis or Medicare outlier payment policy, and discuss the policy options we
presented.

DR. CROSSON: Okay. Thank you, Craig.

Clarifying questions. [Inaudible.]

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

On the top of page 5 in your paper.

MR. LISK: In the paper?

DR. CHRISTIANSON: I just want to make sure I understand. So, basically, there's a policy decision that Medicare should spend about 5 percent of payments to hospitals on outliers, or is it no more than 5 or is it about 5?

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

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

[Overlapping speakers.]

DR. CHRISTIANSON: So then what drives reaching that is the setting of the threshold.

MR. LISK: Correct.

DR. CHRISTIANSON: So that's the manipulated policy. It turns out that's the variable that makes sure that --

MR. LISK: [Inaudible.]

DR. CHRISTIANSON: So it's a zero sum game.
MR. LISK: Yes. So CMS is estimating each year what that cost threshold would be to get them to that amount of money, and 5.1 percent is what CMS is --

DR. CHRISTIANSON: And you give us two years for the threshold values, this year's and last year's.

MR. LISK: Yes.

DR. CHRISTIANSON: Has there been any trend in that, that is motivating our discussion of this topic, or --

MR. LISK: No. That's not really part of our topic of discussion here. It has -- it increased between -- it increased this past year but it's fluctuated somewhere in the -- generally in the 20s -- lower to mid 20s.

DR. CHRISTIANSON: So that's not driving the fact that we have this session.

MR. LISK: No.

DR. CHRISTIANSON: So what is driving is you guys have taken a look at this and you think there's a better way to do this. Is that right?

MR. LISK: We think there could be some improvements.

DR. CHRISTIANSON: Yeah. Sure.
MR. LISK: I mean, that's what we're offering you to think about.

DR. CHRISTIANSON: Yeah. Okay.

DR. MILLER: There were a couple of things written in the last year that were pointing to raising questions about this, and we had look at outliers several years back, and we hadn't looked at it recently. So we thought --

DR. CHRISTIANSON: So the point is this isn't something that's just generating lots of new expenditures by Medicare.

MR. LISK: No. This is -- that's why we're saying -- we actually mentioned budget-neutral a couple of times here, so we're not at that part. I mean, the charge markups have these other -- there's the -- you know, there's the other issue of the charge markups and what they might be doing on the private sector and stuff, but --

DR. CROSSON: Can I see hands again? I'm sorry. So Pat, Alice, Jack, Bruce, and Bill. Sorry. Did I miss Rita? Sorry. Pat?

MS. WANG: But Craig, on that last point -- so the outlier withhold, if you will, is set by law as being
between 5 and 6?

MR. LISK: Yes.

MS. WANG: It is? Okay. But it's theoretically possible, to Jon's question about why the focus here, it's possible, isn't it, that if there were more accurate identification of true outlier cases, that the total outlier payments would come down and perhaps it could influence the amount that all hospitals are nicked in their DRG payments to fund the outlier?

MR. LISK: No, it wouldn't. It still would be 5 to 6 percent.

MS. WANG: Okay.

MR. LISK: It just would be --

MS. WANG: The threshold might be --

MR. LISK: -- the payments themselves would be more accurate. It might change the threshold some because some hospitals that were getting outlier payments wouldn't get them --

MS. WANG: Okay.

MR. LISK: -- or they would get less. But it probably would be a relatively small change --

MS. WANG: Okay.
MR. LISK: -- on that side.

MS. WANG: So my question is on page 15, with the recommendations. Are these -- if you did number one and had a more accurate estimate of case costs, would you need number two?

MR. LISK: Well, number two -- you still might, yes, but it might be less so because you'd be getting more accurately at their cost, but you would never get at what might be happening in some of those hospitals, because I saw -- what we see in some of those hospitals is very high markups on devices -- charges on devices, but not higher markups on devices. So there might actually be manipulation within the -- that specific device category that they're marking up particular devices, taking advantage of the system. We're never getting at that part of it with current system.

DR. MILLER: [Off microphone.]

It won't -- I thought Warner had his kill switch on.

[Laughter.]

Well played, my friend. You're going to let me get going. Fair enough.
I think about it two ways, in my head. So a couple of articles were written over the last few years, and we hadn't looked back at the outlier policy in a while, and every once in a while you open it up. We found, in the past, some strange things. This year we're not finding a lot of odd things but there are two things that came to a head. One is, we found a set of hospitals which just, in a face validity kind of way, didn't make a lot of sense -- for-profit, small surgical hospital, don't have a long length of stay, but have gigantic costs. And it's sort of like the outlier pool isn't for being inefficient. It's for getting a patient who's, you know, really crashed. The length of stay probably boots those hospitals out of the outlier pool. Then the first one, the CCR, and whether you use the average or all the revenue centers, that probably just increases that equity among the hospitals who are probably rightfully in the outlier pool. That's the way I think about these two things.

DR. CROSSON: Okay. Alice.

DR. COOMBS: So Craig, what was the $500,000 loss? Is that something that the hospital has to qualify first before you get to the next step?
MR. LISK: So that is -- so one part I didn't go over in the discussion here is the reconciliation. So what happens is that -- because we're using older cost-to-charge ratios in terms of on the claims, to determine what cost estimates are, and then what happens is there's a reconciliation process that goes on, and there's a two-part test for that reconciliation process, to use actually the cost-to-charge ratios -- the cost-to-charge ratio reflects that -- the claim -- the claim year costs. But it's a two-part test. And first you have to have outlier payments of over $500,000 and your total CCR has to change by more than 0.1. So it has to change from 0.3 to 0.2 or less before you have reconciliation kick in.

DR. COOMBS: Okay.

MR. LISK: And we have not seen, at least on the claims, seen much reconciliation go on. So I'm not sure whether CMS isn't doing it -- there was no OIG study about CMS was behind on doing reconciliations. But the other thing is I'm not sure that this criteria that CMS has put in place -- and this wasn't part of our discussion --

DR. COOMBS: Right.

MR. LISK: -- in our paper, really -- whether
that's actually taking -- whether it's not taking place or hospitals aren't meeting that criteria because they're keeping their charge growth down enough that it won't kick in.

DR. COOMBS: So they're holding just below that.

MR. LISK: They could be holding just below that.

I did not do a longitudinal analysis to be able to take a look at that, to see if that's what's happening, but that's something that could be there, or another area that could be discussed too, if you wanted. But we didn't bring that to you.

DR. COOMBS: Okay.

MR. LISK: It's not --

DR. COOMBS: Appreciate it. So in the reading material and the chart with the procedures -- the table -- I'm sorry, Table 4 --

MR. LISK: Right.

DR. COOMBS: -- MS-DRGs with highest share of outlier cases, 2014 --

MR. LISK: Mm-hmm.

DR. COOMBS: -- and I'm looking at the diagnosis,
millions of dollars for most of these cases. So it's not unusual that it would be -- these would be the outliers.

MR. LISK: No it's not -- no, it's not surprising --

DR. COOMBS: Okay.

MR. LISK: -- that these cases are, and there's a lot of variance in terms of what ends up happening in those cases, and that's why you have probably a lot more outlier cases in those.

DR. COOMBS: So one question I would have is that when we talk about centers of excellence we look at what's called low-volume hospitals and high-volume hospitals for some of these procedures, in that low-volume hospitals are said to have a greater complication rate, have providers who have less volume per year, and so that there's all these criteria for reaching proficiency. You won't want -- I wouldn't want someone to do a CABG on me if he only does five a year.

And so that, in and of itself, may be a piece of this, in terms of the volume of the institution. Within an institution you can have high-volume providers and low-volume providers. But the question really is how does
volume relate to this, and then I have another question for Round 2.

DR. CROSSON: Sorry. Alice, was your question how does volume relate to it, or how does the proportion of outlier cases that are due to complications relate to that?

DR. COOMBS: Right. So how does an institution who has low-volume cases relate to the number of outlier -- the number of times they fall into the outlier status.

DR. CROSSON: Right. But the middle point, the implication of that is the lower volume, higher complication, higher outlier.

DR. COOMBS: Right.

MR. LISK: That very well could be. We did not take a specific look at that. That is getting more complicated than we were trying to do initially here.

DR. COOMBS: So there's a lot of literature, especially when you talk about transplants and CABG surgery. Looking at those would be something that would be of interest, because just the complications -- when you have complications in those procedures, you are going to meet your benchmark quite easy.

DR. NERENZ: But also you're going to a higher-
DR. COOMBS: Well, no. These are already high-paid DRGs. I mean, this set of DRGs are complicated cases to begin with. It just is -- basically they're all losing -- generally losing money on them anyway. It's just that everyone has the same loss. Just remember, every DRG, to get outliers, is actually -- has the same loss. So loss doesn't vary.

DR. CROSSON: So maybe this is too simplistic, but do we know to what degree -- what proportion of outlier payments are due to potentially preventable complications?

DR. COOMBS: No, we don't.

DR. COOMBS: That's a really important piece of this whole process, because when you take these highly -- you know, just what's required for these procedures, at any event -- at any point you can have a complication, and it has a lot to do with the patient's biology and the makeup, in terms of their advanced disease process.

DR. CROSSON: Jack.

DR. HOADLEY: So I was wondering if you look at all at the potential impact, particularly on the first of these. It's obviously budget neutral so it's a question of
redistribution across the hospitals that are collecting outlier payments. And I assume, from what you've described, it's got to be pretty small.

MR. LISK: So what happens is that the hospitals are tending to get more outlier payments. Their outlier payments would go down. So the top group is actually getting overpaid by about $2,800, on average, between -- if you changed the method of calculating. And the bottom half of hospitals, when they have an outlier case, they're getting underpaid probably, on average, about $1,000. Or some -- I mean, that's a broad -- those are just broad numbers, but that's kind of how it comes, in terms of cost estimate.

DR. HOADLEY: Have you looked at all at the sense of what's the percentage, up or down, for hospitals in --

MR. LISK: No.

DR. HOADLEY: Okay. At some point, that's something we should do that, if we get any further.

DR. CROSSON: Rita.

DR. REDBERG: Thanks. I was trying to understand better what was going on with these outliers, and I'm wondering if we have any outcomes data on how these
patients do.

MR. LISK: A lot of outlier patients end up not doing well in the end --

DR. REDBERG: Like dying.

MR. LISK: -- because they were very sick and many die. And we did not take a look at that as part of this. But because a lot of these patients are very sick, many -- but many recover too, so it's a mix -- it's a mixture, and it may be difficult to really tease out. It may even be difficult to tease out who has really complications or due to the source of care and stuff too, in terms of just -- or were more biologically based issues that happened with the patients on some cases too. So --

DR. REDBERG: Like, for example, do these represent any duals, or are they all just Medicare over 65 patients in the outlier group?

MR. LISK: They're all Medicare patients, so there's going to be both under 65 and over 65, duals, non-duals. It's a mixture of patients.

DR. REDBERG: It looks like heart transplant is a big source of outlier payments, and I'm assuming they were not at the surgical -- for-profit surgical --
MR. LISK: No.

DR. REDBERG: -- special hospital.

MR. LISK: No, those were not --

DR. REDBERG: Those are orthopedic cases.

MR. LISK: -- no, no.

DR. REDBERG: Because, you know, obviously a heart transplant is a very limited resource and it's very important to choose -- you know, many more people are going to die on the -- you know, waiting for a donor, and having all these high proportion of outliers just makes me think that perhaps -- that we could be choosing recipients better. What's going on here?

MR. LISK: Or maybe -- I mean, there's another issue that could come up, is actually is a fixed payment per case for some of the transplants, because -- with such high variance. Because the other thing that happens is that there are huge profits for the inlier cases on some of these cases, and again, I didn't go over this. On the caseload there's huge profits made by some of these cases, for some of these cases.

DR. REDBERG: Is that the outlier cases?

MR. LISK: Huge profits. Yes -- no, the inlier
cases.

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

MR. LISK: So the losses are -- you know, losses and profits are supposed to even out, but for some of these places there are very big profits on the cases that do not become outliers. So that kind of raised the question of -- it could raise a question of maybe this set of cases, does the DRG system work for them because there's such high variance in the cases.

But I agree with you in terms of what you're talking about, in terms of saying are the -- in terms of what places are doing these things.

DR. REDBERG: I'm just thinking, you know, the point of the outlier I understand, but you don't want to give people incentives to do surgeries or transplants on patients that would have been better of -- that you could have predicted would become outliers because they should probably -- were -- you know, and you wouldn't want to reward that behavior with the stop loss insurance. We need more data.

DR. HOADLEY: I think we usually don't, because these cases are generally unprofitable, because they have
to reach that fixed loss amount before they start getting outlier cases. So if you look at -- generally, outlier cases are not going to be making you money, so you don't have an incentive to do it. That's why there is that fixed loss amount, because we don't want people to have incentive to do it.

DR. CROSSON: Okay. So Bruce, you have the last question, and -- I'm sorry. Did I miss something? No. You have the last question and you're also opening the discussion, so you've got a twofer opportunity.

MR. PYENSON: Oh man. I don't [inaudible] my mic for a while.

[Laughter.]

DR. CROSSON: There is a kill switch.

[Laughter.]

MR. PYENSON: That explains a lot of things.

A question on page 7. Whether it would be possible to look at the stability in this from year to year. That's kind of getting at the issue of whether these are random from one organization to the next, that is, do the organizations that have a high percentage, they persistently have that?
MR. LISK: They tend to persistently have -- yes, in terms of share of outlier cases they get, it's pretty persistent in terms of the general areas that they are. Hospitals that don't get many outliers tend to -- year by year don't get many outliers, and cases tend to have above average number of outliers tend to be the same hospitals. So that is pretty -- relatively stable.

MR. PYENSON: Another question is when you look down the listing, what's the biggest payment in a year you've seen?

MR. LISK: Oh, in terms of a per-case payment? I mean, it's over -- there are a couple that are over a million.

MR. PYENSON: It's -- and I wonder if, for comparison, you could look at the probabilities and sizes distribution of other kinds of risks, like med mal or workers' comp. And where I'm getting at is that the purpose of -- from my eyes, the purpose of an outlier program is a financial backstop for risks that you can't sell funds, and for sure there's self -- lots of self-funding or an insurance market for med mal, workers' comp, all sort of other liabilities. So I think those are -- the
frequency and size distribution of those are pretty well known.

MR. LISK: Yeah. I'm not sure exactly how to respond.

MR. PYENSON: Well, yeah. I guess to turn that into a question is, can you put that together?

DR. MILLER: Well then, one thing I would ask here is how far down this road, in hospital outlook -- is that where you guys were going? I'm representing my clients. How far down this road do we want to go? I mean, you know, Jon asked a good question at the beginning, which is why are we talking about this? We felt like other people were sort of raising questions. We hadn't looked in a while. We looked.

I wouldn't characterize what we found here as oh, my God, there's a huge problem. We found a couple of nits that, like, you know, these hospitals are showing up in this distribution where standards civilian would go "I don't think they should be here," that type of thing. So you could clean this. If you want to really unpack it, I'd want some more sense from, you know, the crew that this is a direction that we want to go in. That's the only thing I
would say there.

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

[Laughter.]

MR. PYENSON: -- I think moving to the second portion of the discussion, I think the outlier issue points strongly to the weakness of the cost accounting -- the lack of cost accounting in the hospital industry, and that as a part of recommendations, that we consider encouragement of a -- move towards cost accounting. As you pointed out, even within departments there could easily be manipulation within the department on the particular device, I think was the example you used, Craig. And, you know, cost accounting is not perfect but it would have a lot of advantage, I think, in this and other areas.

And the question I was getting at before is whether it actually makes sense to let some organizations self-fund this risk, and lots of hospitals have offshore captives self-fund their med mal, so fund workers' comp and other risks. And that involves, you know, lots of discussion. But I think that could result in a net savings rather than a budget-neutral that we've been discussing.
MR. LISK: Just to explain -- sorry.

DR. MILLER: I'm finally starting to see --

MR. LISK: Just to say one thing in terms of the variance and risk. It's one thing that I did some stuff on a couple of years ago, in looking at outliers, is a hospital receives a transfer case. They are more than 2-1/2 times likely to become outliers, for instance. So the risk is not uniform, and that distribution you see, I think, is reflective of the different risks of the cases and mix of cases hospitals have. So the risk is not uniform across hospitals. It varies by the type of cases they receive and such too.

DR. MILLER: No. I mean, I think I've started to connect the dots now, on what you were saying, an dos tell me if these two sentences are so, are what you're saying. So you were asking us whether there was some rethinking of the cost accounting structure that underlies, you know, a lot of this -- the cost report -- and I think we should talk about that. I know there are feelings about this around the table. But I think what you were saying is if you were to convert to more of a cost accounting type of approach, the program wouldn't have -- would be -- would
not necessarily have to continue to provide the -- reinsure the outlier, and that this would be something that organizations would be better able to predict and self-fund. Possibly.

MR. PYENSON: Yeah. I'm happy to be your client. In part, I mean, but even without a cost accounting system, I think some organizations could look at this and say, "We're getting dinged 5 percent and we're maybe playing these games to collect on it, and if we just self-funded this in some way we could do fine."

And I think, you know, there's implications, redesign, and selection issues. I think Craig pointed out certain hospitals are much more likely to get -- to need this than others. But in the scope of things, it sounds like if the biggest case in a year, across all the hospitals in the U.S., is $1 million, that doesn't strike me as, you know, real dramatic compared to other kinds of risks hospitals are dealing with all the time, you know, med mal and things like that.

MS. WANG: Can I -- but Bruce, this is a self-insurance for a very large pool of hospitals. It's 5 percent of, you know, the DRG payment. And the reason that
it seems appropriate to spread it across that large a pool is that there's a concentration of the cost in, you know, teaching, academic, whatever hospitals. If everybody was left on its own and said you got 100 percent back, the folks who never had an outlier payment would say, "We don't need to self-fund anything." But then the guys who actually need the help -- I mean, they might need to self-fund at a huge level.

I mean, I feel like the way that it's set up now, it is a kind of a self-funding mechanism, but the pool is appropriately large enough.

MR. PYENSON: It's a form of redistribution, and the question is we don't do that for what might be bigger risks that hospitals are managing without redistribution. So -- and perhaps this is off topic, but, I mean, that's the question.

DR. GINSBURG: I really need to answer this.

Jon, can I?

Yeah, I mean, there are two perspectives, reaction to the self-insurance. One is the fact that I don't think outlier payment, historically, has been pursued as an insurance mechanism. I know that Craig described it
as stop loss insurance. I think it was really always envisioned as making the payment, the DRG payments as to more accurate, and that was a goal in itself.

The other comment is that, you know, I think it is extremely dangerous to have any type of voluntary opting out into a self-insurance. I just don't think we could do it right. I don't think it's worth the thought resources to try to figure it out and monitor it, because we're not talking about a system that's working particularly badly. I think they're two good ideas for tweaks, but to, you know, revamp it, I think there's very little return and big risk.

DR. CROSSON: So just to be clear, were you talking about essentially scrapping this program and replacing it completely, or having opt-out, as Paul is suggesting?

MR. PYENSON: Well, perhaps I was actually asking that we look at the -- almost from an insurance basis, what -- how this program compares with other stop loss type programs, other risks that hospitals face. It's -- you know, it strikes me in the scope of things this is a nice -- not -- it is a relatively stable and small program within
the DRG structure, and certainly, you know, I'm not opposed
to tweaking it along the lines that are proposed here. But
I'd feel better if I understood these risks in the context
of other risks that hospitals seem to manage on their own.

DR. CROSSON: Warner did you have a point on
this?

MR. THOMAS: I was just going to make a comment. I think -- I agree with Paul. I mean, to me, this -- what's been identified in the chapter is that you've got some organizations that have been able to adjust their charge structure to benefit from this program, where it appears, you know, probably inappropriately, or disproportionately to others. And I think the specific department CCRs, I think, probably helps to adjust that and so does the length of stay.

So I think that to reconfigure the whole program is -- it's a lot of work for -- and I think to have people opt out of it, you know, it's -- to me that's just not going to work. It's going to hurt the organizations that actually need it, if you actually have folks that opt out, because the only people who are going to opt out of it are the people that don't need it. So I think it's really
designed to deal with those patients that have a -- you
know, a significant additional issue that a typical DRG
payment doesn't capture. So I would agree with Paul and I
think the recommendations that are outlined make a lot of
sense.

DR. CROSSON: Oh, did you have --

DR. CHRISTIANSON: I may be following on -- Mark
said something. It's late in the day so this may -- but he
said something recently that actually made sense to me.

[Laughter.]

[Overlapping speakers.]

DR. CHRISTIANSON: So he said, you know, the
system is designed to compensate hospitals that have bad
luck and not to reinforce the decisions of hospitals that
have decided to have a certain kind of cost structure, and
I think that's exactly right and I think that if these
things can deal with that problem, then I think that's
great. I'm in favor of them. But given the other things
that are on the plate of the staff and things that have to
be accomplished, I wouldn't spend another few minutes on
this topic, I don't think.

[Laughter.]
DR. CROSSON: Yeah. Feel free to say what you want.

Jack and then Kathy, and then I also am getting ready to call it quits.

[Laughter.]

DR. HOADLEY: My question was simply -- and I don't think you said this -- is this something -- are these two items things that can be done administratively by the secretary, or do they require statutory?

MR. LISK: I was trying to figure that out.

[Laughter.]

MR. LISK: I'm not quite sure, because I was trying to look at what flexibility the secretary has. I'm not specifically sure there yet.

DR. HOADLEY: Because I'm thinking in the context of the way we're talking about it, if this is something that's going to require a change in law, like, you know, we've got a long list of those things and this isn't going to get very high on that. If it's something the secretary could do, then to put it out there, I mean, there's no harm, obviously, if we can just say this, even if it requires law. But if it's something the secretary can do,
then I think that makes it more useful to make the
recommendation.

MR. LISK: I think that the secretary has a fair
bit of discretion in some things, but this kind of was the
-- the outlier policy was phased out so I'm not sure about
the day requirement. I think the CCR may -- there may be
some flexibility there but I really need to check back or
have legal advice on what is or not on that one.

DR. CROSSON: Kathy.

MS. BUTO: Meanwhile, having -- I tend to agree
with the idea that this isn't work a lot of -- a huge
amount of work, but I don't think it's that difficult to
find out what Medicare does on malpractice. And it did
something, and while I was there there were a whole bunch
of lawsuits, and we changed what we did. So if somebody
could just look that up, what is it that Medicare does with
respect to malpractice, in terms of a policy with
hospitals, I think that would shed a little light to
Bruce's question. And I think it ended up being more
complicated than simple. But a change was made, and I
think it was actually made as a result of lawsuits, not
legislation.
DR. CROSSON: So that's something, Bruce, we could bring back to you. But, I mean, here's what I'm sort of thinking here. I haven't heard a lot of objections to these two ideas. Now, there is the question of how difficult they would be to accomplish, and we can potentially get more information about that. But on the other hand, I'm not sure that bringing this topic back for another discussion is worth the squeeze, as somebody has like to say.

So I'm going to say something here. Is there anybody who disagrees with either of these two approaches? Alice.

DR. COOMBS: Just briefly, the second one. Although it may reduce gaining the -- because you look at the components of that table, it may or may not be able to address, because of the disease processes that are occurring the procedures, I personally don't think the length of stay is going to be helpful with the priority of that chart that we're dealing with, in terms of transplants and things of that nature.

And part of it has to do with the nature of transplants. They are prioritized based on how sick they
are. So the New England Organ Bank will put someone on the list and they move up the list the more sick they are. So I don't know if length of stay makes a difference because the mortality is very high and they may still have, you know, major interventions for greater intensity, for a shorter period of time, which may still result in them reaching their outlier benchmark to qualify. So the second part, I have a problem with. It decreases gaining but because of that chart -- the chart says that those diseases that are in that chart, and the procedures that are being performed, are not going to lend itself to length-of-stay issues because of the severity of the illnesses.

DR. CROSSON: So I think what I hear you saying is -- yeah, and I'm going to ask you in a second, Craig -- is that some of this lower length of stay in the higher charge ratio hospitals may be a function of the severity of the DRGs and patients are dying and so they're at a higher rate, so their length of stay is less. Is that what you're saying?

So can you speak to that, Craig?

MR. LISK: Well, what I was going to say is what
I said in my presentation but not in the paper was that you could actually have an exception for people who died, so that you would not end up -- that if the people died, the length of stay criteria would not apply. Because we're talking about these places that are taking simple cases -- and I think, in general, in terms of -- and you could -- I mean, there could be a second type of length of stay criteria too. There could just be -- set relative to the DRG, or it could be a set length. But it would tend to be still cases that are going to be -- just five days is, you know, one quarter of the way to what a typical length of stay is for an outlier case. So --

DR. COOMBS: I don't think we need to bring it back, but the other issue regarding transfers -- because some large institutions will do that CABG surgery and then do a shuttle to that rehab, and they don't go back to the primary hospital where they had the high-intensity procedure. They wind up at a community hospital. And right now there's no one really tracking that right now.

MR. LISK: So what I was going to say is another thing I brought up in the paper, and did not discuss extensively, and the length of stay takes care of this, is
there is a different criteria for outliers for transfer cases. And transfer to post-acute care even. So they have a -- they get a shorter stay and the length of stay criteria would take care of that. But the transfer issue is another one. Those short-stay hospitals had a lot more -- a fairly higher proportion of their cases is transfers. About 5 percent overall have a lower outlier criteria -- outlier cost threshold criteria because they are transferred to either post-acute care or to another hospital.

DR. CROSSON: So that said, if the mortality were extracted, would that go a long way to resolving --

DR. MILLER: I think that would largely -- I mean, I think it would largely address the issue you're raising.

DR. COOMBS: The first part, yes, and then the second part, transfers, and we have had this discussion before regarding the transfers, so that would be --

DR. CROSSON: Okay. So I'm not seeing any other hands so I'm thinking that what we have is, as we've often said, a bobble-head consensus --

[Laughter.]
DR. CROSSON: -- to support these two recommendations. And, you know, maybe at some point in the ES in the next couple of meetings we can just do a quick follow-up in terms of, you know, what would be required to get this to happen. How does that sound. Okay?

DR. CHRISTIANSON: Sounds good.

DR. CROSSON: Okay. So we have come to the end of this discussion. Thanks to Craig and Jeff. And we are now at a point where we're ready for our public discussion period, public comments.

If there are any members still remaining in the audience who would like to make a comment, please come to the microphone.

[No response.]

DR. CROSSON: Not seeing anyone, we are adjourned until 8:30 tomorrow.

[Whereupon, at 5:15 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, November, 4, 2016.]
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
PAT WANG, JD

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AGENDA

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

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

DR. JOHNSON: Yes.

DR. CROSSON: Well, take it from the top.

Thanks.

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

Today Scott and I will give you a head start on two issues that we discussed last year. I will begin with an overview of how risk adjustment affects payments to MA plans and will then present our updated analysis of the impact of coding differences on MA risk scores. Next, Scott will present analysis on how CMS calculates the fee-
for-service spending measure that is the basis for MA benchmarks.

Now to begin with risk adjustment, Medicare pays MA plans a monthly amount that is unique to each enrollee. These payments are the product of two factors: a base rate that is based on a local benchmark and a plan's bid, and a beneficiary-specific risk score. The base rate represents the average spending for the fee-for-service Medicare beneficiaries in a given geographic area. The risk score is a standardized measure of expected spending and adjusts the base rate, by increasing payment for beneficiaries who are sicker and more costly than average, and decreasing payment for beneficiaries who are less sick and less costly.

A risk score is calculated based on a beneficiary's demographic characteristics and whether he or she has certain medical conditions. In the risk adjustment model, medical conditions are identified by diagnosis codes and are grouped into hierarchical condition categories, or HCCs. Each demographic characteristic and HCC is associated with a relative expected spending amount. A risk score is the sum of those relative spending amounts.
The more HCCs that are indicated for a particular enrollee, the larger the risk score and the larger the associated Medicare payment will be for that enrollee.

The relative spending amounts in the risk adjustment model are estimated using Medicare fee-for-service diagnostic and spending information and, therefore, reflect the relationship between diagnostic coding and spending that exists in fee-for-service. The vast majority of HCCs are identified through physician and outpatient claims, which in fee-for-service are paid based on procedure codes and do not depend on diagnoses. Hence, there is little incentive to document all diagnoses or identify all HCCs for fee-for-service beneficiaries.

In MA, however, payment is tied directly to identifying HCCs, so there is a significant financial incentive to documenting all diagnoses. These differing incentives have led to diverging rates of diagnostic coding between MA and fee-for-service Medicare, such that enrollees of equivalent health status have higher risk scores and, therefore, generate higher payments when enrolled in MA.

This result is shown in a prior Commission
analysis which looked at beneficiaries who spent at least one year in fee-for-service and then switched to MA. Compared to the beneficiaries who remained in fee-for-service, those who switched to MA had risk scores that increased at least 6 percent faster in the first year. For each subsequent year of MA enrollment, MA risk scores increased by an additional 2 percent faster than fee-for-service.

For the past few years, we have also conducted an analysis to estimate the overall impact of differences in coding. For MA enrollees in each year, we calculated the cumulative increase in their risk scores over a period of past continuous MA enrollment, and then we compared these estimates of growth to similar cohorts of fee-for-service enrollees.

For 2015, we estimated that MA risk scores were 10 percent higher than fee-for-service. This estimate includes the effect of phasing in a new risk adjustment model, which excludes certain diagnosis codes that have had particularly divergent coding rates between MA and fee-for-service. Although the new model produces a lower overall impact of coding, both the old and new models exhibit a
steady divergence in MA and fee-for-service risk scores of about 1 percent per year, shown in the first two rows of the table.

By law, starting in 2010, CMS has reduced all MA payments by a single factor to adjust for differences in diagnostic coding. Starting in 2014, the law specified a minimum adjustment amount, and in each year since then CMS has applied the statutory minimum adjustment. For 2015, the statutory minimum was 5.16 percent. After factoring in all adjustments for coding, we found that 2015 MA risk scores were 4 percent higher than fee-for-service due to coding differences.

Given the impact of unadjusted coding differences and evidence of variation in coding intensity across plans, last year the Commission recommended adjusting for the full effect of coding differences and emphasized equity in the adjustment across MA plans. First, the Commission recommended using two years of diagnostic data for risk adjustment. This would reduce coding differences between MA and fee-for-service and would naturally target HCCs where coding is inconsistent across years. This policy would reduce the impact of coding differences by about 1 to
Second, the Commission recommended excluding diagnoses that are only identified through a health risk assessment from risk adjustment. This policy would affect MA plans in proportion to the number of assessment-based diagnoses that have no follow-up care and would reduce the overall impact of coding differences by about 2 to 3 percent.

Finally, after implementing these two policies, the Commission recommended that the Secretary apply an adjustment to account for the remaining impact of coding differences, which we estimate to be about 5 to 7 percent. The Commission discussed options for implementing this adjustment in an equitable manner across plans.

This graph shows coding intensity estimates for individual MA contracts and highlights the variation across contracts. On the left-hand side, some contracts have coding practices similar or below fee-for-service Medicare, and on the right-hand side, some contracts have average risk scores that have grown in excess of 30 percent over fee-for-service growth. Although the graph does not account for the effect of implementing the Commission's
first two recommended policies, I'll use it here to explain one idea for implementing the final part of the Commission's recommendation, addressing the remaining impact of coding differences.

The solid red line represents our estimate of the overall impact of coding intensity on MA risk scores. As you can see, a policy that reduces all risk scores by the same amount disadvantages some contracts, while allowing other contracts to retain a significant amount of revenue from higher coding intensity. A three-tier adjustment, illustrated by the three yellow dashed lines, would group contracts into low, medium, and high coding intensity categories and then apply an adjustment for each category. The adjustment for each category would be estimated based on the coding intensity of the contracts in that category. CMS has used these low, medium, and high coding intensity categories previously when selecting contracts for risk adjustment data validation audits.

Given the coding intensity recommendation you made in the March 2016 report, my part of the presentation requires no action. My presentation today was designed to give you an update on the impact of coding differences, to
provide some additional detail about the extent of variation in coding intensity, and present an idea for the Secretary to implement the Commission's recommendation that offers significant equity across plans. I also want to remind you that, if implemented, the recommendation would result in savings to the Medicare program.

I will now turn the presentation over to Scott to discuss MA benchmark calculations.

DR. HARRISON: Thank you, Andy.

Let me start with a little background on MA benchmarks. Benchmarks are county-specific, risk-adjusted, and serve as bidding targets for the MA plans. They also represent the maximum payment rate for MA plans in a county.

Each county's benchmark is determined by organizing the counties into four quartiles based on their per capita risk-adjusted fee-for-service spending. Counties are ranked by average fee-for-service spending; the lowest spending quartile of counties have base benchmarks set at 115 percent of local fee-for-service spending. The next quartile of county benchmarks is set at 107.5 percent of fee-for-service spending, followed by a
quartile set at 100 percent of fee-for-service spending. And the highest spending quartile has benchmarks set at 95 percent of local fee-for-service spending.

Conceptually, low fee-for-service spending counties have benchmarks higher than fee-for-service in order to help attract plans, and high fee-for-service spending counties have benchmarks lower than fee-for-service to generate Medicare savings.

As I noted, the starting point for calculating a county benchmark is the estimate of the county's fee-for-service per capita spending.

CMS calculates average risk-adjusted per capita fee-for-service Part A and Part B spending for each county. The calculation includes spending for all fee-for-service beneficiaries. All are included whether they have both Part A and Part B or they have Part A only or Part B only.

The main problem with this approach is that MA enrollees must be enrolled in both Part A and Part B. And our most recent data show that only 87 percent of fee-for-service beneficiaries are enrolled in both Part A and Part B. And we have found that beneficiaries who are in both Part A and B have higher average spending than other fee-
There are several issues arising from the inclusion of the Part A-only beneficiaries in the fee-for-service spending calculations. The big spending difference between all fee-for-service beneficiaries and those with both A and B arises because 12 percent of all fee-for-service beneficiaries have Part A only. And their average spending is much lower than the average spending for those with both A and B. This results in an underestimate of fee-for-service spending comparable to MA spending and, thus, an underestimate of MA benchmarks.

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

The Part A-only effect on the benchmarks varies because there's a lot of variation in the percentage of Part A-only beneficiaries in the fee-for-service population across the country. The share of A-only reached 25 percent of beneficiaries in some counties and as low as 3 percent in others. And as I will detail on the next slide, Part A-only beneficiaries are growing nationally as a share of fee-for-service beneficiaries.
Over the last few years, a high percentage of Medicare beneficiaries have joined managed care plans, and a higher percentage of those remaining in fee-for-service Medicare have not enrolled in Part B, meaning they are A only.

From July of 2009 to July 2015, the percentage of beneficiaries in Medicare managed care plans rose from 24 percent of all Medicare beneficiaries to almost 32 percent. Of those remaining in fee-for-service, the percentage of beneficiaries who have both Part A and Part B has declined from about 89 percent in 2009 to about 87 percent in 2015. That decrease is due entirely to the increase in the share of A-only fee-for-service beneficiaries, shown on the third row here, from about 10 percent to about 12 percent of fee-for-service beneficiaries.

In the Medicare program as a whole, and not shown on this slide, there was only a modest increase in the A-only share from about 8 percent in 2009 to about 8.5 percent in 2015. But that increase is amplified as all of the increase is contained in the fee-for-service population because beneficiaries who are not enrolled in Part B cannot enroll in Medicare managed care plans. Thus, as more
beneficiaries enrolled in A and B join plans, those
beneficiaries remaining in fee-for-service are less likely
to be enrolled in both Part A and Part B.

We found total average fee-for-service risk-adjusted spending for beneficiaries enrolled in both Part A
and Part B about 1 percent higher than the average spending
for all fee-for-service beneficiaries. However, those
counties with higher proportions of Part A-only
beneficiaries -- say 15 to 25 percent -- are likely to have
had larger reductions in their fee-for-service spending
numbers due to the calculation being based on all fee-for-
service beneficiaries. Alternatively, counties with
significantly lower shares of A-only enrollment may not
have been significantly affected by the current benchmark
calculation process.

As MA penetration continues to grow, we expect
these calculation issues to grow. Higher MA penetration
leaves fewer, and perhaps less representative,
beneficiaries on which to calculate fee-for-service
spending. The fee-for-service calculation could be
corrected to ensure that the population that is used to
calculate the fee-for-service spending is representative of
the expected spending for MA beneficiaries.

Because by law beneficiaries must have both Part A and Part B to enroll in MA, it might be more equitable for CMS to calculate the county-level fee-for-service spending on which the MA benchmarks are based using only fee-for-service beneficiaries who have both Part A and Part B. This way the calculations would be more reflective of MA enrollment.

Compared with the current CMS process of calculating county-level fee-for-service spending based on all beneficiaries, we estimate that using the average fee-for-service spending of only beneficiaries with both Part A and Part B in the benchmark calculations would increase benchmarks by about 1 percent nationally and, thus, result in an increase in payments to MA plans on the order of about $20 billion over 10 years.

Counties with 15 to 25 percent of their fee-for-service beneficiaries in Part A would likely have higher increases, up to 3 percent. Areas such as Pittsburgh, Denver, Albuquerque, Portland, Oregon, Hawaii, and several areas in California have 20 percent or more of their fee-for-service beneficiaries without Part B. These areas all
have MA penetration rates over 47 percent, and the estimated effects of using only beneficiaries with both Part A and Part B on fee-for-service spending could have a significant effect and result in higher benchmarks in areas like these.

We look forward to your discussion and are interested in learning whether the Commission is interested in making a recommendation to change the calculation of fee-for-service spending that determines the MA benchmarks.

DR. CROSSON: Great. Andrew, Scott, thank you very much.

We'll now take clarifying questions.

DR. HOADLEY: A couple of questions. Andy, on risk adjustment, the number that you show on Slide 5 that overall 2015 would be 4 percent higher, what's the comparison? What number were we looking at a year ago?

DR. JOHNSON: 3 percent.

DR. HOADLEY: 3 percent. So it's actually getting to be a larger --

DR. JOHNSON: Yes.

DR. HOADLEY: And, Scott, I think I asked some of this last year, but when you look at the Part A-only folks,
you talk about the fact that Medicare is a secondary payer for active workers, income-related premium folks maybe who opt out of Part B and so forth. But we don't have any numbers, is that right, from CMS on those different categories?

DR. HARRISON: We do not have numbers on the different categories. They must exist somewhere. We have not found them.

DR. HOADLEY: Yeah. And with the Medicare secondary payer, I mean, those are still part of this population that you're looking at?

DR. HARRISON: The plans get a reduced payment for people with -- a significantly reduced payment, obviously, for people with --

DR. HOADLEY: If they enroll in MA.

DR. HARRISON: Yes.

DR. HOADLEY: But they're still in the denominator for the fee-for-service calculation.

DR. HARRISON: I'm not clear. To be in, I think you have to have had a period where you're actually in so they can measure you. I think a lot of the people that are Medicare secondary payer aren't that, you know, for a long
period of time. So that gets a little dicey.

DR. HOADLEY: I mean, because, clearly, that population is drawing -- in many cases drawing almost nothing from their Medicare benefit.

DR. HARRISON: Right. And the other thing I want to note is that this is -- for the Part A-only people, we're only looking at the A spending.

DR. HOADLEY: Okay, right.

DR. HARRISON: So they're not included in the B denominator.

DR. HOADLEY: Okay. But even there, I mean, many of those -- certainly the secondary payer people are unlikely probably to incur any kind of Part A cost because their primary insurance is probably picking up all or most.

DR. HARRISON: You would hope.

DR. HOADLEY: Right.

MS. WANG: Are risk scores -- when the comparison is on this A/B, A and B, or A-only phenomenon, when risk scores are compared to fee-for-service, are they compared to A and B enrollees, beneficiaries?

DR. HARRISON: No, they're much lower. So --

MS. WANG: No, no. Does the comparison group
also include Part A-only beneficiaries or is the comparison -- the risk score comparison when you do these analyses --

DR. HARRISON: When you do this -- on Part A only, right, I would have a risk score that would be calculated, but I wouldn't have any Part B diagnoses, so it's usually a very low risk score.

MS. WANG: So is the coding intensity adjustment comparison of MA plans who have only A/B compared to a group that's A/B and in addition A only that --

DR. HARRISON: No, they were not done that way.

MS. WANG: Okay.

DR. HARRISON: When we did the comparison, we took only people with A and B.

MS. WANG: Got it. Okay.

The other question I have, I'm just curious about this with the A/B phenomenon. When the ACA sent benchmarks as a percentage of fee-for-service, do you know whether or not the fee-for-service that they were, you know, aiming at included A and B only or also this cohort of A only? I mean, the question is --

DR. HARRISON: Yeah, that's what we're -- right, that's what we're trying to get at, that when CMS
calculates it, they include people who are A only.

MS. WANG: Yes, but when Congress set, you know, the 115, 107, and half 100 and 95, do you know whether or not in their definition of a low-cost area versus a high-cost -- would this possibly --

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

MS. WANG: Meaning that they included A-only beneficiaries in their estimate or --

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

MS. WANG: Average fee-for-service.

DR. HARRISON: There's secretarial discretion on how to measure it.

MS. WANG: I just am curious. You know, this is a totally different conversation, but if this recommendation or this observation about sort of limiting to people with A and B only has implications for the level at which the percentages against fee-for-service are set. Do you know what I'm saying? If there is an area, if there --

DR. HARRISON: That's what we're saying the
problem is. It's that there is a mismatch.

DR. MILLER: Can I take a shot at this?

The way I would answer her question is, implicitly, Congress said all of fee-for-service. A few years back, depending on how far back you go, this wasn't really an issue. There wasn't this big difference between, just to keep it simple, the A-only population. So what we're saying in this analysis is if you set the MA benchmark using A plus B, it would move up. It would move up a lot in certain counties, a little in some counties, or maybe none in some counties, but it would move up, and so on net, this is increasing the benchmark.

Now, here's the second thought, I would say, to try and answer your question as directly as possible. Implicitly, the 95 and the 115 is off of whatever that baseline is. Are you okay with that?

MS. WANG: Right.

DR. MILLER: So we are talking about should we make a recommendation to move that benchmark up about a percent across the country, and then implicitly all of the 95, 115 would drive off of that new baseline.

MS. WANG: Right. I guess the question I have
is, Is there a further thought that the 95 and 115 would
need to be recalibrated if the estimate of underlying fee-
for-service spending was higher? I don't know.

DR. MILLER: I feel like we might be talking past
each other. I'm saying it would -- and maybe we do need to
just talk about it in more detail. The 95 percent number
would change too because if it came up a percent, that
whatever that dollar amount would --

MS. WANG: It would be 95 percent of the
additional percent.

DR. MILLER: Yes, right.

MS. WANG: So I'm saying maybe it would be 96
percent of the new fee-for-service equivalent or 112
percent of the new fee-for-service equivalent because the
base you're comparing against is different. That's all.
I just wonder whether it extends that far in
implications.

DR. CROSSON: Right. But, I mean, from a dollar
point of view, you arrive at the same point, I think.
You're just saying, "I'm going to take 95 percent off of a
different number instead of making the level of variation
off of that number."
DR. NERENZ: Well, if I can try to paraphrase, if you're talking past each other, I may be in the middle.

[Laughter.]

DR. NERENZ: I think what I was hearing is that if the effect of including only Part A, Part B would be to raise the benchmark, you could then counter that effect by changing the 115 number or the 95 number, and you could bring it back to budget-neutral. Is that --

DR. MILLER: But our point here -- I'm surprised. I am surprised by -- our point here is we think what's happening right now is not fair to the managed care plans, that the proper baseline is -- since I can only enroll an A/B person and you're comparing me to an average, that includes some people I can't even enroll. The whole point of this exercise, it's not budget-neutral. We're saying there's some dollars that should probably go back into the baseline to benefit the plan.

MS. WANG: Right. And I'm actually not speaking from the perspective of being in an A plan. When the percentages against fee-for-service were established, there was an assessment of lower cost areas that needed a higher percentage and higher cost areas that it was appropriated
I am simply asking are some of the implications include only A/B as the fee-for-service comparator, that those assessments of what's high cost and low cost might change, so that in a budget-neutral scenario, there is a redistribution of the percentage because there is a new and better -- so the example of the counties that were given as an example, that there is a high penetration of A only, there's also a very high penetration of MA. So that's kind of interesting. This is just observational.

DR. MILLER: And I do think it's possible that given that this phenomenon doesn't occur uniformly across the country, if you went back and reset everything, you might find small differences or some differences in the percentages of here's the counties that are here, you know, 95 and 115.

For the purposes of at least how we opened this conversation, this is something that we were thinking of that we wouldn't go back and recalculate it. As a technical question, it could potentially have some implications for that. Given the fact that these counties aren't distributed uniformly across the country and where
they would fall on each of those quartiles maybe would affect those percentages a bit, and maybe it's a further thought. But the idea here is right.

DR. CROSSON: Just to be clear, as it stands, this is not a budget-neutral proposal.

MS. BUTO: If I could just add one thing, I think Pat is assuming greater precision in coming up with these percentages in the legislation than probably existed at the time it was written. I mean, there were some rough justices, I guess, the way I would describe it and the way they came up with the numbers.

DR. CROSSON: Okay. Craig, I think, is next.

DR. SAMITT: Right. Thanks.

Great job with the paper. It was very clear. I was intrigued by Slide 7, and I was curious predominantly about the outliers to the far right, but I remember reading that there had been some -- one of the other alternative proposals to consider was a risk adjustment, risk-coding adjustment specifically for outlier pools as opposed to affecting everyone, including these three tranches. And I know you talked in the paper that doesn't have to be just three tranches. It can be more.
So you can even envision to the far right. There's an even higher adjustment.

But did you look at -- I think it may have been referenced in Kronick's paper in 2014 and even prior CMS proposals. Have you looked at an outlier-only adjustment as opposed to either an across-the-board adjustment or a triple-tiered adjustment as another alternative?

DR. JOHNSON: We haven't looked at an outlier adjustment only, mainly because I think most of the contracts have some level of coding intensity or increasing risk scores above fee-for-service. So, even if it is a small amount, that it is consistent over time over a couple of years that we've done this analysis that it shows up regularly, and I think that's the main reason for not focusing on just the highest end.

DR. SAMITT: I'll come back to it again in Round 2.

DR. CROSSON: Bruce.

MR. PYENSON: I have a couple of questions for Andy, and let me compliment you on the report, really a terrific report.

The two questions are -- the first is referencing
the CCIIO March report on risk adjustment, different context applies to the HHS risk adjuster, and that's concurrent, not perspective, of a bunch of differences. And they're recommending and going to use drugs for, I think, seven or eight categories of their HHS HCCs. Forgive me if this has been discussed before I got here, but I would ask your thoughts on whether that would be an idea in addition to the two-year span on risk adjustment, what your thinking is about that.

DR. JOHNSON: I think CMS has been pretty hesitant to include any measures of utilization in the risk adjustment in order to avoid any adverse incentives. I think the HHS risk adjustment uses the drug information only to adjust severity of given HHCs.

MR. PYENSON: The biggest example is probably -- it's to confirm a diagnosis, for example. There's, I think, two categories where they're doing a severity. For example, someone who has insulin and is not coded with diabetes would be presumed to have diabetes, sort of a flag mostly.

DR. JOHNSON: I don't know if the Commission has taken a position on --
DR. MILLER: Well, this may predate both of you, if I am remembering properly.

So Dan did some work on risk adjustment -- I want to say a few years ago -- and talked through some of these different ideas.

Andrew is correct, and the Commission also expressed these cautions that with these prospective approaches, there has to be a distinction between just utilization or those kinds of adjustments because you're basically starting to return a prospective system to a cost-based or utilization-based system. So there was real caution in putting prospective types of measures in.

Although, as you've pointed out, there are careful ways you can do it and also utilization that you can pick that is less gameable. So if you say somebody falls and breaks a hip and that's a prospective adjustment, that's not something that's gameable, whereas if you say I'm going to put in the amount of drugs that you use, then obviously there's a real incentive to do it.

My sense on the drug world -- and, again, I think you said this -- is there's markers to confirm diagnoses as opposed to counting numbers of scripts or utilization, that
But I also thought there was a -- and now I've walked off the end of the pier of what I remember, but I also thought these models are built in fee-for-service, off of fee-for-service, and in fee-for-service, there's still something of a disconnect of who has drug information and who doesn't because not everybody is enrolled in drugs. So bringing the drug stuff in would have to be thought through. That's not a "hell, no," but there's a little bit of a mismatch.

And then on the more general point on the perspective would be if you went in that direction, it would be picking almost sentinel events that were un-gameable, so that they made sense in the risk adjustment, but then didn't just turn it into a cost-based -- that's not quite the right word, but utilization-based adjustor. And we had some of that discussion -- I don't know -- two or three years ago. I'm forgetting.

MR. PYENSON: A second question, which is there is a process for submission of risk score information and transition from RAPS to EDPS. I'm not sure if it's clear how that would interact with your findings. Do you have a
sense of that?

DR. JOHNSON: Eventually, starting next year for
2016 risk scores, when the risk scores are based on a blend
of both RAPS and EDPS, we would include that information on
estimating the overall difference in MA risk score growth
compared to fee-for-service. So I think we'd have to see
what the analysis shows next year first before making any
judgment on how to further address that.

DR. CHRISTIANSON: So, on Jay's list, we have
Warner, Bill, Brian, and Kathy. So, Warner?

MR. THOMAS: One of my questions is on the
adjustment, this kind of three-tiered adjustment that
you're contemplating. I know there's several adjustments
that are being considered or are already implemented in MA.
I mean, do we have a full understanding of what the total
adjustments will be, once they're all fully implemented?
It seems like there's a lot of moving parts, some that are
already implemented, some that could be being proposed.

DR. JOHNSON: So the two specific adjustments to
address coding intensity or at least that clearly have an
impact on coding intensity are the phasing in of the new
model. So that is taken into account in the payment blend
in the bottom row here, and then subtracting from that, the 5.16 across-the-board adjustment that CMS implemented. That's where we come up with the resulting 4 percent difference, at least for 2015, and that's before, as Bruce mentioned, any encounter data effect it might have.

MR. THOMAS: So then what would the cumulative -- what's the potential cumulative adjustment? Are those additive? Do you have to add those together or --

DR. JOHNSON: It would be roughly the 10 percent overall estimate that we have of the full difference between MA and fee-for-service.

MR. THOMAS: So the 5 percent is included in the 10? 5.1?

DR. JOHNSON: Yes, yes.

MR. THOMAS: Okay.

DR. JOHNSON: So it's 5.16 plus 4. With rounding it, it comes up to 10.

MR. THOMAS: So then this 10 percent that's being contemplated there, is that inclusive of the new recommendation as well, or is the new recommendation on -- would be on top of that?

DR. JOHNSON: So the recommendation from last
year would get rid of the 5.16 percent and do two years of data, remove health risk assessment diagnoses, and then make an adjustment after those two are in place.

MR. THOMAS: Okay. All right. Thank you.

MR. GRADISON: The question has already been covered. Thank you.

DR. DeBUSK: First of all, thank you for a great chapter. It was sort of exciting to read.

I had a question on page 19 of the reading. As you talk about doing contract-level coding intensity, you speak to grouping contracts into different categories -- high, medium, and low coding intensity. And I had a question there about circularity. How would you tell the difference between a contract that has a high degree of coding intensity versus a plan that just has a higher acuity patient? Because it seems like if you had the information to put them in the appropriate category, you would already know the adjustment. So it seems circular to me.

DR. JOHNSON: So there is -- I mean, the way that we did this analysis is looking at the enrollees in a contract in 2015 and then looked at their past history
based on how long they were continuously enrolled in MA, and we compared those change estimates to the fee-for-service, similar cohorts of similar length of enrollment.

So, at the contract level, there's some consistency over year, but it moved a little bit. So that's why we suggested that there be a grouping of contracts. Contracts did not tend to jump from the low category to the higher category with the specific numbers, so that this grouping was a way of sort of combining like contracts into an estimate that's predictable from one year to the next.

DR. DeBUSK: So, basically, once you learned your reputation for, say, being a highly intensely coded plan, you sort of stayed in that category, then?

DR. JOHNSON: I think that is either something for the Commission to take a stance on or for CMS in implementing the policies, how frequently assigning contracts to a level would happen and whether or not that happens prospectively or after the fact as implementation issues.

DR. DeBUSK: Thank you.

DR. JOHNSON: Thank you.
DR. CROSSON: Kathy.

MS. BUTO: I think I understand this, but I wondered if you could walk through again the budgetary effects or the supposed budgetary effects or estimates related to first addressing the coding intensity issues and then taking out Part A only. So, obviously, they're moving in different directions. Is the Part A only adjustment which will raise the payments to MA plans much smaller, I guess is the way I'm thinking about it, than taking out -- or much larger, I guess is the question. Will the amount go up by such a great amount that by taking the -- doing a more thorough job on coding intensity, they'll still benefit from the two things happening at one time?

DR. JOHNSON: I think all of our estimates show the coding intensity adjustment to be larger than the MA only.

MS. BUTO: Than the MA only -- or the Part A only?

DR. JOHNSON: Part A only. Excuse me. Yes.

DR. HARRISON: There could bed plans who operate in counties that would get, say, a 3 percent bump in the benchmark, and they're low coders. It could be that they
would end up actually benefitting on that, possibly. Don't know.

DR. CROSSON: Okay. Do we have all the clarifying questions, or have we missed anyone? Alice and Jon.

DR. COOMBS: So I had a question regarding the impact of employee on the calculation going forward. Is that a significant effect in terms of predicting the Part A, Part B participation?

DR. HARRISON: So you're talking about people over 65 working, whether that --

DR. COOMBS: Yes, yes.

DR. HARRISON: So, typically, they would be in Part A and then not sign up for Part B until they needed to. So, if they still had employer coverage, they probably wouldn't sign up for B.

DR. COOMBS: So, as regions change based on the employment in that age group, different areas -- say the employment for a 70-year-old might change the dynamics within certain geographies as opposed to others.

DR. HARRISON: It could, and CMS pays plans.

There's a special Medicare secondary payer adjustment that
they use when they pay plans, so they pay plans much less if Medicare is --

DR. COOMBS: And so there is some kind of knowledge about a variation, a regional variation of that, or how does that work?

DR. HARRISON: I assume there is a regional variation, and it's taken into account when the rates are set. And every plan has a different Medicare secondary payer adjustment.

DR. COOMBS: What percentage range is it? Do you have a number?

DR. HARRISON: We don't know. It's going to be less than -- it's going to be less than 12 percent, but we don't know.

DR. COOMBS: Okay, okay.

DR. CROSSON: Jon, and then I saw -- sorry.

DR. CHRISTIANSON: Paul said maybe he can jump in.

DR. CROSSON: Oh, you're jumping in on that.

DR. GINSBURG: So sorry about the geographic variation in the Part A only.

You mentioned the cities that have the highest.
It sounds like all knowledge economies -- Denver, Portland, California. That's probably where we'd expect the highest rate of labor force participation over 65, so I suspect that's --

DR. HARRISON: Does Portland have any people over 65?

[Laughter.]

DR. CROSSON: Look around the table, please.

DR. MILLER: You can see Scott is very pleased.

[Laughter.]

DR. CHRISTIANSON: You started off by, I think, correctly saying that the fee-for-service sector doesn't have an incentive to completely code, and the MA sector has an incentive to -- I think the words you used -- generally aggressively code. So I thought it might be useful to review for the Commission the evidence for why Congress has taken the position, it seems like implied, that the problem is in the MA sector. The MA plans would say, "We're accurately coding," and yet Congress had said we need to reduce -- you know, basically reduce payment to account for the fact that there's this more aggressive coding.

Can you review for us the evidence that would
lead us to assume that the problem is overappropriate
coding in the MA sector that needs to be reduced or whacked
down by 5 percent every year?

DR. JOHNSON: I see it as sort of a conceptual
framework issue in that the payment policy is based on fee-
for-service, diagnostic, and spending information because
that's currently the only data set available to make the
link between those two sets of information and to estimate
the set of risk score coefficients.

So in order to produce accurate payments to MA
plans, there is a necessary adjustment to ensure that
there's similar levels of coding in both MA and fee-for-
service, and to make sure that when the numbers of HCCs
identified for a particular enrollee are different, that
the dollar amounts get adjusted at the end through this
coding adjustment.

DR. MILLER: Can I also take a shot at it?

DR. CROSSON: Yeah.

DR. MILLER: So I'm kind of making this up and
trying to put it in, you know, civilian terms -- well, for
everybody. I know Jon has a deeper understanding of this.

So in a sense, what you do is you go into fee-
for-service. That's the complete database. That is what
the benchmark is based on. And you go through, and you say
there's a set of -- you know, there's a set of
relationships, and you build the relative relationships in
the risk model using that. And in a sense, you're
implicitly saying there's a block of dollars and you have
distributed them across people and said this is how it
would work or this is the relationship of those dollars.

Then there's a second step. So you've built this
model, and it sits out there, and you say each time you
code on this, there's a dollar increment in your payment.
And so if that was built using three codes per person --
just pretend that that's what happened -- and then somebody
had an incentive to more -- and this isn't incorrect, but
an incentive to go find each and every code that that
person could possibly be coded on, they could come up with
five codes or six codes. Okay? Because your dollar amount
just follows how many codes you are, you are not
necessarily back at that implied total spend that you built
the model out of. So if you built the model out of $100
and said on-net there's $100 in a population that looks
like this, and then said, okay, now, tell me your codes,
and I came up with, instead of three, six codes for each person, you end up spending more than $100.

And what you're seeing over time is that fee-for-service coding grows like this and MA coding grows like this [indicating], and the difference is what they're spending above what they would have spent if it was the same sets of codes that came out of what the model was built on.

As I listen to myself, I realize that's not clear.

[Laughter.]

DR. CHRISTIANSON: What you're saying is it's not an issue -- if I understand what you said, it's not an issue of accuracy of coding; it's an issue of trying to make everything fit within a given dollar amount?

DR. MILLER: Yeah, and that's -- thank you, Jon, and I think you were just being nice, and I appreciate that. Yeah, that is what I was trying to say. It doesn't necessarily mean that the plans have coded inaccurately. It may truly be that the person has, you know, multiple conditions that in the fee-for-service world it wasn't worth an extra dollar to code. But now when you step out
of the fee-for-service framework and get your payment on
the managed care side, it is definitely worth the trouble
to go find that code, and you just don't end up back to a
budget-neutral dollar, like Jon said.

MS. WANG: So that's very clear. There is sort
of a brute force kind of like get back into the original
pot of dollars that we started with. You know, I think
that the coding intensity discussion is very confused --
not confused, but complicated by a lot of incoming. You
know, you have this chart on page 7 that shows this extreme
coding behavior among some plans that drives risk scores up
and leads people to believe there's kind of gaming or
people are just doing this to get money. And then there
are plans that think they're doing their job by identifying
previously unidentified conditions so they can work on
them, and that shows up in what's called coding intensity
because fee-for-service didn't catch them.

I do wonder what the implications are, though,
because my understanding is that within ACOs, ACOs also are
gathering risk scores -- is that true -- when they compute
against their baseline? There is a risk score adjustment
there. So I think that there's a bigger implication here
that any -- if we're saying that any change in the capture
of HCCs and conditions that somebody is identifying because
they're working on them must be by brute force returned to
zero, to the fee-for-service -- I think we've got a
problem.

So, you know, I do -- I think that the focus on
eliminating the worst effects of sort of the revenue
maximization from coding activities is very, very
legitimate and needed to be addressed. But I'm a little
bit worried about the underlying philosophy that says,
whether it's an MA plan or an ACO or any kind of value
base, we have to return by brute force back to net neutral
to fee-for-service.

DR. MILLER: But there are a couple things in
there, and just to be, you know, very direct about this,
I've had my own travels among managed care plans, and there
are lots of managed care plans that are pointing fingers at
each other and saying actually they aren't -- that there
are people who are aggressively engaged in revenue -- and
you've acknowledged that. And so even among managed care
plans, there's a lot of finger pointing of like this is
going on, they've hired these consultants, and they're just
The second thing I would say about the ACO -- and this is, you know, with two seconds of thought, and so I don't feel real confident in it. If it's happening and there is some coding that results in fee-for-service, more coding that results in fee-for-service as a result of the ACO, then the comparison baseline off of fee-for-service should go up. And so, you know, in theory, whatever these calculations are should catch that.

The other thing I would say is some people in the managed care industry say, well, you know, if we would just move to an encounter-based risk model, we wouldn't have to worry about this scoring -- or I mean this adjustment. And there's some truth to that because you'd be kind of renormalizing to the behavior of the plans. But even there, keep in mind that if another plan codes a lot more than your plan, then they're going to -- of that revenue, they're also going to draw more out of it there.

So I think even if this problem were to switch and say it should be more of a managed care phenomenon, I still think among the plans there would be finger pointing and questions about, well, shouldn't you be going after
certain types of plans? I don't know that the problem goes away entirely --

DR. CROSSON: All right --

DR. MILLER: -- even if you move off of fee-for-service. I'm sorry.

DR. CROSSON: We've moved away from clarifying questions into content here, so let me ask, are there actually clarifying questions? If not -- Warner, and then we're going to move to Craig and go into the content.

MR. THOMAS: Just real quick. I had asked earlier about the aggregate change, which you've indicated here. Do you have a range of -- you know, because I understand this is an average across all -- across the country. Do you have a regional or a market look at what these variations look like or a plan look at what the range of -- I mean, I see this, but I guess at the end of the day, what would be the calculated impact of -- or the estimated impact of all these changes kind of on plans kind of across a broader spectrum, you know, a range of change?

DR. JOHNSON: I think the -- I mean, the way that we have described and estimated the impact of the Commission's recommendation is that using two years of
diagnostic data would have somewhat of a broader effect across plans, but might affect certain HCCs where fee-for-service coding is more inconsistent across years. So that might have a differential effect across plans. Using health risk assessments would also have a differential effect across plans. And then when you -- so 1 to 2 percent and 2 to 3 percent is the aggregate numbers. I don't think we've done an analysis to figure out exactly how much the first policy would do. Last year, we did put up some graphs about the impact of health risk assessments across plans, and the graph looked similar to this one where there was a big right tail. But then the remaining portion is this 5 to 7 percent, which we estimated would be -- you know, introduce some inequity across the contract.

So I don't know that we've put an estimate together for specific contracts of how each of the three policies would work together, but there is evidence that we'd be tending in the right direction so that there would be larger adjustments for plans that have higher coding intensity and smaller for plans at lower coding intensity.

MS. BUTO: Very quick, and this sort of goes back to my question that's related to what Warner was just
asking. So the only number we have in the paper is the $20 billion over 10 years increase in the benchmarks. And I think what's helpful to know is what is the cumulative 10-year number roughly for the adjustment that we're talking about making, because that feels like it's going to be a lot bigger. But I don't know -- I don't have a sense of what those two are. So the number that we see is the $20 billion, but my sense is that overall this is going to be a fairly significant hit.

DR. JOHNSON: So the $20 billion estimate over 10 years from using A and B beneficiaries to calculate the benchmark matches up against what we say is a 4 percent increase in coding in one year. Scott's estimate comes up to about 1 percent per year, so there is a differential in each year, and that would be expected to continue forward, you know, in parallel. There would continue to be higher impact from coding recommendation than using A and B.

MS. BUTO: Right, but you don't have a rough number of what that impact is?

DR. MILLER: That's something we can work through and come back to [off microphone]. The way I think about it is that the Commission made some recommendations on
coding, and a lot of those recommendations were driven by
the equity issue that you see here in a couple, two, three
ways, and some savings come out of that. And the point I
wanted to put across to you guys and get you to understand
is if you want to go after the A/B issue, which is sort of
a different, you know, equity issue, there's probably
something of -- you don't have to worry about the fact that
you're spending the $20 billion because you've already made
recommendations on savings, is kind of the thought process.

DR. CROSSON: Okay. So let's go into the
discussion. Could you throw up Slide 14 just to remember
we have a question on the table as well? Craig, you're
going to start off.

DR. SAMITT: Thanks very much, Jay.
I'd start with sort of the context that I've
practiced in and led provider organizations in both the
fee-for-service Medicare and the managed MA world, and I'm
going to focus most of my remarks around the risk intensity
adjustment, because this isn't just a coding issue. This
is a clinical management issue that the practice patterns
and the clinical models are different and distinct in many
respects in the practices and the fee-for-service world
than the practices in the MA world. And so in many respects, I echo Pat's concerns that we're painting a risk intensity adjustment with a broad brush when in all reality you've got good performers and you've got bad actors.

And while certainly a three-tiered approach, or I would even argue it should be four or five tiers, is better than a single tier, I'm concerned, when you look at Slide 7, that you can't tell which contracts are good actors and which contracts are bad actors. And in many respects, we're penalizing everyone.

What I'm most concerned about is you've got complex Medicare populations that are being served by organizations that need accurate risk adjustment coding to support the resources needed to manage their care. And the intensity adjustments may very well dismantle or diminish the ability for those practices to do that.

It may just suggest that the risk adjustment methodology overall, to Mark's point earlier about is there an alternative, is just generally flawed because we can't easily tease apart what is a risk adjustment for the sake of coding only and what is true intensity, because these practices are investing greater resources to support that
care. So I have concerns about the adjustment overall.

Certainly, again, the tiering is better, but it still feels to me as if it's inadequate.

I also would tag onto Jon's comment. You know, we talk about the MA part of the risk intensity adjustment as kind of the flawed part, but I'm concerned about the fee-for-service side. So, you know, what do we do to encourage not just appropriate coding but appropriate management and appropriate identification of disease state in fee-for-service as much as may exist in Medicare Advantage? And so it's not referenced much in the paper. I think it's underappreciated. But to what degree does the MACRA legislation move this needle? Should we think about a requirement for more accurate coding and diagnosis in fee-for-service through MACRA? And, you know, it's mentioned in the paper that ACOs do focus on coding, but maybe it's a significant both undercoding and undermanagement issue in fee-for-service that needs attention. And I guess I'd be interested if MACRA would advance that.

We didn't talk about this in the clarifying, but I do agree kind of with the removal of special needs plans
from this analysis, and it wasn't clear to me in the paper how we would think about risk intensity adjustment at all in the SNP population. But you could argue that SNP selection is true intensity selection, that these complex patients would choose to be part of SNP plans. So I would imagine that if we do remove SNP, it would be done in a non-budget-neutral manner in that SNP truly is excluded, and if we think about intensity adjustment, if we must, that it's the balance of MA versus fee-for-service as opposed to siphoning off resources from risk intensity adjustment in MA because we're pulling out SNP.

And then, finally, just a comment about the benchmark A/B. I am in support of this recommendation. It seems rational. It doesn't seem appropriate that benchmarks would be set for A or B as opposed to A and B. And I would be in favor of that recommended change.

DR. CROSSON: Thank you, Craig.

Scott, Andrew, let me just ask a question in follow-up to what Craig said. So the type of coding process or diagnostic identification that is inherent in the ACO payment system, is that different from or the same as what exists in MA?
DR. JOHNSON: I don't know if I know for sure, but I think that to the extent that there are incentives in ACOs to code more completely, that those efforts would be captured in our comparison fee-for-service group.

DR. MILLER: And, also, David wrote me a note that there is actually an adjustment that is done in the ACOs if they see that the coding is exceeding --

MR. GLASS: There are limits on [off microphone].

DR. MILLER: Right. So some of the same behavior that's being applied on the MA side is applied on the ACO --

DR. CROSSON: I'm sorry. So CMS makes an adjustment?

MR. GLASS: Yes [off microphone].

MR. PYENSON: Under MSSP Model 1, risk scores for existing patients can't go up by more than --

MR. GLASS: The demographic [off microphone].

MR. PYENSON: I'm sorry?

MR. GLASS: The demographic [off microphone].

MR. PYENSON: Yeah, just the demographic, people get older. But they can go down.

Now, one of the dynamics here, the reason why
using two years of data is such an important thing is that codes disappear, right? You see something like, I don't know, 20 percent of HIV/AIDS patients where we know there's no cure not being coded in the next year, and that's been a challenge for MSSPs until they figured out they have to do a better job of coding, because risk scores are allowed to go down for Model 1. So it's a very different incentive for the ACOs than for the MAs.

DR. CROSSON: Thank you for that.

Okay. So let's go to continue the discussion. Can I see hands for people who want to -- so let's start with Jack and move this way.

DR. HOADLEY: So I agree with some of Craig's comments in terms of the need to think more about getting things right on the fee-for-service side, but I kind of look at the exercise we're in here as more of sort of a math and mechanics issue. So the mechanics is the sense that a couple of the references has been to, that if you don't happen to have an encounter in a given year in the fee-for-service system, there just may be no mechanical way that that diagnosis shows up. And that's part of why we have the two-year recommendation is to say, well, if that
encounter about your HIV, you didn't happen to see any
physician because things are stable, and maybe you had an
encounter where you broke an arm, and the orthopedist has
no particular reason to put an HIV diagnosis code on,
that's no longer in the data set. So it's those kinds of
mechanical things.

And, sure, it would be better if each physician
sort of recorded more of the full history because,
obviously, that orthopedist wants to know if the person has
HIV or diabetes or whatever as part of treating the
orthopedic issue, but mechanically, that's not just the way
it happens. So it seems like that's part of our -- we're
just sort of trying then to correct the math, that when we
do a calculation with fee-for-service data and then the MA
world is just doing things differently, mechanically, that
we're just trying to get the math to line up. And I think
sometimes the rhetoric becomes "Oh, we're correcting the
incorrect coding intensity on the MA," and some of it, in
particular, things we've illustrated on the nonmedical
encounters may be about that. And that's, again, one of
our other recommendations.

But to the extent that it's just in the system
differently, it seems to me like we're just kind of correcting the math, and we should maybe be careful not to -- I don't know that we have done this wrong in our reports or anything, but just in general, when people are talking about it, talk less about, oh, well, the MA plans over-code. They just code differently, and so we're trying to reconcile it. And that's kind of the way I think about it. And I think the suggested alternative goes in that direction to try to get the math even further right among the MA plans, and that goes to the equity. And that comes back on the other issue where I think I also agree with the recommendation, and I think it's partly that when we started doing this or when CMS started doing this, the amount of people in this box of Part A only was smaller, so it didn't matter so much. And you made this point. It's growing, but it's also growing unevenly, and those are reasons to say it creates some inequity. So there's a logic to fixing it, just like the inequity in the graph that you showed on the risk scores builds the case to make the kinds of corrections we see there. So I think we're going in the right direction on both of these issues.

DR. CROSSON: Kathy.
MS. BUTO: So I really like two of the adjustments that you're recommending for dealing with intensity, the two years of data, and then excluding the diagnosis, which diagnoses only documented through health risk assessments. I think those are pretty solid.

I also like the tiers, the fact that we made an effort -- and I think this was your design -- to group plans by coding behavior. I think that's really a good direction to go.

I'm queasy, though, about this whole notion of just taking the residual, and it goes back to, I think, what Craig and Pat were saying, which is I'm not totally sure that we should take all the residual back. My sense is some of it. Not knowing any other way to do it, I guess what I'd prefer to see is for CMS -- or for there to be some way to audit or look at this issue of coding intensity on a sample of plans, maybe in the tiers, in such a way that you could actually develop at least another data point to test our assumption that the whole residual needs to be adjusted for.

So that's the only part that really gives me pause. I don't know that there's a good way to do that
without spending a lot of money to do an audit like that, but it just strikes me that at some point, we need to know whether that assumption is totally correct, that the whole residual needs to be adjusted for. So that's my only concern.

DR. CROSSON: Paul and then David.

DR. GINSBURG: Yeah. Well, I think the recommendations on Part A only are very good. I was particularly struck when you showed how certain metropolitan areas, this is a big deal for, and so I think that could be --

I think Craig's comment about looking into ways to get better coding in fee-for-service is very intriguing. One thought I had, the degree to which areas with higher MA penetration or higher ACO penetration would actually influence coding and fee-for-service in the way that management often does have spillover effects and influences practice patterns in the fee-for-service sector.

I presume you could just look at the fee-for-service trends in those areas with high MA penetration and see if they're different from others, and so I'm not sure what you do with it. Other than have influence go from MA
and ACOs to fee-for-service, I don't know of any other way
to actually influence fee-for-service coding because the
incentives are fee-for-service incentives.

So I think I'll stop there.

DR. JOHNSON: Can I add to that point? That we
did look at the comparison of MA contract-specific coding
to national fee-for-service and then a separate comparison
to local fee-for-service areas based on the service area of
the MA contracts, and it did make some difference for
individual contracts. We did not look at whether or not it
aligned with MA penetration rates, but overall, there was a
little bit of change, and it seemed to be fairly random.

DR. GINSBURG: I have one more comment that I
forgot about. Kind of an overlay to this whole discussion,
thinking back to our premium support discussion is that one
of the major issues about going forward with premium has
always been is the risk adjustment good enough in the sense
we're dealing today with risk adjustment which -- I mean
risk coding which has a threat to the trust funds that's
going to cost the program more than it should, whereas
under premium support, it can drive up the prices of the
fee-for-service plans, in a sense, lead to a situation
where there's a bigger share of MA than what the beneficiaries would really like because it's distorted the price signal. I don't think we want to get into that today, but I just wanted to point it out for context.

Frankly, after reading your paper, I was actually much more optimistic about the ability to do premium support and not have it be really impaired by risk-coding issues.

DR. CROSSON: David.

DR. NERENZ: This is going to be an arithmetic question, but I want to walk through a little exercise. I am particularly thinking about the effect of this change on movement of counties among the quartiles, so just walk with me a little bit. And let's use Portland as the example, even though there aren't any over-65 people there. We'll use it anyway, whatever county that is. I don't know that.

But they would be an example, I guess, of this problem, if it's a problem, that they have a lot of folks there who are Part A only. So, therefore, that depresses the estimate of fee-for-service spending. That is a starting point.

Now, it seems like, then, the immediate effect,
all else equal, is it puts them in either the 107 percent
or even the 115 percent because they're a low per-capita
thing artificially.

Now, I guess one thought is that part of the
relief is present in the model already, then, because they
get to bid against the 115 percent of that artificially low
estimate. So part of the problem, I would say, is perhaps
already solved, but let's keep going, if I'm good so far.

Then if we do this, the effect is we're going to
now peg that county's estimate to Part A/B only, and it's
going to go up. Okay. But that's not automatically a
benefit because what it might do is drop them from the 115
quartile to the 107 quartile, and it may be that it's a
wash, then, maybe, or they drop to the 100 quartile. I
don't know. But that will happen, right, if this occurs?

DR. HARRISON: Yes. Counties could go both ways.
That's right. Yes.

DR. NERENZ: Well, but in this example, the
counties presumably that this would help, in some cases,
wherever they sit at the margin, they may drop into a lower
quartile and may lose whatever benefit they were going to
get. And we haven't modeled that.
So I understand that across all MA plans, doing this might kick payments up 1 percent or so, but I'm just trying to make sure that we all understand that some of the relief to this Part A-only problem is already baked into the formula, I think, in the sense that they will -- all else equal, more likely fall into these 107 and 115 quartiles.

DR. HARRISON: Yeah. It's distributional. I mean, no county would see more than a 3 percent raise, but it could cross over.

DR. NERENZ: No, but it's quartile. I mean, somebody is at the margin --

DR. HARRISON: Yeah.

DR. NERENZ: -- and some of them are going to fall. Okay. All right. So there's that.

Then I guess if that's so -- I guess, now to follow on Craig's -- just simply to be more accurate and fair, I guess this still might be okay, but only if it's easy to implement because I just think the effects finally on the ground may be small relative to whatever administrative hassle there might be. So if it's easy to implement, I'd say go ahead.
Then I guess the last thing, it seemed like in other areas of our discussion, we have made the point one way or the other that, in general, MA plans are not underpaid, and that seems to be part of our premium support discussion. And it's popped up other places. Now, if that's so, I guess I'd say I'd probably figure out better ways to use $20 billion over 10 years than here.

DR. CROSSON: I missed one thing in what you said, David, when you said if it's simple to implement. Are you talking about that adjustment, or are you talking about somehow fixing the quartile, the fall from one quartile to the other?

DR. NERENZ: No, it would be this specifically.

DR. CROSSON: That, that, that.

DR. NERENZ: I assume if you leave the quartile things in place, if you leave the specific 100, 107 --

DR. CROSSON: Right, right.

DR. NERENZ: -- if it's just simply administratively really easy to implement this, then, yeah, okay. Go ahead. But I don't think the effects will be profound.

DR. CROSSON: I thought where you were going was
saying hold harmless, counties, which would fall --

DR. NERENZ: No, no, no.

DR. CROSSON: Okay. All right.

DR. NERENZ: How many man-hours or women-hours
does it take to make this change happen?

DR. CROSSON: Yeah, yeah.

DR. NERENZ: Some things are easy; some things
are hard.

DR. CROSSON: Do you want to respond?

DR. MILLER: The only thing I -- I was going to
respond to a different point, and my take, Scot, would be
to respond to the point that you two just had. My take on
this would be it wouldn't be terribly difficult to
implement. We would expect CMS to come up with their own
estimate and see where they ended up, and then they would
start publishing county benchmarks that were A/B instead of
total fee-for-service. That's my sense.

And I don't mean to discount. They have to think
through it. They have to get the risk adjustment right.

They have to do all that, but this isn't a thousand moving
parts.

You did also say something else in the midst of
all of that. We don't think managed care plans are
underpaid, I think was your construction. There's two
things I wanted to say in response to a couple of comments.

One is you may recall from yesterday, Jeff hit
this point really quickly. We're about 105 percent of fee-
for-service, and part of that is because of the coding
effect. The Congress is going to continue to pay attention
to that, and one way to look at the coding recommendation
we've already made is if you do anything here, at least do
it more equitably. So, at a minimum, kind of keep that in
mind.

Then I'm going to say this. I think everybody
understands this, but sometimes the tenor of the comments
are not entirely -- I'm not entirely sure. Looking at you
two, make sure this sentence is correct. If fee-for-
service coded exactly the way MA plans coded, it's not that
there would be 10 percent more dollars. There would be 10
percent less. Everybody gets that. Because sometimes I
feel like I'm in rooms with managed care plans and they're
sort of saying, you know, fee-for-service -- and this whole
bit about fee-for-service is wrong, MA is wrong, whatever,
and I think Jack's points are on point, and our vocabulary
should be.

But if they coded the same, there would be no additional dollars in the system. I just want to make sure that everybody gets that.

DR. CROSSON: Bill.

DR. HALL: Going around now?

DR. CROSSON: Yeah.

Sorry. Did I miss you? I'm sorry.


I want to go back because Craig and Kathy's comments about the risk score intensity in particular, I think, are very important to consider.

While we are trying to figure out the perfect system, though, to capture this, I want to go back and ask people to stare at Slide 7 again to understand really what it means to tier the impact of any kind of coding intensity adjustment. In the current system, the solid line is -- again, I call this "brute force" -- is a way for Medicare to recover the amount of money that they deem they need to recover, rightly or wrongly. Plans below the solid line are getting the same cut, so that their risk scores may actually fall below one because they're just getting that
10 percent cut. Even if their coding intensity is 2 percent, they're getting a 10 percent reduction in the risk score, and the dotted-line tier above the solid line is being subsidized by that because that 10 percent dollar amount is being recovered.

I think that not only is this an incredibly important sort of advancement to ensure equity in the way that the current coding intensity adjustment is applied, it also -- I realize that we don't know kind of the sort of composition of what's driving this distribution of risk score increases, but to the extent -- to the extent that organizations are investing a lot of dollars and collecting risk scores, this creates a really perverse incentive to just keep doing that and driving that up because you're never going to get cut more than the across-the-aboard amount.

So I think it is extremely important. It's in the slide deck, and I appreciate that it has been raised again as something to ensure more equitable distribution of the coding intensity adjustment, while we are grappling with what that adjustment should be and whether it should be and what the composition is. So this is an incredibly
important element of ensuring equity.

As far as the A/B issue is concerned, also, it has to make sense, right? You have to sort of have an apples-to-apples comparison. I think David's comments about sort of maybe noodling over the implications of that to overall -- the quartiles of the benchmarks is important to note. I don't know if it's an automatic thing that happens or if that's by statute. Who's in which quartile, I honestly don't know.

But I also would observe that despite the flaws, managed care, MA penetration in those counties is extraordinarily high. So maybe the problem is getting worse, and what we're anticipating is that the fee-for-service equivalent calculation is going to sort of degrade and be more of a problem in the future. But at least from the establishment of that methodology to the present, it doesn't really seem to have affected the attractiveness of MA plans. It's just interesting.

DR. HOADLEY: Can I follow up on that?

DR. CROSSON: Jack.

DR. HOADLEY: In looking at that Slide 7 -- and I think you said this in the presentation -- this does not
also incorporate what might be the impact of our second recommendation on excluding the diagnoses. If that recommendation works as it's been designed, that would also deal with that right-hand tail, we would speculate. I mean, maybe we don't quite -- can't document that. Is that right?

DR. JOHNSON: That's correct. This is just an illustrative example, and we expect that the first two policies will dampen the significant increase on the right-hand side.

DR. HOADLEY: And that would mean that the three dashed lines might even do a better job of approximating the adjustment.

DR. GINSBURG: I think what we're really talking about is that the more we can do proposals like the two we have about the two-year and the risk assessment thing, the less residual we have to be faced with. So, clearly, unless the ideas are erroneous, it seems like a big win just to get that residual down.

DR. CROSSON: Bill.

DR. HALL: So it seems to me that a lot of what we're talking about depends on our faith that the coding
around the country is uniform, that it represents, as I think Craig alluded to, the quality of medical care or the value of medical care that's being distributed.

I like the fact that you used bad actors and good actors, Craig, in your description. This may have serious implications.

The community that I work in has very high Medicare penetrants -- MA penetrants, some of the highest in the country, and the practical sequelae is that when I'm active on our clinical services in the hospital, that there's such intensity and interest in coding that the diagnostic sheet that I'm asked to sign off for, let's say, after a hospital admission, it doesn't necessarily reflect what I think are the clinical factors that lead to intensity and, therefore, more resource utilization.

Let me give you an example. Bruce, you mentioned that HIV doesn't get coded sometimes, even though we know it's there. So 20 years ago, HIV was a 100 percent fatal disease, so that's pretty serious. Today, it's not. The majority of Americans with HIV right now are over age 50, and that will be true for the next 20 or 30 years. They're leading normal lives.
So the fact that if I miss that diagnosis when I'm filling out a diagnosis sheet, the coders will come in and they say, "Dr. Hall, how could you possibly have missed HIV in this patient? What kind of doctor are you?" Well, I suppose I should have remembered that, and I will try to remember that in the future, but it has almost no bearing on the quality of care and the intensity of resource utilization.

So from my standpoint, I think coding at the local level is still pretty much of a black box, and to the extent that we're assuming that that's a really reliable indicator or as reliable as we would like it to be, I think we may be going in kind of a wrong direction here. But that's just, I guess, my personal clinical opinion on this.

So do we really believe that coding is that accurate and that consistent across the country that we can really use this as the data from that to make very sweeping decisions here?

DR. CROSSON: Okay. Amy.

MS. BRICKER: I need some help really shoring up something that I'm struggling with. On Slide 11 -- and maybe this was a Round 1, but it's haunting me, so help.
Part A, not Part B. So the 12 percent from 2015 that are in Part A not Part B is because, we gathered, they're offered insurance or some plan through their employer?

DR. HARRISON: No. There are reasons why people might not buy Part B. They may not be able to afford it just outright. You know, it's a hundred-and-some-odd dollars a month. There can also be high-income -- income-related premium. So some people are actually paying close to $400 a month for it, and they may just decide, "That's not worth it for me," and so they don't sign up for B. And we think there's more of that going on the last few years.

And so while there may be some Medicare secondary payer in there, we think most of it is people choosing not to buy Part B either because they just can't afford it or they don't think it's a good deal.

MS. BRICKER: So they're uninsured.

DR. HARRISON: For the B portion.

MS. BRICKER: Okay. So where I was headed may not actually be relevant. The question I had really was: Do we have the ability to gather the claims information from those employers? Not that we don't believe there isn't, quote, Part B spending done elsewhere. It's just --
yes?

DR. HARRISON: So the other thing is we aren't looking at the Part B spending for these people. It's just that their Part A spending is lower. So, in other words, you're not going to a doctor, maybe you don't get sent to the hospital, so you're not using the Part A. It's the Part A spending that's lower. So the Part B people -- the people -- if you don't have Part B, they don't calculate your Part B spending for those people, right?

MS. BRICKER: Right.

DR. HARRISON: They don't include them. But they do include them on the A. And what we think is that if you're less likely to buy B, you may be a lot healthier, and you don't use services. And so not only are you not using any B, you're also using less A, and you're using dramatically less A.

MS. BRICKER: Okay. So just to finish my thought, it was--

DR. HARRISON: Go ahead.

MS. BRICKER: If there was, quote, Part B spending but paid for by someone else, are we able to actually see that, require that, include that, versus
reducing our subset to just those that have A and B fee-
for-service?

DR. HARRISON: No, we're not. Now, if you were
Medicare secondary payer, though, I think you would still
kick in A claim. So I think we would still see --

MS. BRICKER: We see that, yes.

DR. HARRISON: -- their A.

MS. BRICKER: Because they've enrolled in Part A
because it's an entitlement or --

DR. HARRISON: Right.

MS. BRICKER: --versus -- okay. So I was just
hoping that we could, in fact, broaden the base versus
reduce the base. We're talking today about just including
A and B as the comparator and, in fact, could you expand
the base to include employer-offered Part B coverage as a
greater subset.

DR. HARRISON: Yeah, we don't have that data.

MR. PYENSON: I'm very supportive of the
recommendations, and just a couple of reasons why that may
not have come out in the discussion. But I think the
recommendations, especially on risk adjustment, tend to
level the playing field among MA plans, and in actually a
positive way. I know we have an interest in the stability of the MA program as well as the fee-for-service program. But I see the recommendations as likely reducing the spending on vendors to optimize coding and perhaps also reduce spending by the MA plans on home assessments, which are a cost item for the MA plans.

So I think these recommendations will tend to level the playing field and reduce what are perhaps administrative but might also fall into medical management spending by the plans.

I noticed an interesting almost counterpoint between Craig and Bill on the role of coding in medical management, and I think that's whether coding is good for medical management or bad for medical management. And I'm not -- I don't want to take sides on that issue, but I think it's a -- I know within the world of coding geeks, there's a -- and sort of risk adjustment geeks, there is a concern that inefficient systems tend to have higher coding in the fee-for-service world, that is, the more that you do to patients, the more codes you generate, whether they need it or not. I don't know that anyone is looking at that in the managed care world, and I think that would be something
-- you know, since risk adjustment is not going to go away and it's going to be with us for a long time, to understand that sort of issue I think would be helpful.

That's it. Thank you.

DR. HALL: I'm not sure we're very far apart at all on this whole thing. I was just struck by Craig's suggestion that coding can represent a number of things. It can represent true resource utilization, or it could represent gaming. And to what extent do we know which is which unless we know what the clinical sequelae are in some of these things, Craig?

DR. SAMITT: And my remarks were purely based on the fact that coding is really a side effect to some degree of identification and documentation, and that's kind of the way I see it, and that's why this is so important, that if plans are truly identifying diagnoses that should be managed effectively and, you know, resources deployed to manage those, then, yes, they're going to get coded. My concern is that those may not be identified in fee-for-service. They're being identified appropriately in the MA plans, and so getting better care, getting more managed care.
MS. THOMPSON: Just a comment on coding. Having come from a fee-for-service environment with very little managed care and learning this in a very painful way, there are other reasons to code and to accurately document than just for reimbursement purposes, and that's around communication to clinicians. So with the patients who are going to a number of different providers, to communicate clearly and accurately, again, is an important side benefit to accurate coding, whether in fee-for-service or a managed care program.

DR. DeBUSK: I support the benchmark being based obviously on A plus B spending -- I think there's a lot of merit there -- as well as the previous recommendations regarding using two years' worth of data and getting away from the risk assessments.

But then you're left with that residual. I know everyone keeps bringing you back to Chart 7. And right now, you know, the idea is this one size fits all -- I mean, to Pat's point, you're using sort of the same club on everyone. You find yourself in this -- I was mentioning circularity earlier. You find yourself in this argument of, well, how do I know -- maybe these patients just have a
higher acuity or is this plan aggressively coding or coding more aggressively? To the extent that you try to stratify that more and more -- let's say we go from three categories to six categories, well, we just made that differentiation much, much harder.

One idea that I wanted to place out there is could we as a first cut just simply try to bifurcate the populations, just to divide and conquer? Could we have a good actor -- basically an adjustment that's applied to a good actor and an adjustment that's applied to a bad actor and just see if we could analytically split the pool in a more automated way? Because what I worry about is, as we go to more and more granular tiers, it devolves into a situation where basically you'd have to audit everyone. And I just don't see that -- I mean, that's not practical, it's expensive. Could we go from a very blunt instrument to a slightly less blunt instrument and see if that moves us in the right direction and if we can do some of that in an automated way?

I also wonder if there would be a spillover effect if people knew you could get in the coding intensity doghouse, if that alone would have a beneficial effect in
trying to move people into proper coding but not necessarily, you know, negative coding behaviors.

DR. CROSSON: Brian, I'm just not quite clear, so help me. I thought for a minute you were saying let's use, you know, two segments as opposed to three, but now I think what you're saying is something like why don't we just change it for like the 90th percentile. Because I'm not sure how you differentiate between the good and the bad, as you call it.

DR. DeBUSK: My thought was that right now I see that single line -- well, in the graph it's around 10 percent. The thought would be: Could you split that into two populations and have a coding intensity adjustment basically for the two populations?

Now, how would you base that? You know, you were talking earlier, I believe, about the methodology that you used -- which, by the way, I thought was very clever in the article about how you looked at people who were in fee-for-service and then transitioned in and looked at their trajectory from there. I think some of the automated methods that were referred to in the reading, I think the larger the buckets you're willing to use, the more
effective or accurate those methods are going to be.

You know, just as a thought experiment, let's try
to go to 12 tiers. I think at 12 tiers the technique that
you are using here where you were following the trajectory
of the beneficiaries as they transition from fee-for-
service into MA, I think you would lose a lot of resolution
there. But I think if you use that same technique just to
simply establish two buckets and maybe an appeals process
or some way to get out of the coding intensity doghouse
should the analytics put you there, I think then you might
be able to take a first step toward applying the
appropriate adjustment to the appropriate population.

Did that help at all? I'm not going to set the
number at 90 versus 10 percent or 50/50. I'd love to see
what their analytics -- you know, if their analytics could
come back and say we know with 99 percent accuracy that
this 10 percent are the people who are aggressively coding
or adhering to some type of improper coding practice, maybe
they get the larger adjustment. And I just don't know
where that population would fall yet.

DR. CROSSON: Right. So I'm still unclear as to
how the segmentation would be created. I thought for a
minute I heard you say something like we would track plans where there was a significant acceleration from the presumed level of --

DR. DeBUSK: Like in the reading, the way they did the cohorts -- and, again, please correct me as we go, but I think you were looking at specific groups of people that maybe started in fee-for-service and then some of them stayed in fee-for-service, others transitioned into MA, and you could see those diverging trajectories. And I would assume that we could identify individual plans where those trajectories were more aggressive.

I could appreciate the fact that different plans have people who start at different places. To me it seems like it would be easier to spot plans where patients suddenly get much, much sicker over three years or five years as opposed to other plans where they have a more steady course.

DR. CROSSON: Right, so that's what I thought you were saying, looking at those plans with acceleration of apparent diagnoses. So I guess -- sorry?

DR. DeBUSK: I'm trying to avoid -- every time I want to stratify -- you know, I love the three levels, and
you wonder, well, could there be five levels? Could there be six levels? How close could we get? I keep slipping into that argument, though, that you're going to have to fall back on audits. And I keep thinking that individual audits or plan-level audits is just an expensive, impractical idea.

So it makes me bounce back into the analytics realm, and I'm thinking, is there an automated way to group these populations?

DR. CROSSON: So I guess one question is -- maybe for Scott and Andrew -- if we were to take a look at that, if we were to say let's just take a look at some subset of plans where we have this differential acceleration from the time that the beneficiary joins the MA plan and what their assumed risk is at that point, to what it becomes after, say, three years, would that differ -- and I know you can't answer this accurately, but would that differ substantially from what is present on that slide? In other words, those plans would be perhaps the same that are depicted on the right side.

DR. JOHNSON: That's essentially what we have on this slide, and I like the idea. I think our first cut at
the analysis would say that some plans, you know, like on
the right-hand side, tend to be obviously more aggressive.
But then there is a gradient of mixture between, you know,
normal increases due to better coding, and maybe then a few
with more aggressive coding. So I think our first cut
would say that it doesn't quite break down by contract in
the same way that there are good and bad contracts that we
could apply an adjustment to. I think that's what led us
more towards a few more categories than good and bad.

DR. CROSSON: Okay.

MR. THOMAS: I'll be brief because I know we've
been on this for a while.

First, I agree with the recommendation on making
sure we compare to folks that are in A and B. I think that
makes a lot of sense.

Just my comment on this, and I would echo Craig's
comments, that, you know, I think there are -- there's a
lot of difference, frankly, between the proactivity of
providers in MA, especially if there's risk involved,
versus fee-for-service. And I think, unfortunately, you
know, in that graph there you've got a lot of folks that
are probably doing things very right and are very proactive
and are identifying HCCs and diagnoses and whatnot that are very appropriate that are not identified in fee-for-service. And I'm sure you have folks in there that are not doing that. And, unfortunately, they're all in this case going to be treated the same. And I just think that that is -- that to me is a concern. I'm not saying I have the answer to how that gets dealt with. But that is definitely a concern. And, you know, I would say that, you know, frankly, there's probably better -- in many cases, there is better identification of the appropriate diagnosis in MA than there is in fee-for-service, especially given many of the arrangements with the provider side of the delivery system.

The second piece is I continue to be concerned about the multiple changes we have going on in the risk adjusters and the coding adjustments and what the aggregate changes will be -- not on average but when it comes down to specific geographies or specific plans. And it seems to me that there probably ought to be some more work done to understand the specificity of that and really what the range is going to be, because you can look at this, you can say -- you could have a range from a couple of percent to
it could be, you know, high teens potentially. And I think
it would be helpful to understand the materiality of that
range, and once again, maybe breaking it into three tiers
is the right way to do it because you have such differences
here.

But I just would like to understand more the
aggregate of many of these changes -- you know, many that
have just been put in, and we really don't know what the
impact is going to be of some of these changes that have
been already instituted, because we haven't had enough run
at what the impact's going to be on the risk scores.

So that's just the concern I have of layering
additional changes on top of things that have happened that
we really don't understand the impact that they've had on
the plans in the different regions. But, overall, the
recommendation I agree with. I just am concerned about
layering other changes on where we don't understand the
impact of what's been put in place already.

DR. CROSSON: Yeah, very good points, Warren.

I'd just make a couple of comments, because I think I heard
the same frustration that I heard from Brian a few minutes
ago, which is, you know, that, unfortunately, we don't have
a way -- with the current measurement process, we don't
have a way of differentiating at a given level of coding on
the part of a plan, whether, in fact, that is simply
recording more diagnoses for individuals, and that
individual, if in fee-for-service, would have less
diagnoses recorded as opposed to the situation I think that
Craig and others have referred to where, in fact, the plan
providers in this case for the most part are, in fact,
identifying and then appropriately managing conditions
which are being missed in fee-for-service. And I suspect
that both situations exist, and I think we're somewhat
hamstrung right now by the fact that we can't do that, we
can't make that differentiation.

The other point I'd make is in terms of your last
comment about sort of, you know, overall what's happening
with MA. We are going to have an MA report at the next
meeting, as I understand it, that will update sort of the
situation with respect to the difference in payment between
fee-for-service and MA and, among MA, different types of MA
plans. So we'll have a better look next month, at least at
this point, at the aggregate impact of these changes.

MR. THOMAS: And I can appreciate that. I think
it's just important that we understand that -- because I think sometimes the tenor is that, gee, these are all just bad actors and there's just, you know, inappropriate coding. And, once again, I'm sure in that graph there is some of that. But at the same time, I think there are some folks that are doing exactly the right thing, and I can appreciate that. It will be helpful to look at the overall report to see if we understand more about what these other changes are driving and then have that understanding as we look to make any additional changes in risk adjusters going forward.

DR. CROSSON: Okay. Scott, Andrew, thank you very much. We'll move on now to the last presentation and discussion.

[Pause.]

DR. CROSSON: Okay. Now we're going to have a presentation in our continuing work on trying to simplify, clarify, elevate, and in other ways improve quality measurements, and we have a few ideas on the table. Ledia and David, take it away.

MS. TABOR: Great. Good morning. Today, we'll provide an updated analysis on three population-based
outcome measures that the Commission has discussed using to
measure Medicare quality. Following the presentation, we
would like your input on the measure results and next steps
for our analysis of these measures.

First, we will review the Commission's direction
to simplify quality measurement in Medicare using a small
set of population-based outcome measures.

Next, we'll provide an update on the prototype,
healthy days at home measure, we have been developing.

Then we'll discuss updated analysis using PPA and
PPV measures in Medicare.

Finally, we'll lay out ideas for future research
for your discussion.

The Commission has become increasingly concerned
that Medicare's current quality measurement programs are
too complex, burdensome for providers, and rely on too many
clinical process measures that are, at best, weakly
correlated with health outcomes.

The Commission has discussed a direction that
would simplify current Medicare quality measurement by
using a common, small set of outcome measures across
providers. Medicare would measure quality in a local area
using population-level outcome, patient experience, and low-value care measures for each of Medicare's three payment models.

The quality measures could be publicly reported to beneficiaries, providers, and policymakers to allow comparison across models and organizations nationally and within market areas. The results could also be used to reward high-quality MA plans and accountable care organizations in a market area.

Many have pointed out the complexity and burden of the new Merit-based Incentive Program, or MIPS. As a simpler alternative to MIPS, we could explore applying the population-based measures to fee-for-service clinicians in a market area.

I will now discuss the healthy days at home measure, which measures the number of days per year that beneficiaries are alive and out of health care institutions, like skilled nursing facilities. This measure takes a comprehensive view of a population's health in a way that is easy to understand.

The Commission discussed the measure concepts last year and thought that the measure could be used to
compare performance across payment models.

Healthy days at home is not triggered by any event in particular. Beneficiaries are followed for the entire calendar year. Healthy days at home is calculated by subtracting from 365 days, the days in which beneficiaries' claims data suggest they were in less than optimal health or unhealthy, such as days in acute care facilities or acute care hospitals, post-acute care, and mortality days.

The Commission has been working with a team from the Harvard School of Public Health to test our prototype "healthy days at home" measure. A critical step in the development of the measure is to develop a risk-adjustment model to make sure the measure reflects an organization's quality of care rather than underlying patient severity.

Using linear regression, we developed a model that included age, sex, and disease burden, since those are common patient severity variables. We also included market effects in the model to control for market-specific practice patterns that may mask the effects of the other variables.

The Commission has discussed the importance of
accounting for socioeconomic status in quality measures, so we also included race, ethnicity, and Medicaid status, which can be proxies for income or State health policy.

We found that disease burden had the greatest impact on healthy days at home. Age and sex had about the same impact. Medicaid status had some effects, but adding Medicaid did not increase the explanatory power of the model. Race and ethnicity had no significant impact.

We did some further analysis to understand the effect of Medicaid status on healthy days at home, but how to deal with the possible effects is still an open question as we wait for more clarity on accounting for SES in quality measurement.

To better understand the Medicaid effect, we considered whether the effect of Medicaid status varied by market. We divided market areas into quartiles based on the proportion of Medicare beneficiaries with Medicaid in the area, the rows. We also divided markets into quartiles based on health day at home performance, the columns. If the proportion of Medicaid beneficiaries in a market area had no effect on healthy day at home rates, then we would expect that each quartile of healthy day at home
performance would be about 25 percent.

In the markets with the highest proportion of Medicaid, 32.2 percent of market areas were among the lowest-performing quartile on adjusted healthy days at home.

In the markets with the lowest proportion of Medicaid, 37 percent of market areas were among the highest-performing quartile on adjusted healthy days at home.

It appears that the proportion of beneficiaries eligible for Medicaid in a market may have some market-level effect on healthy days at home, which emerges at the highest and lowest concentration of Medicaid status.

Medicaid status, representing State health policy, may play a role in healthy day at home rates. We could continue to explore healthy day at home rates among peers in markets with a similar share of Medicaid beneficiaries, as we have done for hospital readmissions and MA stars.

We calculated healthy day at home rates adjusted for age, sex, disease burden, and market-fixed effects.

The mean adjusted healthy day at home for all populations in all market areas is 346.2 days healthy and
To assess the face validity of the measure, we also calculated healthy days at home rates by different population segments. We would expect that older beneficiaries with multiple chronic conditions and severe chronic conditions like congestive heart failure to have fewer healthy days. We did find that older age and a chronic conditions burden was associated with fewer healthy days at home and more variation in older populations with congestive heart failure.

The Commission is interested in monitoring the progress of ACOs, so we calculated adjusted healthy day at home results for beneficiaries attributed to ACOs in 2013. We found small differences between ACOs and non-ACO fee-for-service across all the population segments, with ACOs having slightly better healthy days at home.

This was a proof of concept analysis to see if we could calculate healthy day at home results for ACOs and compare payment models in market areas. We hope to continue to refine the ACO calculations.

Now we are going to move on from healthy days at home and discuss our analysis of the potentially
preventable admissions and potentially preventable ED visit measures.

PPAs and PPVs are population-based measures designed to examine the ambulatory care system in a defined area like the market areas that we used for the healthy day at home analysis. It is not a measure of individual hospital quality. PPAs and PPVs are based on the premise while not every PPA and PPV can be averted, comparatively high rates of these events points to markets where beneficiaries may be admitted to the hospital or getting the treatment in an ED unnecessarily. There is likely a need for improved care coordination and access to care in those areas with high rates.

In the past, MedPAC has contracted with 3M Health Information Systems to use its definitions of PPAs and PPVs and their software.

Hospital stays can pose risks to patients, particularly the elderly. Adverse events represent a prominent risk, including hospital-associated infections, medication errors, device failures, and pressure injuries. PPAs include admissions for conditions that might have been prevented by using coordinated care; for example,
short-term complications of diabetes, asthma, and migraines; and second, procedures whose appropriateness has been questioned by clinical experts or might have been avoided with medical treatment, such as back procedures and spinal fusion.

This analysis excludes hospital readmissions within 30 days of the index admission because readmissions is a separate concept measured in another population-based outcome measure. Also, in a previous analysis, we found that PPA results are comparable, whether including or excluding readmissions.

Hospital EDs are not the ideal venue for treatment of non-urgent acute conditions and management of chronic conditions and can encourage overtreatment, since ED providers who do not know a patient's medical history may err on the side of providing too much care.

PPVs include ED visits for medical conditions that might have been prevented by coordinated care -- for example, asthma attacks and migraines -- and, second, conditions that could have been addressed through other sites of care, like primary care or urgent care centers for conditions like upper respiratory tract infections or
gastrointestinal diagnoses. The measure of PPVs excludes the ED visits that resulted in an inpatient admission because those visits are captured by the PPA measure.

To compare performance between areas, the 3M methodology makes two types of adjustments. First, the number of preventable events is weighted by the type of services and relative resource intensity of the events to reflect the relative burden of different events on the health care system. For example, a PPV for a migraine that results in an MRI and administration of a costly drug consumes more resources than a PPV for a respiratory infection that results in a general antibiotic.

The second adjustment attempts to control for differences in the underlying health status of the population, using age and burden of chronic illness, as you would expect.

Since, again, the Commission has discussed the importance of accounting for SES in quality measures, we also performed a linear regression of the PPA and PPV rates using race, ethnicity, and Medicaid status as proxy variables for SES.
We found that the regression coefficients were all very small. So it appears adjusting for age and disease burden accounts for nearly all patient-level effects, so we did not include any additional variables in the adjustment methodology. However, if this preliminary work progresses and the Commission wishes to pursue, we will sort markets by relevant SES variables to determine whether these effects are present across market areas.

In 2014, PPAs accounted for about 15 percent of all fee-for-service Medicare hospital admission claims, excluding readmissions, with a national average of about 41 PPAs per 1,000 beneficiaries.

PPVs accounted for about 75 percent of all fee-for-service Medicare non-admission ED visit claims, with a national average of approximately 291 per 1,000 beneficiaries.

The 75 percent PPV rate may be surprising, so I would like to point out three things when interpreting these national numbers. First, the denominator, or total ED visits, is for a subset of the Medicare fee-for-service population. For example, we excluded beneficiaries who died in 2013 or 2014 or who had Part A or Part B only at
any point during those two years. Second, PPV excludes admissions. Third, these numbers are broad estimates; for example, the PPV calculation errs on the side that most non-emergent procedures and diagnosis could have been handled in another site of care.

Even with these broad interpretations, these numbers demonstrate opportunities to improve the quality of care received by Medicare beneficiaries.

We calculated PPA and PPV rates at the local market area level, as we did for the healthy days at home. The rates are presented as a ratio of the actual rate to the rate that would have been expected, given the population's age and burden of chronic illness. A rate below 1 is better because the market area has less than expected PPAs or PPVs.

We found that PPV and PPA rates varied by market area. PPV rates showed about double the variation, between the 9th and 10th percentile, than the rate of PPAs. We also analyzed PPA and PPV rates for ACOs and fee-for-service-only beneficiaries in five different local market areas to compare relative quality within a market.
area for different payment models, as envisioned in the Commission's alternative quality concept.

We chose five market areas that had a high number of ACO beneficiaries and for geographic variation. Across the markets, the percentage of fee-for-service beneficiaries in ACOs ranged from about a quarter to a half. The number of ACOs in the areas ranged from about 5 to 11.

The reference point for each measure is 1. Overall, ACOs tended to have slightly better PPA and PPV rates than fee-for-service only.

ACO PPAs were better in three of the market areas -- Houston, Minneapolis, and Orlando -- with rates less than or close to 1.

ACO PPVs were better than fee-for-service in all of the markets.

Looking at PPA and PPV rates within a market area, across markets, and nationally may allow policymakers and providers to understand opportunities to improve care within those markets.

As discussed in the beginning of the presentation, we could explore applying the population-
based measures to fee-for-service clinicians in a market area.

Some of the market areas we used in this analysis are large, so using them to represent fee-for-service clinician quality may not be appropriate. Within a local market area, we could measure PPA and PPV rates at the hospital service area level, or HSA, which is a smaller geographic unit that is more similar to the ambulatory care environment clinicians affect.

We explored this concept by identifying which HSAs were tied to one local market area, then calculating PPA and PPV rates for each HSA, and comparing those rates across those HSAs.

In the market area that we looked at, the mean PPA rate was .98 and for PPV was 1.17. We identified 13 HSAs that had a range of market of PPA and PPV rates, .55 to 1.26 for PPAs and 1.15 to 1.64 PPVs.

If these measures are statistically reliable, the range of HSA rates supports the concept of measuring a smaller geographic unit within market areas and perhaps holding fee-for-service clinicians accountable to their HSA rates.
If the Commission would like, we will continue to evaluate the measures and their potential to compare the quality of care for Medicare beneficiaries. After answering any clarifying questions, we would like to discuss your reactions to the measure results and these ideas for future analytic work on all three measures.

Thank you.

DR. CROSSON: Okay. Thank you very much, Ledia, and David as well.

Who has clarifying questions? We'll start with Brian, Bruce -- I'm going to do this more slowly so I don't screw it up -- Bruce, Brian, Amy, Bill H., John, Pat, Alice, Paul, Kathy, Jack. Gotcha.

DR. MILLER: Yeah. It's all you all.

DR. CROSSON: Yeah.

[Laughter.]

DR. CROSSON: Right. Let's start with Bruce -- I'm sorry. Brian, Brian, Brian.

DR. DeBUSK: First of all, I'm so wildly supportive of what you guys do and like this work so much, I was almost afraid to ask a question. But as you can see, I got past it.
[Laughter.]

DR. DeBUSK: First of all, on page 18 of the reading, I noticed that for the healthy days at home you used the -- to assist disease severity, you used HCCs. And then I noticed as we moved over to the 3M methodology for the PPAs and the PPVs, you moved to these clinical risk groups, the CRGs.

So my first question is: Could you speak to shifting the methodology and also speak to how feasible it would be to use a standard methodology, say all HCCs, for doing disease severity?

And then the second question I had was the healthy days at home measure by its definition saturates at 365 days. I mean, it tops out. Have you looked at the engineering equivalent, say a mean time between failures? And did that go into your calculation of maybe doing MTBF versus a measure that would top out? And did that factor into any of your analysis?

MR. GLASS: I must say I never thought I'd get to use the term "mean time between failure" again.

[Laughter.]

MR. GLASS: Because I used to have to actually
deal with that all the time in maintenance. But, no, we
didn't think about using that. We wanted something that
would be really easy to understand for a beneficiary who
could say, "Hey, look, this ACO looks like a better chance
of keeping me healthy and at home than the one over there."
So, no, we didn't think about that, though we could explore
it, but I think it might be hard to -- you know, for many
people to comprehend.

DR. MILLER: Does anybody want to tell us what
that means?

MR. GLASS: Oh, mean time between failure? So if
you had a jet engine, you'd like to know what the mean time
between failure is

DR. CROSSON: You would like to know it a lot.

MR. GLASS: Yeah.

[Laughter.]

MR. GLASS: So you could figure out how to do
maintenance on it.

DR. DeBUSK: The other issue, too, is that
there's a whole host of engineering tools that you could
then bring into play for the analytics around mean time
between failures because you'd inherit all that as well.
DR. MILLER: Here we would be talking about mean time until somebody dies or somebody --

MR. GLASS: Or has one of these events.

DR. MILLER: Or has one of the events okay.

DR. CROSSON: I think David's point is that while one may be more accurate and perhaps, as Brian suggests, you know, allow for greater differences because the time would extend infinitely, the optics of it, the marketability of it sounds different to the -- could sound very different to the average beneficiary, or something like that.

MS. TABOR: For the first question, we used for healthy days at home the HCC model just because it's available, it's known, it's commonly used when risk-adjusting outcome measures. And the clinical related groups is a 3M methodology. It kind of came with the package of using their prototype, which, again, was just a prototype. We're just testing the concept, not saying that the 3M methodology is the way to go. But I think in theory we could use HCCs across all the measures. And I think we've heard before from the Commissioners the importance of having common risk adjustment across the measures, so we'll
MR. PYENSON: I want to echo Brian's comment.
I'm real hesitant to ask any questions because this is really great. But one technical question: The midyear -- how do you handle midyear entries in the healthy days at home?

MS. TABOR: They had to be enrolled for 365 days. That was one of the conditions to be included in the denominator.

MR. PYENSON: So midyear enrollees are excluded.

MS. TABOR: Exactly.

MR. PYENSON: Another question related to the 3M methodology and HCCs. I think AHRQ, Agency for Healthcare Research and Quality, has similar metrics that are open source, ambulatory care, sensitive admissions, and I think they've developed ER metrics that are similar. And, you know, part of my question is there's a real virtue in open source, which is, yeah, there's private sector risk adjusters that claim to be better than HCCs and so forth. But there's really a virtue in having open source, and I wonder if you looked at how well they compare.

MS. TABOR: We did look at the AHRQ measures. We
didn't do any kind of sophisticated analysis, but one reason we wanted to use these 3M measures was because they're comprehensive, they cover all conditions; whereas, the AHRQ prevention quality indicators, PQI measures, are condition specific. They look at diabetes versus heart failure versus pneumonia. So we wanted to kind of test this concept of a comprehensive -- and, actually, the Commission does track those PQI measures in our March report.

And then as far as the PPV, the last I look, the AHRQ measures were a little -- they were not fully developed yet, but we can continue to track those because we know the open source is a good point to --

DR. MILLER: And, traditionally, you know, we're way back at proof of concept stage here. We're just talking about a measure and all that. If for some reason CMS were to take up something like this, they would go to an open source type of approach, go through rulemaking and comment to sort of say this is how we're doing it. And sometimes the way that works, either they develop a methodology just completely new, or they might go to, say, a 3M or whoever has developed this and contract with them
to develop an open source owned by the program type of
thing. The notion that this would go forward as policy,
which we're way, way away from, using a proprietary group
or whatever the case, would not be the case.

MS. BRICKER: I can't help but be reminded of the
discussion we had yesterday around stand-alone EDs, and
Slide 16, Houston looks like it's performing quite well
with respect to preventable ED visits. This data, though,
is from '13 and '14, and yet Houston is leading the pack
for stand-alone EDs based on '16 data. And I'm curious if
we're able to actually bring those two together, if we
think there's value in that to see how Houston actually
would be impacted, to refresh this data, you know, with
something that's more current when that's available to us,
by see if that, in fact, just having more access to stand-
alone EDs because I don't feel well versus it truly being,
you know, because I feel like I need to be hospitalized, of
course, just because of an access, it's just across the
street, it's easy, I see it, they're everywhere, if there
actually could be some correlation there to just additional
access of stand-alone EDs.

MR. GLASS: That will be fun to keep track of. I
1 think we're going to update one more year?
2
3    MS. TABOR: Yes.
4
5    MR. GLASS: Yes, so that will still be '14, not -
6    - that will probably be before that phenomenon.
7
8    MS. TABOR: It's an interesting concept, though.
9
10   DR. CROSSON: Good. Thank you.
11
12   DR. CHRISTIANSON: Did you want [off microphone]?
13
14   MR. GAUMER: I was thinking the same thing that
15    Amy was, and I think this is probably a year issue. So,
16    you know, the phenomenon is probably going to show up in
17    '14 and '15. They were certainly around in '13 and doing
18    their thing, but to a lesser degree. So I imagine that the
19    '14 data may show different numbers. Not sure it would
20    jump above one. There might be something else going on
21    here, too, but I'm unclear what that is.
22
23    DR. CHRISTIANSON: Okay. So two things. One is
24    I just continue to be really annoyed by the name of this
25    metric. I mean, if you have somebody who is, as an
26    example, experiencing really severe arthritis, taking their
27    medication, is in severe pain, and then telling them that
28    they're having a healthy day at home is just tone deaf.
29    And I don't think we can drop off "healthy" because as part
of the metric, we have home health visits, which presumably
you get at home, and that raises the other question of
whether you guys have looked at this metric not using home
health visits as part of it. It strikes me that doing that
penalizes ACOs and MA plans that are trying to manage
chronic illness aggressively, keep people out of the
hospital, keep them out of the emergency room, and have a
program that involves home health visits, and you get
penalized for that program under this metric, which doesn't
make a lot of sense to me.

So one way to think about this is what happens --
I mean, maybe they've already done the analysis without
including home health, and I understand why it's there.
But I don't think it's the right incentives for the way
we're trying to compare outcomes across different delivery
systems which are going to use different ways of trying to
manage care.

MR. GLASS: Well, if you're using home -- we
switched to home health visits, by the way, rather than the
length of the home health episode or time between first and
last visit to de-weight it some from last time. But if
it's successful in keeping people out of hospitals, et
cetera, then I don't see why we'd be penalizing you. Yeah, you'd get --

DR. CHRISTIANSON: Because you're subtracting days that --

MR. GLASS: But presumably you're not having the other days in there --

DR. CHRISTIANSON: That doesn't mean you're not penalized --

MR. GLASS: -- so it would outweigh --

DR. CHRISTIANSON: You might get an offset down the line, but it doesn't mean you're not penalizing for an aggressive in-home program.

DR. MILLER: Can I also just say one thing? I think conceptually I see your point, but there has been -- we've looked at home health utilization and sort of bouncing from home health agency and hospitalization rates related to home health use, and there has, at least at a national level, been very little relationship between that. I believe there can be one, but --

DR. CHRISTIANSON: And that's what we're talking about going forward. We're trying to get people incentives to manage care effectively. If that involves home visits,
fine. No, my question was more have you looked at this measure eliminating that, and do you get real different results in terms of your analysis when you don't include that? Then you could change it to "days at home."

MR. GLASS: Yeah, we did it with and without last year. I don't think we did it this year. We could look at it again. It is one of the bigger ones. It's like three days, you know, on average.

DR. CROSSON: This is going to be an odd comment, but I have to say my own personal experience is that the term "healthy" changes over the decades. I'll leave it at that.

[Laughter.]

MS. WANG: Actually, I think this is great work, but I think the questions that Amy and Jon asked are questions that I also have. First of all, I think it's a great clarification on the 3M and the PPV, so that's just to clarify. That is just for purposes of proof of concept and analysis, because the fact is I think most people are using HEDIS measures. But this does not presuppose that the 3M, you know, measures are better. It just introduces more complexity because I think people are orienting
towards the HEDIS measures.

MS. TABOR: That's correct, and this is just a prototype.

MS. WANG: So it's just an analytical exercise.

MS. TABOR: And there is no HEDIS measure, unfortunately, for these two concepts yet.

MS. WANG: Well, there's a new HEDIS measure for the prevention, for the potentially avoidable that plans actually are going to be subject to in 2017, and I can't remember the acronym, but yeah, there is. Okay. In any case, okay, this is just an analytical exercise. Do you have -- so I think that the concept is really interesting, whether you call it "healthy" or "days at home" or whatever, and it involves a lot of value judgments about the tradeoff between home health, for example, is better than inpatient or are they all equally, you know, counted against you.

Putting it in the other extreme, to Amy's question, do you have any concern that this measure would look good, for example, in a rural area that does not have a good health care delivery infrastructure? It doesn't mean that people are healthier, but it does mean they're at
home more because, you know, the nearest hospital is far away, there are no home health services in the community, there are no IRFs, there are no -- I mean, does this adjust for those kinds of access issues?

The other thing I wanted to ask you about was whether you were considering looking at -- if we go to uniform measures, the risk adjustment and the adjustment for, for want of a better word, socioeconomic status becomes critically important. And one of the things that I noticed was that there really wasn’t anything yet considered around sort of community resource characteristics in the SES, and that is, there’s been a fair amount of work around that, you know, access to primary care, do you reside in a health profession shortage area? I think there’s been some correlations to sort of the rate of homeownership in communities and correlation to health status, poverty levels in local communities, things of that nature. I just wondered if that was kind of going to be on your list at some point to examine.

But, you know, going back maybe to the first question, I’m sorry, I jumbled them all together, but is it possible that healthy days at home could look good, meaning
you have more days at home, simply because there's no --
the delivery system infrastructure is different from place
to place?

MS. TABOR: One way we did try to account for
that is by adjusting for market effects, so taking into
account the practice patterns within each individual market
area and adjusting to each beneficiary for that.

MS. WANG: Could you explain a little bit more
about what that means, market effects and local market?

What is that exactly?

MS. TABOR: It's a very complicated statistical
methodology that our very smart contractors used, but the
best way I can kind of explain it is that it is taking into
account that the different market areas do have kind of
different healthy days at home because of practice patterns
and kind of the delivery system within each market. So
they did an adjustment to allow comparison across the
market areas.

MR. GLASS: And so --

DR. MILLER: It's like coming through and, you
know, you do your standard -- we're talking about healthy
days at home, right? So I'm trying to visualize what I
read. So, you know, think of you have a regression equation, you have your healthy days at home. But before you report out, you adjust for the demographics, you adjust for their conditions. Then you put in dummy variables for the different markets that they're in to try and take into account the very two things you're saying -- supply differences, practice differences. We tested out some SES; you know, either it washed out or had some odd effects. And then what you're basically saying is the variation that you see here left would be over and above what happened to be present from market to market on supply and utilization, is kind of the way -- which is what you said just a few more sentences.

MS. TABOR: Much better.

DR. CROSSON: On this point?

DR. NERENZ: Yes, on this point. Thank you. If we look at Slide 7 then, again, to clarify, the analysis here is looking at numbers that are not adjusted for market characteristics the way you just described? Would that be true?

MS. TABOR: They are adjusted for market fixed effects.
DR. NERENZ: Okay. Because then I'm trying to --

because then this is looking at the effect of Medicaid
above and beyond a market factor? Because it would seem to
me that the market-level adjustment brings with it all
kinds of SES and infrastructure effects and all sorts of
things. It just captures it without identifying it and
pulls it out statistically. So when we're looking at 7,
we're looking at the effect of percent Medicaid with a
market factor already pulled out --

DR. MILLER: You keep saying Medicaid, but you
mean Medicare [off microphone].

DR. NERENZ: Well, Medicaid.

PARTICIPANT: No. Medicaid [off microphone].

MR. GLASS: No, but the market fixed effect, I
think, if I may say this -- and tell me if this is correct
-- that's being put in when you're doing the risk
adjustment modeling to understand the true effects of, say,
patient severity. And it's kind of taking into account
that healthy days at home may differ from one area to
another. Say one area tends to use lots of home health,
the market fixed effect would be able to adjust for that
when you're trying to figure out the parameters on the
other -- on the other things like severity.

DR. NERENZ: Yeah, but it would be -- just for an example, I'm envisioning some enormous set of dummy variables, for example, where, you know, Detroit's a market, Topeka's a market, northern Minnesota's a market, however you define a market. And just having that yes-no variable for market just brings with it every possible characteristic of that market -- practice patterns, infrastructure, SES, poverty. It's all in there. It just all gets pulled out at once, right?

MR. GLASS: Well, when you're figuring out the correct parameters for the other variables, but then when you report healthy days at home for that market, it's not like you're dividing, you know, beneficiaries in that market by that amount.

DR. NERENZ: No, no, and I'm not saying that's wrong necessarily. I'm just trying to understand when we look at the effect of Medicaid --

MR. GLASS: Yeah, so I think --

DR. NERENZ: -- it's above and beyond and all that.

MR. GLASS: Right. So, I mean, the -- yeah, so
the earlier results show that as a beneficiary-level adjustment. It doesn't seem to add to the explanatory power. But when you look later, after you've done all that, it does seem to have this change at the market level, which is I think what Pat was talking about. This may be a proxy for all sorts of other things.

DR. MILLER: But you are referring to Medicaid [off microphone].

MR. GLASS: Medicaid. So I think this is where it shows that it seems to be a proxy for lots of other things that might be happening.

DR. NERENZ: Yeah, well, people often interpret it as an income effect, and within states it is indeed that. But then if you've also got income picked up as a market -- part of that market variable, that -- I'm just trying to understand what's moving when here.

DR. MILLER: You're going to go back to your questions, right? Well, because I -- well, I don't want to forget you. I didn't want to move on and forget your question.

The other thing I'm trying to remember from our urban and rural analysis, Jeff -- and I just need a nod.
here; I think you know what I'm about to say -- we didn't
see tremendous differences in levels of utilization.

DR. STENSLAND: Almost exactly the same --

[speaking off microphone].

DR. CROSSON: Can you repeat that for the record?

DR. STENSLAND: [Speaking off microphone.]

So we looked at things like how many physician
visits did they get, how many home health days did they
have, how many SNF visits, how many admissions, how many
prescription fills did they have, and it was almost exactly
the same for urban, for rural, and even for frontier areas
of rural, so really sparsely populated areas. And,
especially, they were getting the same volume of care.
They might be just traveling further for it.

DR. MILLER: It is a surprise, which is why I
wanted to work it out.

MS. WANG: It's very interesting, because what
does that do to regional variation?

DR. MILLER: Well, you see, what's really
interesting -- because a lot of people walk around with
this in their head and which is why I think it's worth the
opportunity to pull it out, even though it's off point and
Jay is going to kill me.

MS. WANG: He'll kill me too.

DR. MILLER: But I'm going to go down for a good cause.

The geographic variation a lot of people carry in their head is urban, rural, but that's really not how geographic variation works in the country. You can think of the country as a big rectangle. There's kind of a diagonal. The Southeast has really high utilization, urban and rural. The Northeast has low utilization, middle, central, that kind of stuff, low utilization, urban and rural. And it really expressed that way, and people tend to think they're seeing rural effects, depending on how they look at the data, when really what you're doing is catching the geographic effect that's more urban and rural in different parts of the country.

MS. BUTO: But could I just ask Jeff?

Did that include all of these facility-based services — inpatient, rehab, psych, skilled nursing — at long-term care hospital? Because the availability of some of those facilities in some of these other regions — Frontier, for example — it would be hard to imagine you'd
have similar access to these kinds of specialty providers.

DR. STENSLAND: Not things like long-term care hospitals. You're not going to get a lot of LTCH use in rural Montana, but you would have similar things on inpatient days, SNF days, visits, home health use, prescriptions, those things, and then when you aggregate all of it together on average, the amount of service use adjusted, kind of allowing some substitution like across from SNFs and LTCHs, then it was really very similar within a State. You're going to see some urban areas in Louisiana really high, but you also see rural Louisiana as equally high, or you'll see someplace like Wisconsin, you have some urban areas that are really low. But you'll see rural areas low also.

DR. HOADLEY: Is ED use one of the measures you looked at in that?

DR. STENSLAND: I don't remember.

DR. HOADLEY: Okay.

DR. CROSSON: Okay. Let's come back. Pat, are you still on? Pat, are you done?

MS. WANG: No. I don't know if you wanted to have the opportunity on the SES, whether you're considering
using -- looking at additional variables. Especially, what I think is kind of missing is the community resource kind of whole element, bucket, whatever.

MS. TABOR: I will say the National Academy of Medicine has been doing a series of reports on using -- adjusting SES for Medicare quality measurement, and they did recently release a report about data availability and looking at these different SES factors, and it was kind of after we had done all this work. So they did sort variables into data that's available now versus data that we wish was available. So we can plan, if the Commission would like, to keep looking at those variables and kind of taking into account that perhaps not everything is available now, but as data gets available, the SES adjustment -- or how to handle SES could get better.

DR. CROSSON: Okay. Alice.

DR. COOMBS: Thank you very much.

I thought -- my thinking was just like Jon about the health days at home, and we brought this up before. I think we actually discussed this before.

So the question I have is, What about combining your linear regression with the PPV and the PPA, having the
whole notion of the healthy days at home with the home health, to see if there's an effect for those two indicators? Because I think it would be a great place for MedPAC to be in the position of simplifying a population measure, if you could bring those two together, that challenges the MIPS and as on a population scale, to look at the population health outcome. It would be incredible if those things could kind of fit together.


DR. GINSBURG: Yeah. I wanted to raise the question about how mortality fits in with your other measures, and my concern is that someone dies in January, and they have this enormous impact, mortality. It's going to wipe out everything else, and I'm really thinking that there may just not be a good way to have mortality be part of this and whether we just have to have it as a separate measure. Mortality is very important, but I think it just blows away all the other things you're looking at.

I don't know if you've examined when you've been crunching numbers that agree to it. A lot is really driven by mortality rates.

DR. CROSSON: I had the same concern. I think --
correct me if this is not correct, but since overall, on average, people die roughly, equivalently -- I know there are peaks in the winter with flu and all that, but more or less, isn't this problem, because it could be a problem, a function of an end, the number of observations that you're using for the measurement pool that you're using? And if it's, in fact, very large, it would wash out, but in some circumstances -- for example, if you were applying this measure to ACOs and it includes ACOs with small populations, you could have that effect. Is that right?

DR. GINSBURG: Actually, that is not what I was concerned about.

DR. CROSSON: Oh. Sorry.

DR. GINSBURG: I mean, I think that this overall approach of looking at large populations is a great contrast with MIPS, which is looking at too small units to be meaningful. But I think it's really a matter of whether the mortality measure just inadvertently dominates the rest of it.

In a sense, I remember Brian's first comment about time between failures, and that that way of thinking might actually be a way to help resolve this. But I think
at the moment, I'm really concerned about that our healthy
days at home is really mostly a mortality measure.

DR. CROSSON: Sorry to persist, and then Brian.

But it would only dominate if all the individuals happen to
die in January, but you're going to have people who die in
December as well. And then it would be a very minor
impact, right?

DR. GINSBURG: But I think just the -- I think
the -- just areas with higher mortality rates are going to
have much lower healthy days at home. That's the concern
as opposed to what --

DR. CROSSON: I see. Okay. So geographically as
opposed to --

DR. GINSBURG: Yeah, because that's how we're
using this, for geographic areas.

MR. GLASS: We can look at that distribution.

So, on average, it's like 8 days, I think. It's mortality
days, which is the biggest, I think, but we could look at
how that's distributed and see if there's a big meaningful
difference among areas.

DR. CROSSON: I'm sorry. Brian, you --

DR. DeBUSK: I remember you had addressed that
concern. You and I had a chance to talk about that earlier, too, about this issue about mortality. Not to push a specific point of view too far, but in a mean time between failure mentality, you know, that mortality would simply be one of many failures. Being admitted into a hospital, being admitted into an inpatient psychiatric facility, that would just be another point of failure along the way. The nice thing is then the mortality wouldn't contaminate -- you wouldn't have that issue of did you pass in January, did you pass on December 30th, because that would just be one failure in the meantime between failure calculation.

We might need a better marketing term for it because no one is going to want to look up their MTBF. But the idea, I think some of the issues that we faced in the PQRS with these top-down measures -- I mean, imagine someone trying to pick an ACO to join, and they say, well, someone who meets your category, here's one ACO that averages 362 days, and here's one that averages 365 days -- well, 6, leap year -- 365 days, you'd be separating such small delineations.

One of the things I was going to ask you to do,
but I wasn't in a particularly snarky mood, was the --

[Laughter.]

DR. NERENZ: -- was your chart on page 9 -- on Chart 9. Replot that with the y-axis as zero, and look at what that graph looks like. It looks like a PQRS measure at that point.

MR. GLASS: Yeah. But don't get attached to these numbers because --

DR. DeBUSK: Oh, I know.

MR. GLASS: -- it's very preliminary, and the comparison population isn't quite right.

DR. DeBUSK: But the good news is a lot of the things that Paul was raising about issues like timing of mortality and all that, engineers solved those problems with calculations like MTBF, but the really good news is I'm not going to bring that up again.

[Laughter.]

DR. DeBUSK: So thank you.

DR. MILLER: Sort of like a time between, you know, when-he-brings-that-up measure.

[Laughter.]

[Laughter.]

DR. CROSSON: Kathy.

MS. BUTO: My question, I think, is pretty simple, I think, how soon we'll be able to do a healthy days at home calculation for MA. In other words, when are we going to have enough encounter data to do something like that? I mean, going back to the real purpose of this, it was to simplify, come up with simplified measures of quality across fee-for-service MA and ACOs, right? So it would be good to know what that MA number is.

DR. MILLER: We feel that, and I think there is - I don't want to promise anything soon. We have slow churning through that data. We found issues, some of which we've put in front of you, and so there's a slow march there. I wouldn't expect this to come up quickly that we could say, "Oh, and here's the MA version of this." I think we're still a bit out on that. So I wouldn't expect to see it this cycle, and I'm hoping either late this cycle or early next cycle to try and bring some encounter data into the discussion, where I wouldn't even be using it in this context, just some basic -- "This is what we find."
Here's the errors and the problems and the missing whatever. And we have it. It's slow-going."

MR. GLASS: I mean, theoretically, if we had it and it was cleaned up and all that sort of thing, I would think you could do the same calculation.

DR. MILLER: Yeah. Conceptually, it should fit the framework. Your question is right on point.

DR. CROSSON: Jack.

DR. HOADLEY: I have a couple, I think are straightforward questions. First is, How did you, in fact, define your Medicaid measure? I don't think you talked specifically about it today.

MS. TABOR: It's the number of partial or all duals, really, is what it was as a measure of --

DR. HOADLEY: Okay. Similar measure of whether somebody got dual eligibility.

MS. TABOR: Yeah. Well, they're partial or full.

DR. HOADLEY: And then on Slide 9, this is nationally all ACOs aggregated, all non-ACO individuals aggregated?

MS. TABOR: So it's actually by market area --

DR. HOADLEY: Okay.
MS. TABOR: -- and then aggregated by market area.

DR. HOADLEY: So if there is a market that has no ACOs in it, that doesn't show up in this?

MS. TABOR: Exactly, yeah.

DR. HOADLEY: And then, third, on the healthy days at home measure, have you looked at any -- you've got some nice ways to look at comparisons across chronic conditions and some of those things. Is there any way to look at some kind of a correlation to health status, perceived health status, if there's stuff you could pull off of CAHPS or somewhere to test that? Because, I mean, getting into this question some others have raised about what does it mean to be healthy, measuring the chronic conditions is obviously a good way to do that, but maybe it would be interesting to see how it lined up as well or not as well with self-perceived.

MS. TABOR: That is interesting. That's a good idea, so we'll look into that.

DR. CROSSON: Clarifying questions. Bruce.

MR. PYENSON: Ledia, I'm curious about how to handle custodial care. It looks like you're tabulating SNF
days, which are paid by Medicare, but if a person is
institutionalized, being paid by Medicaid, that's
considered at home.

I think through some data manipulation, you can
attribute people who are institutionalized through the
Medicare data, and how that might work in this model from a
policy standpoint, I think having a measure that connects
big area of Medicaid expense to Medicare and integrates the
two has appeal to me because it talks to Medicare and
Medicaid integration.

But from a technical standpoint, what do you
think about that?

MR. GLASS: Well, this came up, I guess, last
year when we discussed this measure, and I guess the
thinking was, A, that's they're home. So you can't just
say days in a nursing facility because outsourced
everything, and so we didn't include that. If you include
it, okay, someone is living in a nursing home 365 days a
year. What would you do? You can't say--

MR. PYENSON: Well, but on a population average
trait, there's huge variability among regional variation.

MR. GLASS: You mean put it in as a risk
adjustor?

MR. PYENSON: No. As an actual measure that some places keep people in home better than others, not their nursing home home, but their real home.

MR. GLASS: Yeah.

MR. PYENSON: That's, as you know, a huge cost issue for Medicaid.

MR. GLASS: Sure. But I guess -- yeah. As I remember the conversation from last year, I think the problem was, A, it could swamp the thing. But, also, could an MA plan or an ACO have a big effect on whether someone was in a nursing home or not? And I guess there are programs and things, but --

DR. MILLER: And that's what my recollection of this is too. So that was my recollection of this too. I think part of the reason, to David's point is -- and David's point is -- and Ledia's point is the market effects variable was trying to get in there in a very broad way, try and capture differences, and if your point is geographically people end up in the nursing home differently -- and I mean the maintenance-level nursing home -- there's something in there to try and adjust for
that.

But I recall the conversation the way David does. It's also the measures that end up in this are supposed to be ideally things that the actions of the MA plan, the ACO, or the fee-for-service environment can actually -- would be held responsible for -- or influence it, actually. Maybe that's a better word.

MR. PYENSON: I can appreciate that, but that's Medicare-centric. So if you had an integrated program, that would be a very budget important kind of measure.

Another clarifying question, I have observed in the data that home health is very strongly negatively correlated with chiropractor use. I don't know if others have --

DR. CROSSON: What?

MR. PYENSON: Chiropractic. I'm not sure why -- or physical therapy. I don't know if you've seen that in the regional data.

MR. GLASS: I don't think we've looked at that.

MR. PYENSON: Okay.

DR. CROSSON: I'm sorry. Bruce, just to clarify, the more chiropractic use that is being enjoyed, the less
home health?

MR. PYENSON: The more chiropractor and physical therapy, the less home health, and perhaps because a lot of home health is rehab-oriented. If you combine the two of those as swappable services, that might have a different -- a better fit.

MS. TABOR: We could take a look at that.

DR. CROSSON: Okay. Seeing no more clarifying questions, we'll move to the general discussion. Let's put up the last slide again, just to remind folks to go back to the engineering analogy for a minute. We're still in R&D with respect to these measures, so suggestions to Ledia and David about support for or other suggestions about future directions are in order as well as other comments, and,

David, you're going to start.

DR. NERENZ: Yeah, thanks. I'm generally supportive of this line, and I made that same comment last month when this was in front of us. The intent of the comments last month was sort of cautionary on technical details, but generally a good direction, and thank you for taking us down this path. And I think that's still the spirit of the points I'd like to make this morning.
First of all, just to play off a comment Mark made, clearly we are not measure developers; we're measure stewards in the NQF sense. And there's only so much we can do before it has to get passed on in the form of a chapter or recommendations, and I recognize that's so. So there's only so much we're going to be able to do with this model and that model, and that's fine.

And I'm trying to think of what ground should be covered sort of between here and the pass-off point. One specific thing -- and this then relates to the last bullet there -- I just wanted to confirm. I thought part of what we were trying to do here was look at measures that would be and could be used for comparison of individual ACOs within an area, individual MA plans within an area. So I guess that's something I'd like to see, that to the extent we have data that would seem to be the next thing we'd want to look at before we then passed this on and said these are measures that could be used in that context. So I'm seeing you nod. That's good. I certainly would like to see that.

I do commend and thank you for the attention to race, ethnicity, and the Medicaid effects, and as Pat has pointed out, you know, there are many other SES-type
variables that could be brought in if what we're doing is basically characterizing market areas or community, because there's a rich set of variables drawn from census, drawn from area resource file, drawn from a number of places. There are some indexes now of community deprivation. There are all sorts of things. And I was curious about the extent to which a whole lot of that had already been folded into this market variable. But I think probably it's better to have them explicitly tested in the model for transparency and just see how many of these things matter and then people know that they're adjusted. So there's more you can look at, but, again, you can't do everything, and at some point a measure developer has to pick it up and go.

On Slide 9, if we could just have that -- and there are other examples, many of -- page 13, 14 in the chapter. And I'm going to play off Brian's point here. You know, these are really going to be tight distributions, at least on the healthy days measure, and maybe on the others as well. We're going to be looking at differences of one or two points out of a total range of -- you know, total topped at 365 on the one measure. And I'm just going
to guess, but we don't know yet, that if we start looking at charts of individual MA plans or ACOs, we're going to see charts that look a lot like this. And as Brian pointed out, if you actually set the Y-axis base at zero, they're going to look the same.

Where I was going to go with this is in the domain of clinical outcome measures, particularly the self-reported measures, there's the concept of minimum clinically important difference, or MCID, measures like SF-36, measures like EQ-5D. The concept is a lot of psychometric work goes into deciding how big a difference or how big a change do you need to see for it to matter to patients. And then you can use it to say how big a difference between treatment A and treatment B is actually worthwhile, or how much -- you know, if a person was considering a surgical procedure, how much benefit would you need to say it's worthwhile doing it? The concept exists. There's a literature on it. I use it in things that I do with spine surgery. Other people do things. It's out there.

We don't really have that here, and I know we can't do the psychometric work, but I'm wondering if we
could at least put a toe in the water or, you know, bring it up in a report and say as this works its way out, somewhere or other we're going to have to decide or at least have somebody think about how big a difference matters. And, you know, Brian already gave the example. If I'm looking at two ACOs and one's 355 and one's 357, do I care? Should I care? And particularly in comments I made last month about signal and noise, until somebody has risk adjustment down really tightly, that 355 to 357 may be noise and no signal.

So there are some things, I guess, we can bring all the way to ground, but at least I think could be discussed in a report and make sure people know these are concerns.

Now, with that in mind, it was interesting -- can we get -- oops. Don't have it back yet. Right side of Slide 9, one of the -- and the corresponding distribution chapter in the report, when we only look at the people with CHF, the measure is not so much topped out. And the measure actually has a broader range, and it may suggest that as this moves into implementation, it may be more informative if it's set in a denominator population like
that where actions by an ACO or actions by a plan could actually move the needle on this more than in just an unselected population, many of whom are perfectly healthy and they're sitting at 365 right now.

Okay, last thing. Everything I like about this, except one thing. On page 24-24 -- and it's mentioned in one of the bullet points here -- there's discussion of using these measures to replace existing physician measures and essentially hold physicians accountable for these measures in their area.

Now, I'm willing to listen to input from my clinicians colleagues here, but that just strikes me -- and I'll say it -- as just a bad, bad idea, and I don't know how I could possibly support it. I think that's actually tangential to what's going on here, and I was a little surprised to see it.

All of the historical precedents I can think of that are bad -- but, again, others may see it differently -- SGR being the more prominent example, I just don't think we go ahead by holding individuals or groups accountable for the collective behavior of something over which they have no control. Everything else about this I like. I
think we're fine. It's a nice direction. I really have

DR. MILLER: It is about trying to go into a

market area -- and this is something that the Commission
talked about in some other settings -- and being able to
walk into D.C. and say, How does MA, how does ACO -- and
you didn't finish the sentence, but I think you see it --
how does fee-for-service as a system -- you know, we've
talked. I knew you knew that. But I also wanted to make
sure everybody else got it, so that on something of a
comparable basis you could see how these different delivery
systems are doing.

The second thing is, as you said, there's very

small -- the topped out point, Brian made the point as well
on healthy days at home, definitely an issue. And I think
you nicely zeroed in -- and I would get everybody else to
track on this. Part of the reason we're parsing it out by
populations and multiple chronic conditions is precisely
for that reason.

But I would also say -- and I think I'm right

about this -- the PPVs and the PPAs have a lot more

variation than this measure has, healthy days at home.
MS. TABOR: They do, yes, especially if --

DR. MILLER: Right. So there's three --
everybody's kind of talked about healthy days at home, I
think mostly because the title of it is really catchy, Jon.

[Laughter.]

DR. CHRISTIANSON: Yeah, we want MedPAC to be
telling Medicare beneficiaries that when they're at home,
they're healthy [off microphone].

DR. MILLER: Right. Everybody's focused on that
one. It does draw a lot of attention. But the other two
have a lot more variation to them, so keep them -- just
keep that straight.

The MIPS thing, you know, I expected that to kind
of set you off potentially, and -- well, I don't mean that
in a -- we've had enough conversation, yeah, I know, but I
think there is a dilemma, a policy dilemma, and the reason
I want you guys to think about this as you go through it is
there's also a lot of consternation around MIPS, you know,
the burden of collecting the measures, the fact that you
don't have comparability because people can kind of pick
their own measures, the fact that, you know, depending on
how the arithmetic is done, the effects could be quite
dramatic. And sometimes, some Commissioners have said, well, maybe you go to more of an aggregate measure and say I know this isn't about your individual and specific performance, but, you know, it's how the delivery system does in general. And to the extent that a physician or a provider says I don't want to be measured this way, it creates an incentive to move into more of an ACO-type of environment. Those kinds of conversations have been made.

But I think your point is well taken. It is the difference between whether you measure what this individual person does or whether you measure the outcome for a population that that provider touches, and that's a huge philosophical question.

DR. NERENZ: Mark, just to sharpen my point, I worry about asking clinicians to be responsible for members of populations who they do not touch, and I think that's where this regional things strikes me -- ACO, okay, MA plan, okay, region for individual fee-for-service docs --

DR. MILLER: And fair enough, and I think what Ledia was trying to say is she'd have to drive it down to a smaller unit if you were to use it that way, and she used hospital referral region as an example, but it may be
incomplete. And the only last thing I want to say -- and this is going to be touchy, too, but we've had enough conversations. I think your point about how much difference does it make -- and you had a term for it, and then Brian's bringing his terms in, it's killing me. So I think that's a really fair comment. I also think you guys should keep that in mind for SES, because once you control for demographics and conditions and take other characteristics into effect, what often happens in these models is they're present but their effects are very small. And that's what we keep running into here. So that I think also is something to keep in mind.

DR. NERENZ: That's fair [off microphone].

DR. CROSSON: You know, having said that, I have to say for myself if I have one year and I'm not in the hospital and I have another year and I'm in the hospital for three days, it may be only -- and those were preventable -- it may be only three days out of 365, but with respect to my subjective sense of health and quality of life, it's a big difference.

DR. HALL: I think this was a great report and a
really important study. And we've kind of tried to pick
out the flaws rather than say that, you know, this is a
really good start. I know many of us consider that the
pursuit of perfection is always the enemy of the good, so I
think we've made a lot of very important points here.
What I took away from this in a general sort of way is that however we define HDAH, there is variability
and, not surprisingly, a lot of that variability has to do
with socioeconomic status, to the extent that Medicaid is a
surrogate measure of SES.
On the other hand, the PPA and PPV variances
don't seem to be directly related to Medicaid status or
SES, and so that there might be some widget in there that
we can work with.
And we've pointed out some flaws or warts in the
system, what do we mean by health? And I think that's a
valid concern, not really a criticism.
So it seems to me that at the 30,000-foot level,
the next steps we might want to consider would -- I sort of
hear the voice of a former Commissioner here, Mary Naylor,
who at this point would be bouncing up and down and hitting
the table, and when you called on her, she said, "It's all
about function, stupid." So I think in honor of Mary, I need to bring that into our discussion.

So I think the next steps on this would be particularly if we're going to look at HDAH as a stretch goal, then some of the comments that have been made here are interesting. For instance, you mentioned that it's associated with chiropractic here. And I think it probably is, but that's also a surrogate measure for paying attention to functional status of patients, which is not a stretch goal. We're getting much better at that. And I think that's really what we'll probably end up going to be saying, is can people do things that are necessary to stay independent at home if we tweak the system in some way. That's how I would define healthy days at home. And there's already an abundant literature that suggests that, and it might lead us to say that within an ACO environment, such things as a simple measurement of can people do the things that allow them to be at home, which generally means taking care of your personal needs, a certain degree of ambulation, et cetera, Mary would say that the model that she's popularized around the country which uses usually nurses in a different sort of observational status in the
home could make a huge difference. That might be another
next step in this.

Also, this may be a perfect example to look at
other things the Commission has been looking at, such as
the utility of telemedicine. It seems to me that so far
that's a tool that's desperately seeking justification or
existing. But we now know that we can make many of these
measurements of quality of life at home very, very easily
and very inexpensively through that, and that may be a next
step.

So I think we really are doing something here
that's very important, particularly in a world where we're
going to be talking about payment for bundles of care,
looking at a much more comprehensive look at how
populations are doing. So I'm really encouraged by this,
and perhaps we're better at picking flaws than imagining
how we can take these initial observations and working them
forward. So I think we're on the right track.

DR. CROSSON: Thank you.

DR. SAMITT: This was an awesome chapter, a great
presentation. Thank you.

I'm in support of moving forward in all the
dimensions that you describe. To jump onto Bill's comments, I think we should be careful for us to not be overly critical, especially this early, of innovative new ways to measure quality. And the comment we should not let perfection be the enemy of good I think is very relevant here, to Bill's point.

You know, we venture in this direction because, as I remember it, we wanted to accomplish a few things from a quality measurement standpoint. We wanted to try to move more toward outcomes focused as opposed to process focused. We wanted to minimize complexity and maximize understanding in quality. And we wanted to hold providers accountable for things that they can control. And it feels to me that these measures hit on all of those cylinders. They're not perfect, but I think these are the types of exact things that we should be considering that will now allow us to compare performance between MA and ACO and fee-for-service.

I empathize with David's concerns about, well, what do we do with fee-for-service since fee-for-service is not an organized unit like MA and ACO? And I'm confident that we can sort that out, but I do endorse future research in this realm.
DR. REDBERG: I just wanted to briefly agree with my physician colleagues. I think it's a really important measure. The chapter was really well done, and whatever we end up calling it, certainly the idea of healthy days at home is really important to our beneficiaries. So I would favor moving forward with it and working out the details.

DR. HOADLEY: Yeah, I think this also represents some really good work in moving us forward, and I keep trying to use sort of a face validity test on this. And I think what you've given us is, you know, a number of good signs that your measures are meeting a face validity test, and then some of the discussion has said some questions of where there are other things you could test. I think the ADL idea, again, like my earlier suggestion, my health status, if there's a way to capture that at the right sort of measurement level, it would be really interesting to see how those line up. And, you know, if nothing else, it will teach us what this measure does and doesn't do.

You know, when I see the PPV measure, I look at that 75 percent that you highlighted, and that makes my face validity, you know, alarms kind of start to ring a little bit. And I think trying to figure out whether that
means it's just -- and you said there's some data issues and so forth, but whether that means we need to go back and think further about what that is or whether there's a reason to think that, in fact, there is a whole lot of misuse or potentially preventable use of emergency rooms, and maybe that high number actually reflects something about how our health system goes. But it seems like -- and then your goals for further research, you know, you don't say explicitly there, but implicitly it's continue to make sure these measures are working. And I think what you've captured -- and we saw it in whichever slide it was that showed the ACO versus the fee-for-service comparison, it's a process of doing those kinds of things to both look for a hint at results -- and you were very careful to keep caveating, "Don't go very far with these numbers yet." But as we do each of the things you say here, hopefully the amount of these are worth looking at versus, well, these illustrate but let's be careful about them, that balance will change as we begin to figure out ways to either gain confidence in the validity of the measures or to refine the measures to make them better. And I think that's going to be the challenge, is we're going to want to start looking
at the results as results, and we've got to keep testing
them against the validity, and yet this is a good way to do
it, so trying these things and each of those results will
give us a sense of is that what I would have expected.
Sometimes it's not what I expected, and there's a good
reason for it, like the rural stuff we were talking about.
Sometimes it's okay, yeah, we seem to be capturing that.
So I think that's going to be the tension for both you guys
doing the analysis and for us reading the analysis.

DR. CROSSON: Kathy.

MS. BUTO: I think this is really important work,
and I want to commend you on getting a good start.
I would support the slide, all the points on
future research, but I would also make sure that you don't
lose sight of the MA analysis. And I'm wondering if there
might be a way for you to at least take a look at PPA for
MA, maybe not the whole healthy days at home thing, but one
of the measures to see how it's beginning to stack up, just
so we begin to bring that into the mix.

I want to agree with Dave that I think for a
consumer, patient, or beneficiary, having something by
major condition, diabetes or COPD or something like that
would be probably more helpful, even back pain.

And, thirdly, I've been struggling thinking about fee-for-service and how this would apply in a comparison, just like Dave, only not from the standpoint of how do you hold everybody accountable when nobody is accountable, but more, is there a way we can think about this in relation to our increasing the role of the primary care physician? So maybe there is some intersection there that doesn't look like a penalty because I don't think we want to just penalize primary care physicians, but is there a way to increase their role in relation to monitoring and overseeing and creating more accountability within fee-for-service, since I think we want to raise the level or see the level go up in all three sectors?

DR. CROSSON: Thank you.

Paul.

DR. GINSBURG: Yes. I also support moving forward. I think this is very promising work. I regret that we didn't talk more about PPA and PPV, which I think are understandable, and I like the variation and I think focus on important things.

I think HDAH, healthy days at home, is worth
pursuing. Maybe another potential refinement is to start thinking about weighting the different components. I'm just really uncomfortable when people take many disparate things together and weight them equally, particularly if there are some tradeoffs, like using more home health visits to avoid hospitalization.

But I also think that we shouldn't strive for just coming up with one measure of a health system or MA plans. Since I don't think we're going to make some of these calls on weighting, particularly weighting mortality against some other measures, we may really think that the goal should be, well, maybe five meaningful measures that can be put in front of people and they make their own judgments, just do their own weighting as to what's important to them.

DR. CROSSON: Very good. Thank you.

Alice?

DR. COOMBS: So I, too, am very impressed with the chapter. Thank you very much, Ledia and David.

A couple things came across my mind in that we're looking at a spectrum of quality metrics, and I'm looking at MIPS on one side and looking at population health
indicator on the other side. And I was just sitting here thinking, well, if I were to put Jay asleep under anesthesia for his gall bladder, there will be some things as an anesthesiologist that I would have to -- according to my MIPS, we check off like eight to ten things on a sheet — would want to make sure that I put you to sleep and I woke you up, first of all.

DR. CROSSON: That would be good. That would be good.

[Laughter.]

DR. COOMBS: That you went to the recovery room, and you didn't have a cardiac arrest, and that you didn't have an infection from the IV and a series of things that we check off on our little MIPS sheet.

But then in the big picture, when I go to the PHO meeting, having an indicator like this would be something very important, not just for patients, but also for the various entities that we contract with and we discuss, because they're going to want to know how good are you. And so this is another way to say how good are we doing for the population that I'm responsible for in South Weymouth, and so I think that this does that.
I would love to see something even more simplistic as a provider. I know this will resonate with Bill. It's that if you could put -- and I said independent living index. Does that sound better than healthy days at home, because you're living independent? If you could put the independent living index as a part of the healthy days at home, combine the PPA and the PPV, and have a single something or another for patients, you give a patient too many choices about variables, and that's not good. They always tell us that too many choices are not good, but if you give them something to interpret that's relatively simplistic, you could break it out and say the components of this next look like this.

So I think those are things that we can do on the patient side, but also we need to do things for the marketplace in terms of how we engage with the various plans that are there that say that, "You know what? We like what you're doing. We're impressed by your outcome, and we think that the thing that you're doing is very good, and we want to incentivize it in whatever means there is."

So the fee-for-service issue that David brought up, I think, is a concern, but I think we have some other
things that we should be basing the fee-for-service on in terms of me as a physician for specialty.

At the population health level, I think that's very different in terms of how you contract. So I think we're looking at some tiered kind of engagement.

One is Jay is going to wake up, and he's going to go home, and that's really important. The other is how well do we do with the group as a whole, and I think each clinician cannot deny that they do play a role, but the role that they play is aggregated with all of the doctors together. So I think that's really important.

In terms of the mortality, I'm wondering if we could take out the mortality altogether and just kind of use it as an independent living index and say that's just what we're doing; we're doing an independent living index. If you're living, then this is what you're going to be reading about.

For patients, I think that might be more valuable, and you explain it, you're going to explain it as these are the components of the independent living index, or you can call it whatever you like.

DR. CROSSON: Thank you.
Pat.

MS. WANG: So thank you for the chapter. I think it's important to continue the work on this, and maybe I'm in a slightly different place on the days at home metric than my colleagues here.

First of all -- and I appreciate the alternative names. It sounds like we're landing on different names. I'm not sure it's really -- I think, at least in my experience, many Medicare beneficiaries are never going to really live independently. It's a matter of functional status, as somebody raised before, so maybe it's functional days at home, but we're moving our sights down from healthy to independent to something that I think might reflect --

DR. CROSSON: Alive.

[Laughter.]  

MS. WANG: Alive.

I'm still not convinced -- and I am very happy to engage in more conversation -- that the measure distinguishes between appropriate utilization and inappropriate utilization, because for many beneficiaries who have multiple chronic conditions, there is going to be utilization. And so, I mean, the tradeoffs, I think that
part of what care management or population health is trying to find the right mixture of services for a beneficiary as opposed to they're not going to receive any services, so they can be at home more, more days out of the year. So I'm not really persuaded by that because it seems to weight everything equally.

I appreciate Mark's explanation about the meaning of regional variation, and I have a deeper appreciation for that. I still am not persuaded, though, that the rural area in Miami does not look very different from the rural area in Wyoming, and that the infrastructure there is not so different that it doesn't skew the results of what looked like days at home versus not at home, just because of infrastructure issues. I'm still struggling with that.

I do think that it is important to continue the work on this. The discussion about function and everything reminds me of the Health Outcome Survey, because the data to find out about functional status is difficult. Right now, that is collected through survey kind of instruments - the uniform assessment instrument for folks who receive long-term care at home. In the MA world, the Health Outcome Survey asks beneficiaries to rate: Do you feel
that your health is better this year than at this time last
year? Are you more or less depressed this year than last
year this time. So there are elements like that that we
should be aware of. There's no encounter claim kind of
system to assess that sort of functional status. So some
of those might be interesting to bring in.

As the thing gets refined, though, I wonder
whether the other sort of gut feeling I have about this is
that this might be appropriate more at the larger level of
analysis than as you get it finer and finer, and the reason
that I say that is I think that it is very important for
quality metrics to measure outcomes, so that you can have
some kind of objective assessment on how the system or the
actor is doing, but also to provide clear enough
information to the actor, whether it's a provider, a
physician, a hospital system, an ACO, or an MA plan of how
you get to that outcome. And I don't see that yet in the
way that this thing is constructed.

I'm not sure that an individual physician -- I'm
listening to Alice's comments really carefully here because
the fact that she thinks that this would be a good thing is
meaningful and is making me pause in this comment, but I
I don't know whether a hospital system, an ACO, or even MA plan knows exactly how you -- what are the component parts to produce this result? So I'll just leave that there.

When it comes to PPVs and PPAs, those are very important metrics. I think, Bill, the report itself acknowledged that the SES adjustment that was attempted was pretty limited compared to -- maybe you didn't say that, but I think that the SES factors that you tried to adjust for are sort of the smallest set of the SES adjustment factors that are being written about today. So some of those community resource issues, those are critical. If you are living in an area that has a grave shortage of primary care, you are going to go to the emergency room more often. That is not reflected in this, and I understand that there's no data source, but I think I would encourage us to continue to talk to the folks who are actively doing research in this area because they are finding very important correlations.

And the final thing on that point, because whatever -- so the idea of going to a smaller number of uniform, more outcomes-driven measures is really, really important and really good, but it ups the ante on
appropriate risk adjustment and adjustment for SES. That becomes critically, critically important.

I do wonder whether -- to your point about you're kind of limited and stuck by the data sources that are available -- whether MedPAC should consider recommending or doing work in the area of uniform data collection or data sets around SES factors, whatever they may be, because these systems in the future are going to have to use them to make these adjustments, and it's not a tomorrow thing. But, at some point, there does need to be some sort of uniform way of collecting this information so that it can be the basis of fair and consistent adjustment.

DR. CROSSON: Okay. Thank you, Pat.

Warner, last comment.

MR. THOMAS: I just have one quick question and then a comment.

The question is, How are we handling hospice days? I didn't see it in the calculation.

MS. TABOR: We didn't actually include it in the model, which is a question that we have for the Commission is whether to include it or not.

MR. THOMAS: Okay. I'm not sure whether we
should include it or not. I just was curious how it was handled, so it's just not considered.

MS. TABOR: We didn't --

MR. GLASS: We did think about it and talked about it last year.

MR. THOMAS: Okay.

I guess I have a little bit of a different view.

As I look at the data and I look at the chapter, I'm just trying to figure what is actionable when I look at this, and maybe we need to look at it with more specificity by ACO or by region or whatnot, but I just have trouble figuring out, okay, if I have this information, now what would I do? Where would I go with it? And so I just throw that out as something else to think about.

I know we're going to move forward with the work, but I just would ask us to really challenge ourself. If we get this data and we're 350 versus 348, what does that mean? And is that a statistically significant variation? Where would we go with this? So I just throw that out as something to think about as you do your additional work.

DR. CROSSON: Okay. Good discussion. Ledia, thank you. David, thank you.
We now have the opportunity for a public comment period. If there are any members in the audience who would like to make a comment, please come forward to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until the December meeting.

[Whereupon, at 11:54 a.m., the meeting was adjourned.]