MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 10, 2015
10:40 a.m.

COMMISSIONERS PRESENT:

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JON B. CHRISTIANSON, PhD, Vice Chair
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AGENDA PAGE

P R O C E E D I N G S

[10:40 a.m.]

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

[Laughter.]

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

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

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

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

[Laughter.]

DR. MILLER: Thank you.

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

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

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

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

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

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

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

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

In general, we question the argument that

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

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

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

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

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

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

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

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

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

DR. SOMERS: Thank you, Jay.

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

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

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

For decades, health care spending has risen as a

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

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

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

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

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

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

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

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

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

What do these current trends portend for

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

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

At those rates, the size of the Medicare program

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

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

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

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

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

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

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

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

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

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

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

Medicare spending, the bottom layer, is projected

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

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

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

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

rates of smoking than previous generations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It doesn't look like a big difference between 6

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

Thank you.

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

DR. CROSSON: Go ahead.

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

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

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

DR. SOMERS: Mm-hmm, will do.

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

[Laughter.]

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

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

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

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

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

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

DR. MILLER: All right. We will look at this. We will write a paragraph.

[Laughter.]

DR. MILLER: All right. Never mind.

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

[No audible response.]

DR. CROSSON: All right. So let's start again. David and then Bill Hall.

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

Bill Hall?

I'm sorry. On this, Cori?

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

DR. SOMERS: Okay.

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

[Laughter.]

MS. UCCELLO: In my own little world.

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

Bill Hall.

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

[Laughter.]

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

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

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

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

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

[Laughter.]

DR. CROSSON: Julie?

DR. SOMERS: That is a counter-argument that

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

DR. HALL: Okay.

DR. CROSSON: Clarifying questions? Mary.

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

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

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

more robust.

DR. SOMERS: Let's see --

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

DR. SOMERS: Dollars per worker?

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

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

DR. MILLER: Kind of the burden that the worker

is carrying.

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

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

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

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

DR. REDBERG: It's on page 21.

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

But, again, what I tried to emphasize here is

that is just Part A, which --

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

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

DR. NAYLOR: [Off microphone.] Yes.

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

DR. CROSSON: Thank you.

Scott.

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

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

MR. ARMSTRONG: Okay. All right.

[Laughter.]

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

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

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

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

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

DR. SOMERS: That sounds great to me.

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

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

DR. SOMERS: That's right.

DR. CROSSON: Jon.

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

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

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

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

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

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

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

DR. CROSSON: Jack.

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

DR. SOMERS: I don't.

DR. HOADLEY: Okay.

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

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

STAFF: [Off microphone.]

DR. CROSSON: Sorry. Where are we?

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

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

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

DR. CROSSON: Thank you, Jack.

Warner, and then Craig.

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

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

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

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

DR. SOMERS: Yes, that's available.

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

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

[Laughter.]

DR. CROSSON: Oh, yes.

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

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

MR. THOMAS: Yes --

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

MR. THOMAS: And then --

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

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

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

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

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

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

the trend is --

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

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

DR. SOMERS: Mm-hmm. Okay.

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

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

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

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

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

MR. THOMAS: [Off microphone.] Okay.

DR. CROSSON: Craig.

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

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

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

DR. SOMERS: I cannot --

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

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

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

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

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

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

DR. CROSSON: All right.

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

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

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

DR. SOMERS: That's right.

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

DR. SOMERS: All duals --

DR. REDBERG: All duals are--

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

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

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

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

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

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

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

DR. REDBERG: Okay. That's close.

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

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

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

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

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

DR. HOADLEY: And MA.

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

DR. REDBERG: That would be 90 percent.

DR. MILLER: Right.

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

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

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

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

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

question would come in.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Mary.

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

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

DR. CROSSON: I was going to say.

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

budget pressures.

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

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

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

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

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

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

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

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

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

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

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

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

outside.

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

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

DR. CROSSON: Thank you.

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

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

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

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

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

the public session.

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

DR. CROSSON: Okay. Craig?

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

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

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

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

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

Okay.

DR. MILLER: Can I do one?

DR. CROSSON: You can.

DR. MILLER: One minor clean-up.

DR. CROSSON: Yeah.

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

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

DR. MILLER: No, no.

DR. CROSSON: Okay.

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

[Laughter.]

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

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

[No response.]

DR. CROSSON: Seeing none, we are recessed for

lunch, and we reconvene at 12:45.

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

AFTERNOON SESSION

[12:47 p.m.]

DR. CROSSON: Okay. We have a few more people coming, but I think we're going to get going. The first afternoon discussion is on developing a unified payment system for post-acute care, Carol Carter and Dana Kelley. Who's starting out? Dana, you're on.

MS. KELLEY: Okay. Section 2(b)(1) of the Improving Medicare Post-Acute Care Transformation, or IMPACT, Act of 2014 requires the Commission to evaluate the feasibility of a unified payment system for post-acute care.

The Congress is looking to MedPAC to recommend key features of a PAC prospective payment system that is based on patient characteristics, not the setting of care. The IMPACT Act specifies that the Commission should use data from CMS's Post Acute Care Payment Reform Demonstration. Congress has also asked MedPAC to consider the impacts of replacing the current PAC payment systems with a unified PPS. Our report is due June 30, 2016.

This will be a complex undertaking in a fairly short time frame, so today is just the first in a series of

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

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

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

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

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

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

At the same time, Medicare's payment systems and

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

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

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

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

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

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

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

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

mandated report.

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

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

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

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

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

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

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

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

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

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

details of the method are in the paper.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the other providers.

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

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

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

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

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

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

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

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

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

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

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

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

DR. BAICKER: [Speaking off microphone]

DR. CROSSON: Okay, all right.

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

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

DR. CROSSON: All right. Thank you.

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

setting where your average --

DR. CROSSON: 4,000.

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

DR. CARTER: Yeah.

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

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

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

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

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

DR. CROSSON: Combined.

DR. CARTER: The institutional PAC would have

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

DR. CROSSON: Okay.

DR. CARTER: Yeah.

DR. CROSSON: All right. Thanks.

Clarifying questions? Starting over here.

Sorry?

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

DR. CROSSON: Yeah, yeah.

Clarifying questions? Over here starting with Cori.

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

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

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

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

DR. CROSSON: Jack?

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

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

DR. HOADLEY: Okay. Thank you.

DR. COOMBS: Thank you very much.

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

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

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

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

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

thing you said.

DR. CARTER: Yeah.

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

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

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

DR. CROSSON: Kate.

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

Presumably with enough variables on the right-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Mary?

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

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

DR. NAYLOR: Covered under the benefit.

DR. CARTER: Right.

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

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

DR. NAYLOR: Okay.

DR. CARTER: Yeah.

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

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

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

DR. CARTER: Right.

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

DR. CARTER: It does not.

DR. NAYLOR: It does not.

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

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

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

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

DR. CROSSON: Kathy?

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

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

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

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

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

DR. CROSSON: Sue.

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

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

MS. THOMPSON: For the clinical.

DR. CARTER: For the clinical group.

MS. THOMPSON: For the clinical group.

DR. CARTER: Yep.

MS. THOMPSON: Thank you.

DR. CROSSON: David.

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

DR. CARTER: Right.

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

DR. CARTER: Right.

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

DR. CROSSON: Other clarifying questions?

[No audible response.]

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

But before we do that, we answer the questions

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

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

[Laughter.]

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

So, Alice.

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

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

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

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

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

yield a consistent outcome.

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

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

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

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

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

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

DR. COOMBS: Okay.

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

DR. COOMBS: Okay.

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

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

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

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

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

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

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

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

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

DR. CARTER: Yes.

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

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

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

DR. COOMBS: Demo.

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

DR. CARTER: The demo, mm-hmm.

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

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

DR. CROSSON: Well, there's that.

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

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

DR. CARTER: Yeah --

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

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

DR. CROSSON: Yeah. Okay.

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

DR. CROSSON: Okay.

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

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

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

[Laughter.]

DR. CROSSON: So, on this topic --

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

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

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

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

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

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

DR. CROSSON: Okay. Bill Gradison.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

DR. MILLER: We can arrange that --

DR. CROSSON: Right.

[Laughter.]

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

up the thread from there.

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

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

DR. REDBERG: Thank you.

DR. CROSSON: Go ahead.

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

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

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

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

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

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

home hospice or inpatient hospice.

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

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

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

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

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

wanted to make sure.

DR. CROSSON: Craig.

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

DR. CHRISTIANSON: Well said.

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

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

[Laughter.]

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

MS. UCCELLO: Yeah, what she said.

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

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

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

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

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

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

DR. CROSSON: Thank you, Bill.

Sue, yes.

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

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

there's lessons to be learned, I believe.

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

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

DR. CROSSON: David.

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

If, for example, the main effect of that variable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CARTER: There is none.

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

DR. CARTER: No.

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

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

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

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

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

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

DR. COOMBS: Right.

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

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

under their institution.

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

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

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

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

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

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

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

DR. CROSSON: Yeah. Warner?

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

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

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

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

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

DR. CROSSON: Jon wants to comment.

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

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

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

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

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

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

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

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

post-acute entity.

DR. CROSSON: Okay. All right.

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

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

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

[Laughter.]

DR. MILLER: But this is what I hear.

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

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

I think the other point that you could be saying

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

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

MR. THOMAS: Correct, yes.

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

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

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

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

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

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

that?

[Laughter.]

DR. CROSSON: Going around. Jack.

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

DR. CROSSON: Craig? Nope.

Alice, the last comment. Not you personally. The Commission.

[Laughter.]

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

The overall quality and usefulness of MA

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

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

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

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

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

Before we look at the numbers, we want to mention

several important caveats to our preliminary analysis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Second, the use rate per capita appears generally

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

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

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

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

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

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

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

These examples point out the challenges in

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

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

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

DR. CROSSON: Thank you, Julie.

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

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

physicians, are capitated.

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

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

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

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

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

example.

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

[Laughter.]

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

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

DR. NERENZ: I'm sorry. Pass.

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

DR. BAICKER: I'll fill it.

[Laughter.]

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

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

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

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

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

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

DR. BAICKER: And then the universe of data?

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

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

DR. LEE: Mm-hmm.

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

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

DR. BAICKER: Thank you.

DR. CROSSON: Jack.

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

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

DR. HOADLEY: Yeah.

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

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

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

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

DR. HOADLEY: Okay.

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

DR. HOADLEY: Okay.

DR. LEE: We just do not have it.

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

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

DR. LEE: Yes.

DR. HOADLEY: Okay.

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

Is that fair, Jim, or --

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

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

current methodology?

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

DR. CROSSON: Where were we? Cori?

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

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

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

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

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

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

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

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

DR. CROSSON: Warner?

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

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

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

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

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

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

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

DR. REDBERG: It is 1.15 --

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

DR. REDBERG: On page 6.

MR. THOMAS: Okay, thanks.

DR. CROSSON: Going down, clarifying questions?

Rita.

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

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

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

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

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

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

DR. REDBERG: Thank you.

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

[Laughter.]

DR. CROSSON: Craig.

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

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

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

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

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

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

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

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

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

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

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

Craig, what is that?

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

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

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

DR. CROSSON: Okay.

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

[Laughter.]

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

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

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

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

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

DR. CROSSON: Jack.

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

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

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

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

And, I think, throughout these, we should be

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

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

DR. CROSSON: Alice.

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

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

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

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

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

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

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

DR. LEE: I think race is.

DR. CROSSON: Okay.

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

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

Jon -- oh, sorry. Kate.

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

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

[Laughter.]

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

DR. MILLER: It's directed at Cori.

DR. BAICKER: Okay, good.

DR. MILLER: Cori's obsession.

[Laughter.]

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

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

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

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

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

[Laughter.]

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

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

[Laughter.]

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

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

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

DR. CROSSON: Jon.

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

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

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

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

DR. CROSSON: Scott.

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

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

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

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

DR. CROSSON: Kathy.

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

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

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

DR. MILLER: Well, I want to --

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

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

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

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

DR. MILLER: Oh, B.

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

MS. BUTO: Part B.

DR. MILLER: Okay.

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

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

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

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

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

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

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

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

MS. BUTO: You can find it?

DR. LEE: Yes.

MS. BUTO: Okay.

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

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

DR. MILLER: Absolutely.

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

DR. MILLER: I completely get it.

DR. CROSSON: Herb.

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

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

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

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

validation.

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

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

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

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

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

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

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

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

reasons for those differences.

Yeah, Jack.

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

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

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

[Laughter.]

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

DR. HOADLEY: Yeah. I mean --

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

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

DR. MILLER: Yeah.

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

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

[Pause.]

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

Carlos?

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

DR. CROSSON: You do.

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

[Laughter.]

MR. ZARABOZO: Okay then.

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

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

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

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

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

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

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

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

the 42 other measures.

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

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

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

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

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

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

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

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

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

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

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

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

and CMS' analysis.

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

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

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

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

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

Returning now to the proposal that CMS originally made to address the issue we are talking about -- which is systematic population differences in quality results that may adversely affect particular plans' star ratings and bonus status because they have a high share of certain populations. What the original CMS proposal would have accomplished would have been a partial leveling of the playing field, in that there would have been more weight assigned to measures that showed no systematic population differences or potential bias. Giving more weight to unbiased measures gives you a more accurate picture of what the differences are in performance across plans because

doing so diminishes the effect of measures that show population differences. Again, this is a partial leveling of the playing field, and it also assumes that there is no issue with regard to measures that are case mix adjusted and which CMS did not examine because they are case mix adjusted.

As for alternative ways of dealing with this issue, the Commission does have a precedent it can look to, which is the peer grouping approach used for the hospital readmission penalty. Another approach I'll explain is to have star thresholds determined by population groups.

For the hospital readmission policy on penalties for high readmission rates, the Commission has suggested that the penalty determination should be based on comparisons among similarly situated hospitals with regard to their share of low-income beneficiaries, given the association between a hospital's proportion of admissions of low-income beneficiaries and its higher readmission rates.

This approach is complicated in the MA setting because the peer grouping would have to vary from measure to measure. That is, for some measures, the majority of

people to whom a specific measure applies may be under 65 in virtually all plans, even though overall most plans have a very low share of enrollees under the age of 65.

Rather than peer grouping of plans, another approach is to group like categories of beneficiaries within a plan to evaluate performance. This graph illustrates what we mean by systematic differences by population. Here we show that for this hypothetical screening measure, rates among the under 65 are systematically lower than among the aged. For each plan, we determine a screening rate for the under 65 and a screening rate for the aged, which is what is plotted here. Rates are generally higher among the aged -- as shown by the yellow, solid line -- and the only instances in which the screening rate is above 80 percent for either population is for the aged in a plan, where the screening rate reaches a maximum of 95 percent. The line of dashes shows that the highest screening rate among the under 65 was 80 percent among some plans.

The preceding slide used an illustrative example to make a point. In this slide we use actual breast cancer screening rates among the HMOs in the subset we examined to

show the difference in results between the disabled and the aged. The first column lists performance thresholds, which you could think of as star ratings, but to avoid confusion we are not using stars here because the percentile cut-off points do not represent how CMS determines cut-offs for star ratings. So what this slide shows is how performance varies between the two populations and what a plan's relative performance would look like if you separated the two populations, versus looking at the combined populations.

The first column of numbers shows results for the combined aged and disabled population. If you arrayed the results for all the plans and you considered the highest level of performance to be at or above the 90th percentile, a plan with a breast cancer screening rate at or above 83 percent would be included in the highest-ranked plans. If you looked only at plan results for the disabled, which is the next column of numbers, and you arrayed only those results, the 90th percentile, or high performance, would be a screening rate at or above 79 percent. This contrasts with the next column where high performance among the aged, when looked at as a separate group, would be a rate of 85

percent or higher -- a six-percentage-point difference between the aged and the under 65. In the remainder of the rows you see the different results between the aged and the disabled at various levels of performance.

To continue with this example, here we look at a hypothetical plan where the only members who meet the criteria for inclusion in the breast cancer screening measure are enrollees who are 65 or older. If this plan had a breast cancer screening rate of 84 percent, when the performance thresholds are based on the combination of the two age groups, as in the first column, we see that this plan is classified as a high-performing plan. Measured against the standard applicable to the aged alone as a subpopulation, in the last column, we see that the plan falls below the highest performing level to what we are calling the medium-high level.

In this slide we illustrate how a plan that includes only the disabled would move up one rank in a population based grouping. This plan, with a screening rate of 76 percent, would change from being rated as average to being rated as medium-high.

As I mentioned, there are plans that exclusively

enroll the dually eligible, and among the D-SNPs there are plans that only enroll the aged. The more common situation is to have a mix of types of enrollees. For mixed plans, you would determine the plan's overall star rating by weighting the plan's composition of enrollment. In our illustrative example, you would determine a star rating for the plan's aged population and then a star rating for the plan's disabled population. If for this measure 50 percent of plan's population was under 65 and 50 percent aged, the overall star rating for the plan for this measure would be the average of the two ratings, given that each population is equally weighted at 50 percent. For other enrollment mixes, you would determine the appropriate weighted average star rating. And I used the terms in the slide Group A and Group B to sort of depart from the concept we're dealing with the under-65 and we're dealing with the aged to say what we're dealing with is we're dealing with a group of people who are being evaluated on this metric and a separate group of people who are being evaluated on this metric.

We have described one method of dealing with systematic differences in plan performance that are the

result of population -- oh, sorry -- one method of dealing with differences in plan performance that are the result of population differences. There are other methods of approaching this issue, such as by scaling the results for one group to have comparability with another group.

CMS is continuing to considers ways to address this issue, including by applying case-mix adjustments to more measures or by increasing the weight of the improvement measure, which has helped some plans that are lower rated in the past.

The population-based grouping that we have described is a complicated way of dealing with the issue we are discussing. One thing to consider in deciding how to address this issue is that there may not be a major effect on plans' overall star ratings if a small subset of measures is adjusted. We tried to simulate the results of CMS' original proposal and found that only a few plans would move from non-bonus status to bonus status. Although the adjustments would be important to a plan seeing an increase in the star rating, the system by which adjustments are to be made should be as administratively simple as possible for both the plans and for CMS.

This concludes my presentation. I look forward to your questions and your discussion of possible options for addressing the issues that have been raised. Thank you.

DR. CROSSON: Thank you, Carlos.

Let me just ask one question. You said at the end, only a few plans. What was the denominator again, number of plans?

MR. ZARABOZO: The 2012 year is 446. Now, I was looking at only HMOs and the data to this extent, but the total plans, 446.

DR. CROSSON: No. But the --

MR. ZARABOZO: Yeah. Sorry. The denominator for that purpose.

DR. CROSSON: Is it a few over or what?

MR. ZARABOZO: Yeah, 446, something like that.

DR. CROSSON: 446.

MR. ZARABOZO: 440, yeah.

DR. CROSSON: And few is less than five?

MR. ZARABOZO: Few would be like four.

DR. CROSSON: Almost close to four.

MR. ZARABOZO: Assuming I did the calculation

correctly.

DR. CROSSON: Right.

MR. ZARABOZO: It was a matter of re-weighting all the steps.

DR. CROSSON: Okay, all right.

MR. ZARABOZO: Based on the original proposal of there are only six measures that would be -- that would be changed.

DR. CROSSON: Right, right. Okay. So the adjusted measure set or something. Right, okay.

All right. So clarifying questions start with -- Herb wants to start. Go ahead.

MR. KUHN: A couple quick questions, Carlos. One is on the CMS proposal that they offered and withdrew. I'm trying to kind of understand, a little bit, the makeup of that. So the way I understood it is it's kind of like a tournament model, that it affected all plans throughout the entire part, and there are those that went up and those that went down, versus an option that just targeted those that needed help as designed by their research that had high numbers of disability in LIS. Is that correct, kind of more of a tournament model than just directly

benefitting those one kinds of --

MR. ZARABOZO: Yes.

MR. KUHN: Okay.

MR. ZARABOZO: Because you're down-weighting a measure where somebody might be doing really well, and so it may affect their overall score. Yeah.

MR. KUHN: And was that primary most of the criticism or the comments that came in? Was that --

MR. ZARABOZO: That was one of the comments, which is "Why are you hurting me to help somebody else?" in a sense, one way to look at it. Yeah.

MR. KUHN: Okay. And then the second thing, I think I heard or read somewhere that RAND is the CMS contractor doing the evaluation on this, and they released some recent findings as early as this week?

MR. ZARABOZO: Yes. Tuesday night. Tuesday night, they released findings.

MR. KUHN: Tuesday, yeah. With a slide deck or something as well.

MR. ZARABOZO: Yes.

MR. KUHN: That I guess the upshot was that they said they continued to find evidence that disability in LIS

do significantly impact. So the evidence continues to build here; is that correct?

MR. ZARABOZO: Right.

MR. KUHN: Okay.

MR. ZARABOZO: Yes. They've added -- I don't know that you would say -- I mean, there are measures for which there are differences, and the impact, you know, varies from measure to measure. And again, they added the disability component there, so right. Yeah.

DR. MILLER: Just to put something in your head to think about for Round 2 -- and I know that deck just came out, so you may not be familiar with it. Did they get into how much movement there is?

MR. ZARABOZO: They did not.

DR. MILLER: Okay. So, at least based on Carlos' analysis, I want you guys to keep in mind not --

MR. ZARABOZO: The validity of this analysis, of course, is, you know, who knows?

[Laughter.]

DR. CHRISTIANSON: Is that what you wanted him to keep in mind?

DR. MILLER: There's somebody at the table who

can prescribe medication, right? I want to talk to that person afterward.

[Laughter.]

DR. MILLER: Yes. Assuming that you've done your best here, Carlos, I do want you to keep in mind the notion that wee and CMS in many ways are saying the same thing. There is an accumulated evidence here, but how much it moves the dice around or the chess pieces around, keep your eye on that and whether you want a very complex solution to the problem or something more simple. That's one thing I want you to think about.

MR. ZARABOZO: Yeah. I will say on the disability, for example, if you looked at the slide deck, something that we talked about in the March chapter was that the medication adherence measures, which are heavily weighted coming from Part D, there's this big difference between the D-SNPs that are aged only versus the ones that include. So when they did the analysis based on disabled, those measures come up as, yes, there's an effect for the disabled that we don't see in the low-income population. So that's very heavily weighted at 9 overall out of about 80 of the weight.

DR. CHRISTIANSON: Are there other clarifying questions? Kate.

DR. BAICKER: So I think that I could probably infer the answer to my question from the combination of information here, but it's way too late in the day for me to be able to divide. So do the plans that serve a greater share of the harder-to-succeed-with populations do better with those populations than the plans with the lower share? And why I'm asking, which may help clarify the ill-posed question is, do we want to think about concentrating people who are harder to hit quality metrics on in the plan? Will concentrating them raise the quality on average that that group gets or lower the quality on average that that group gets?

MR. ZARABOZO: Yes. It's a question that at least I have been thinking about, and we have periodically -- it's sort of like the question -- we have D-SNPs that are specialized plans. Is there really a reason? Do they provide what they're supposed to provide? It has been hard to show one way or the other.

Now, some of the data would indicate that there are high-performing plans and there are plans that don't

perform as well, and for example, in the data where I showed the one plan on the blood glucose monitoring, that is a very, very high-performing plan that includes vulnerable populations. So they have -- in other words, part of the component is a D-SNP, and they do well on their D-SNPs. They don't do as well for the disabled and the low income as they do for the aged, but if you compare them to other plans, they do much better for this population. But again, this is among the highest-performing plans.

So yes, we would like to be able to answer the question: Do these specialized plans really -- you know, is this the best way to serve this population through a specialized plan? No. Do they do better? Yeah.

DR. BAICKER: But we don't know what the answer.

DR. MILLER: NO, we don't know.

MR. ZARABOZO: We don't. Yeah. And I have been trying to look at what are they good at kind of thing. For example, risk fall management, they are very good at risk fall management. Some of the plans, the members are very loyal, for example. They have very low disenrollment rates. So there are some things that they are very good at, some things that they are consistently not good at.

DR. BAICKER: So a simpler version of the question. What's the correlation between the share of a plan's enrollees who are disabled and the quality of care that their disabled enrollees receive?

MR. ZARABOZO: And I can't answer that question right now. I mean, but from the star ratings, the more disabled you have, the lower your --

DR. BAICKER: But that's the lowest -- overall, that's telling you that that group on average has lower quality.

MR. ZARABOZO: Yes.

DR. BAICKER: But I want to know conditional on being in that group.

MR. ZARABOZO: Right. Yeah.

DR. CHRISTIANSON: Clarifying questions?

DR. SAMITT: Can I ask Kate: How do you answer that question? So how do you --

DR. BAICKER: That is an easy factual question if one had the data in front. You'd just look at the correlation between the plans, share of enrollees in a particular bucket, and the share of success in that bucket on any of these quality measures. So it's the

interpretation. It's open to multiple interpretations, but the basic fact is not a tricky one. You can't calculate it off the top of your head, of course.

DR. NERENZ: And there are some of those analyses out there and not necessarily in this context, but perhaps for commercial HMOs. I mean, some of these exist, and a couple I know about, there's essentially no relationship, meaning that the gap, say, disabled or poor or whatever, is essentially a constant across plans, regardless of the proportion. That's one possible outcome, but other outcomes are possible.

DR. CHRISTIANSON: Clarifying questions, Scott.

MR. ARMSTRONG: Yes. More of a process question, and that is my understanding is, as we're doing this work, it is parallel to CMS and what they are doing, and I don't really know how they relate to each other and what the likelihood is that we'll do a whole bunch of work here, and CMS will draw some conclusions independently, anyway?

DR. MILLER: Actually, what I would say, I think they have been listening to us quite a bit, and there has been a lot of back-and-forth between the staffs. So, for example, when CMS came along and did their low-income stuff

and we started looking at it, we were kind of looking at it anyway, because the questions were coming independent from various sources.

And then Carlos' work suggested it wasn't just income; it was also disability. And then CMS turned around and went back and started to pick that up and tease through it.

So what I would say is this is one of those situations where I think if you wanted to say something and directionally orient, I think they are listening, and I don't think there's any sense of conflict. I think they are feeling like they're trying to figure this out, and to date have appreciated the input that has come out of, largely, Carlos' work here.

DR. NAYLOR: So you had this somewhere in the chapter, but can you remind me? You talked about the number of plans that would have moved to a bonus situation if the adjustments were made, as you described. How many would have improved? I mean meaning gone from 3.0 to 3.5.

MR. ZARABOZO: What I was looking at was how many plans are not in bonus status under the --

DR. NAYLOR: I'm asking how many plans would have

gotten better. I mean been on the path to improvement because you're looking --

MR. ZARABOZO: Well, you mean closer to 4 than they previously had been?

DR. NAYLOR: Improved, yes.

MR. ZARABOZO: Yeah. I didn't do that calculation. Yeah, I didn't do that.

The other thing is that the way I would do the calculation, it's just an average of all the measures, but then CMS also has this sort of -- the additional bump-up for high-quality plans where the quality is good across all the measures, so I would have to take that into account too. So it's a little bit complicated, but --

DR. NAYLOR: Thank you.

DR. CROSSON: It raises an important point which is, is this about the stars, or is it about the money?

DR. MILLER: I mean, I think what at least one of the things that we're trying to say here is that if a plan has a lower star rating, we may want that information available and would like that plan to be trying to improve its performance and for these populations.

Next thought. However, recognizing from a money

point of view -- and I don't mean this to be all about money -- from a money point of view, maybe you don't want to penalize them as much, given the fact that -- or at all, whatever the case may be, given the fact that they're struggling with a more difficult population. So, in a sense, in other conversations and potentially in this one -- this is why I'm saying it -- there is this "Well, what is the performance of the plan?" then second thought, "What do you want to do about the money given that they might be working with a harder population?" And I think we're trying to address at least starting this conversation with the second one, but it's an open conversation.

DR. CROSSON: Right, because, you know, I mean, I think you could argue both sides of it. It is really about the money. In that case, the solution becomes potentially a little easier. But if it's really about the stars, whether that's getting to the threshold of four or being able to evaluate the performance over time if you're a manager of these plans and if you're looking outside as a beneficiary, is this plan improving, getting worse, staying stable, then that's a different kettle of fish.

MR. KUHN: I think it's a little of both,

particularly on the money side. It really optimizes the resources those plans need to reach this population. I mean, these folks are hard to reach. They're hard to build trust. Oftentimes, they take more resources. So it's really critical for these plans to succeed to make sure that they have the resources to deal with this tougher population.

DR. CROSSON: Right. I'm sorry. I don't doubt that. I'm just thinking in terms of solutions.

MR. KUHN: Oh, I see.

DR. CROSSON: You could imagine a scenario here, particularly for dealing with -- if we're just dealing with the threshold to get to the bonus, and in support of what you're saying, if it's really about the money, a relatively simple solution would be to identify these small numbers of plans that are disadvantaged and provide, through one mechanism or the other, the money, which could then be used to help them improve. So it's kind of like do we want to solve both problems, or which one do we want to solve?

DR. MILLER: Yeah. And I know you're not saying this. And in that instance, just to -- you wouldn't make a lot of -- I'm asking -- make a lot of changes to the star

methodology.

DR. CROSSON: Yeah.

DR. MILLER: You would just do some after-the-fact adjustment.

DR. CROSSON: Exactly. Right.

DR. MILLER: Whereas, some of these solutions we've put in front of you definitely get into the star methodology.

DR. CROSSON: Right.

Clarifying questions. Jack.

DR. HOADLEY: Your analysis was just HMOs?

MR. ZARABOZO: Just HMOs.

DR. HOADLEY: Why did you not include the portfolios?

MR. ZARABOZO: I didn't want to confound results based on plan type, and also, all of the D-SNPs, the 100 percent D-SNPs are HMOs.

DR. HOADLEY: Are HMOs.

MR. ZARABOZO: Yeah.

DR. HOADLEY: And was the CMS analysis also --

MR. ZARABOZO: CMS is all plans. I think they're doing all plans. We do have a couple measures, one measure

where we do have a difference in result, and then they did not do the separation of administratively ported and medical record group, so we have a difference there too.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Okay. So now we will get into the substance more, and just by happenstance, we're going to start at that end of the table with David.

DR. NERENZ: Thanks.

Thanks to Carlos. This is wonderful work, and I want to thank both you and those managing our agenda for putting this in front of us. I think this is crucially important, and I want us to keep paying attention to this.

And let me follow on Jay's comment. I think this is important not only in the context of stars and Medicare Advantage, but also related concepts like hospital pay-for-performance and public reporting, physician pay-for-performance and public reporting. It's a lot of the same issues, same dynamics, same consequences. So I think we're going to see this -- or should see this over and over again outside this particular context. I think it really does matter.

I would echo Jay's points and maybe answer the

question. As I look at this issue -- and I have been very actively involved in this now for much of the last year and a half -- I think it's more about the stars our the public reporting than it is about the money. We're embedding -- we're doing physician compare. We're doing hospital compare. We're doing the star ratings. We're getting into this for, say, home health and nursing homes. And we're getting more and more in a position of identifying providers as being good or bad publicly, and we're presumably offering this information up for consumer choice, perhaps for choice among professionals who might be referring patients or choosing providers. So this really matters, and it matters more than simply, say, the threshold from bonus to no bonus. And I think when we do that, it's crucially important that we do that fairly and accurately.

And everything I've looked at recently suggests that without some form of attention to these social and demographic factors, the ratings and the rankings that we put out there, again, without adjustment, can be biased. They can be misleading. They can be unfair and just flat out wrong, and to me, the most compelling argument for some

form of attention to these factors are it's just good measurement, and it's good public reporting to take these into account in some way.

I think the evidence of the effect of factors like poverty or like we had earlier this afternoon, living alone, are accumulating. There was a nice article in Health Services Research just last month relevant to this. I understand there's an article in JAMA Psychiatry today about the effect of some of these social factors on quality-of-care measures, so we just see it over and over again. It matters.

Now, we can debate in a certain context. Is it 6 out of 19 measures? Is it this or that? But I think enough for us to pay attention, it matters.

And as an example of sort of why it matters or sort of the underlying dynamic, outcome measures in general are part of these overall packages. They lead in this example to star ratings, but they're used sometimes as stand-alone; for example, hospital readmission. And as a class of measures, outcome measures are multiply determined. They reflect quality of care, to some extent, and they reflect other things. And many of those other

things are outside the purview and the control of the entity being measured, whether that's a plan, whether that's a doctor, whether that's a hospital.

And in many of the things I've looked at closely, the effect of measurable quality of care is very small. If we're thinking about it as R-squared, the R-squareds that we see are in the 5 and 6 percent range for the entire set of measurable process variables.

On the other hand, the effect of external factors, including one study set in the context of hospital readmission, is very large, 60 percent R-squared, .6.

So particularly, when we look at outcome measures, we have to be careful about the extent to which we think of them as literal measures of quality. I think we have to back off a bit and think of them as hints, as indicators, but we get trapped in our own language a little bit. So there's a significant signal and noise problem, particularly in the domain of outcome measures, and I do think it's important that, in one way or other, we think about how to get rid of the noise so that we can see or hear the signal more clearly.

Now, you've given us a really nice example, in

fact, a couple possible examples of how that might be done in this context, and that's good. I would just point out that there are other ways. There are direct and indirect standardization methods. There are regression-based models that yield coefficients that then can be used for adjustment. There are all sorts of ways, and to the best of my knowledge, there's no one way that always stands alone as being best or right. They have pros and cons. They fit certain circumstances better than others.

So the two things I would take away from this and offer for suggestions, one is it is great that we are working on this. Again, thank you. I think we should stay on top of this not only in the context of stars and MA, but also in other similar things that involved P for P or public reporting.

And I think we should remain flexible and actually actively explore alternative methods of dealing with these statistical relationships. You've shown us a couple, and they're interesting, and they have interesting features. But there are other adjustment methods as well, and I think as our discussion of this continues, we can get more into those pros and cons, so thank you.

MR. ZARABOZO: I would like to mention that what CMS posted on Tuesday night, they included an SES factor, the census tract funding poverty and education, which had minimal effect or no effect, I think. I forget exactly how they phrased it. Now, some -- our factors included income, you know, income in the sense that we have the duals, and on the other end we have the employer-sponsored people who tend to be higher income. So, there's, to some extent, a socio-economic content here.

DR. NERENZ: Yeah, and that's all to the good, and that just prompts me to say, and then I'll let this move on, the effect of these variables and how you deal with them is always context dependent -- what unit of measurement, what particular type of conclusion we're trying to draw.

In our system, for example, we have 36 primary care clinics and we measure HEDIS measures at the level of the clinic. Empirically, there's a correlation of about 0.6 between neighborhood median household income and HEDIS measures. That's pretty powerful. And if we didn't somehow adjust for that, we would conclude that the clinics and the doctors in the rich neighborhoods are good and we

would conclude that the clinics and the doctors in the poor neighborhoods are bad, and we would be wrong. We would be absolutely, flat out wrong.

So, in that context, there's a pretty powerful effect, but in other contexts, you might not see that effect. So, it always has to be judged on what the data tell us, what sort of the theoretical relationships might be. Sometimes, it's a big deal. Sometimes, it's not a big deal.

DR. CROSSON: Let's move down this way. Bill Hall.

DR. HALL: David, I admire your passion on this issue.

I think we could help inform CMS in this analysis, because I think star ratings are very poorly understood by consumers and even other people who make decisions for consumers, like health care providers. The new Medicare population with the Baby Boomers are used to looking at star ratings. If they're going to buy a new toaster or a computer, they'll look at star ratings. And what they find is that sometimes the star ratings, while they may be different, are not particularly relevant to the

purchase that they want to make. And, also, many times when you go to the store, you find out that the item has changed. It's a different item now, and so how do you make these determinations.

So, if you look at the consumer part of the CMS website, it doesn't really explain the star ratings except to say that a certain star rating is always better health care than one that isn't. So, I think in terms of looking at how we can help the beneficiaries, any of the clarification work we do here could be very useful.

DR. CROSSON: Thoughts? Scott.

MR. ARMSTRONG: Yeah. I wish this was a more well developed point of view, but I, just in thinking about -- the underlying goal for the star ratings is to improve overall the effectiveness of the system, to achieve outcomes, quality, service, and so forth. And part of what a star rating does is it creates a set of standards by which we evaluate how people are doing relative to their past and relative to other alternatives. And, so, actually, we want the star ratings to demonstrate differences, and to force us then to ask, well, what's the underlying reason for these different outcomes so that you

have something actionable and you can do something with it.

And, so, I just -- I worry about methodologies for adjusting the rating system that smooth out some of the differences driven by economic status or whatever other variable we might be talking about, because the star rating system, in fact, is supposed to amplify the differences and give us insight into what you might do about that.

Now, that sets aside, of course, the fact that the star ratings now also are tied to payment, and so there are a lot of concerns about disadvantaging certain systems to achieve incremental payment if, in fact, they have a harder population to manage.

But, I just -- I don't know, it's, like I said, it's not very well formulated, but it seems like those are two different issues that are getting kind of bungled up in the same conversation.

And then a final question that I think I certainly have as we go forward with this evaluation is that SNPs, for one thing, but there may be other programs, are designed, in fact, with different kinds of tools and resources specifically for the purpose of creating a more effective system for advancing the health towards higher

quality outcomes. And, so, my question would be if -- how much do you rely on the design of the tool itself to close the gap between the outcomes versus, you know, adjusting the metrics that measure outcomes so that you're not creating disadvantages given the population that you're serving.

And, I assure you, before we talk about this next time, I'll think through that question again. But, it just -- that's just disclosing sort of how I'm having a difficult time really understanding what the best approach to solving this. I agree, it's a real issue and we should be taking responsibility for how we improve the health of all the beneficiaries that we serve, and some are having consistently differential outcomes. What are we going to do about that? I think that's a real issue.

DR. CROSSON: Jack.

DR. HOADLEY: So, I was -- I found Dave's comments very provocative, and Scott's, as well. Scott, you talked about stars having a purpose of creating some incentive for plans to improve, to give them a sense of where they stand. There's the payment side of it that sort of is complicated and in some ways orthogonal to the other.

And then there's also the consumer shopping or even the general public awareness.

And, I think about it, and I thought about a lot of this on the Part D plan side, which is really the same set of issues, although it doesn't have the payment bonus involved, and I'll hear the statement made that the benchmark plans on the Part D side that are the ones available to low-income beneficiaries at zero premium are not as good as the other plans. They're just sort of -- they're poorer quality, and that's sort of set as an assumption I'll hear people make without necessarily having looked at any data on the point.

And, in a sense, this is the kind of thing that I think this whole thing goes to, because if we do look at stars to sort of go back and see if that's true, well, it's a problem if the stars, in fact, are correlated with some of these economic and other factors that we're talking about here.

And, so, on the one hand, there are some measures -- again, the one I can think of on the D side is, and we don't actually have this as a star measure, but if we had a measure, say, of what drugs are on formulary and sort of

the quality of the formulary, that's something that's just a fact. I mean, it's their list of drugs. You can analyze it. It doesn't matter who's enrolled in the plan. But, most of the measures we use are not that sort. They are these other kinds of measures.

And, I guess what I really struggle with is how to fix this if it needs to be fixed, or how to use this information, use these findings, because I'm taken by the comment that maybe we don't want to go inside the methodology and jigger it around and change it, and then you really have no longer, in one sense, apples-to-apples, although in another sense you've made it maybe more comparable. Do we want to do something that says, well, if the real problem is the payment bonus, and I think, Jay, maybe you were the one that was sort of saying this, that we could just fix that by having some mechanism to pay the bonus differently if we had evidence that the stars are penalizing certain kinds of plans.

That still leaves alone sort of what it looks like to consumers, and if we really think, you know, this plan is out there and it's got a lower star rating, but it's really for factors outside of its control, we're sort

of saying to the public profile, to the consumer shopping among plans, that's not as good a plan. But, in fact, maybe it is just as good given the circumstances it's operating under.

The only other thought I would make, and this goes to one of the down in the weeds things, but, you know, you had to start this analysis from the fact that the stars are assigned at the contract level, and I wonder if there should be some push-back to CMS about rethinking that concept. And in particular, and I know -- I think you said that a contract cannot have a mix of PPOs and HMOs, but it can have a mix of SNPs and regular plans, and it can have mixes of other kinds of plan types mixed in. And, so you're -- on the Part D side, it can have a mix of benchmark plans and non-benchmark plans or basic plans and enhanced plans under the same contract that all get the same rate, even though they are doing different things.

And, so, you know, maybe one small fix we could make, or could be -- CMS could make -- is to say that a contract at least has to have plans all in the same category. We could figure out which dimensions of category we want to mean by that, but at least not have, you know,

SNPs and non-SNPs mixed together, or basic and enhanced drug plans mixed together, and that might be -- I mean, that's not going to fix the larger set of these problems, but it might help at least to sort some things out and let us understand better what's going on.

DR. CROSSON: Thanks, Jack.

Cori.

MS. UCCELLO: All right. Since Carlos said we've got a lot of time, I've got a lot of comments.

[Laughter.]

MS. UCCELLO: I'm not sure any of them will be useful, but --

[Laughter.]

MS. UCCELLO: First, can someone on staff -- not this instant, but at some point -- send us a link to that slide deck that people are talking about.

Two, so, Mary was talking about with Carlos this idea of, well, how many plans show just an increase in their star rating if we change the way it's measured and the word "improve" was used, and I just kind of want to highlight that if we change the measure and a plan goes from a three to a 3.5, that doesn't mean that the plan

improved. It just means that our assessment of that plan's quality changed. So, I just want us to be careful about how we frame that.

Another thing is in the paper, I think, Carlos, you did a really good job of highlighting several areas of bias. We talk about biased measures, biased ratings, but there can be different reasons underlying -- sources of that bias, and those reasons could have different ways to solve them. And, so, I think you kind of did this in the paper somewhat, but, you know, one source of bias is that the outcomes that are being measured for certain subgroups are outside of the provider's control, and that would suggest some kind of adjustment.

Another is that certain subgroups might just answer questions differently. So when we're talking about patient experience, I think was the example you used, that certain subgroups might just be more easy on the providers than others. So, that would maybe suggest a different kind of adjustment to those responses.

And, the third source of bias, which is where I'm really interested in us exploring more, is whether the questions that are asked, the metrics that are included,

are relevant for the different groups that we're talking about. Are some metrics that are being used just not really relevant for this particular subgroup, and are there better questions that we could be asking that gets at better of whether or not that group is being appropriately cared for.

So, just thinking more about, well, what are -- for the disability group, are there certain questions that aren't part of this -- not that I want to add to the number of measures we're having, but are there certain outcomes measures or whatever that better get at is this group being cared for well. So, just thinking more about that, I'd be very interested in.

Another thing is, I would just urge caution when we use the term "level playing field." I use this term in my day job a lot, so it gets thrown around. But, I just -- this afternoon, it just hit me. It's, like, well, level playing field for whom? You know, we're coming at this from the context of the plan, but what about from the perspective of the beneficiary, and we want to make sure that those beneficiaries in those vulnerable subgroups are not, you know, we don't have lower expectations for them.

Let's level the playing field for them.

And, finally, several years ago when we talked about this issue of risk adjustment, we brought up the QIOs and providing additional funds for low-performing providers and enabling those funds to be used for -- I don't know what the right terminology here is, but for reaching out to the community and doing more coordination with the providers to kind of help certain vulnerable groups, bringing in all the resources of the community to help provide them better outcomes. And, I didn't know if any of those funds used for those purposes would also be benefitting these plans that serve these populations. So, that was just a question.

DR. CROSSON: Craig -- oh, I'm sorry. Warner.

MR. THOMAS: Just a couple of comments. I agree with Scott that I don't think we should modify measurements just to potentially have plans look better, or as Cori said, have a situation where we drop a measure and then a star rating goes from three to 3.5. However, I do think that comparing plans that have different mixes of members when it looks, according to the data, that it looks like it could be proven that the scores on those measures are

different based upon the types of members you have in your plan is something that should be considered seriously. And, I think, going to Cori's point, I also think that you don't want to have a situation where somebody thinks they're going into a four-star plan, but yet that plan is four stars because of the mix of members it has, and you may not be one of those types of members. So, it can play the other way, as well.

So, I just think considering the comparator and the mix of members to me is really important, not necessarily changing the measures. To me, the measures ought to all be consistent. But, the mix of -- I think, going to David's point, the mix of members or the mix of patients does drive a difference in the score and I think it ought to be considered.

DR. CROSSON: So, I want to -- just to the earliest point you made there about perhaps creating a separate category of plans, so you'd have to -- you've got some threshold for plans that had lower socio-economic patients, and I could see how you could -- so, you're suggesting having a different --

MR. THOMAS: No, I'm not saying --

DR. CROSSON: -- rating system?

MR. THOMAS: I'm not saying you have a separate categorization of plans. I think the point being, somehow, you probably ought to be able to have some sort of weighted view of the types of members that are in one plan versus another. So, if one plan has a disproportionate share of under-65 dual-eligibles, you ought to be able to be considerate of that mix of members in the plan versus one that has a disproportionate amount of over-65 members.

DR. CROSSON: And, so, to get right down to it, whether we're talking about lower socio-economic group or disabled tend to correlate, based on what you're saying, then you have two choices. You've identified this group of worthy plans or disadvantaged plans or whatever you want to call them. You could either -- well, you could do three things. You could go into the star rating system and rejigger the mix of measures, which has been done.

MR. THOMAS: Right.

DR. CROSSON: You rejigger them more so that you favor those sorts of plans more than they're disfavored now. You remove more measures that seem to be affected by these external factors. Or, you could not do that but just

simply leave the measurement process in place, but then get an uptick based on that status.

MR. THOMAS: Right. And I think the latter is the one I would look at, because I think the measures are what the measures are across the plans. I think to start measuring plans with different measures based upon their mix of members doesn't -- it seems like it's overly complicated, frankly.

DR. CROSSON: Well, let me just say that the third option is -- again, this has to do with is it the star rating or the money, you could simply say, we're going to leave the measurement process alone, because 3.5 is 3.5 on these measures, right.

MR. THOMAS: Mm-hmm.

DR. CROSSON: But, we're going to recognize that these plans are disadvantaged in terms of getting to that threshold, and whether it's through the QIO process or some other mechanism, they're going to receive more money, the explicit purpose being to try to help them overcome the barriers that they've got in getting to these measures.

MR. THOMAS: And, you know, I think that there's a number of reasons the star ratings are important. I

think Scott has mentioned before that it may not necessarily be the key factor in how someone chooses a plan. I think that probably one of the biggest issues is that, I believe it's five-star rated programs have reenrollment kind of year-round, is that correct?

MR. ARMSTRONG: [Off microphone.] Correct.

MR. THOMAS: So, I think that's probably one of the bigger factors, if you will, of a plan that ends up achieving five stars, in addition to the money.

So, once again, I would not -- I would not recommend personally that we change the measures based upon the type of member, that the measures are what the measures are, but that the comparator be considered. You know, if we have a plan that has 40 percent people that are under age 65 and one that has ten percent, that that ought to be considered in the evaluation process.

DR. CROSSON: And we leave open the question of how it should be considered. So, I think -- Kate, on this topic?

DR. BAICKER: Just the way I feel about whether to include those SES, disability, other kinds of things as risk adjustors, I think Cori would, on the one hand, say we

don't want to say that it's okay for those groups to have worse outcomes, but then other people might say, well, wait, we don't want to punish plans --

DR. CROSSON: Right.

DR. BAICKER: -- that enroll those groups of people. And how I feel about which of those competing factors is most important depends on the answer to my previous question, which is are those plans that disproportionately enroll the harder to serve populations doing a better job with those populations than other people, because I want to steer people and money to the place where they're getting the better outcome. So, the answer to that question would help me weigh those two competing factors that have been raised.

MR. THOMAS: I think you've got to have a plan that has, that, for whatever reason, is more attracted to a disproportionate sector of the population. You could also have an area that just has a disproportionate amount of those folks that are just in that plan. So, I think you could have both that drive that situation.

DR. CROSSON: But, Kate, you wouldn't extend what you said to say, okay, now we're going to have two classes

of plans. We're going to have these plans and we're going to have plans that have passed this threshold of more vulnerable patients and we're going to have them rated against each other. You just want to know experientially what the difference is.

DR. BAICKER: Right, although I don't think anyone -- I haven't heard sentiment in favor of that extreme that you're talking about, but I think we have to acknowledge to ourselves that if you include those SES kind of risk adjustors, you are implicitly generating a different schedule --

DR. CROSSON: Yes, you are.

DR. BAICKER: Even though it's the same formula, you are letting -- you are comparing plans holding that enrollment mix constant, which is a subtle version of that extreme thing that I haven't heard anyone really get behind.

DR. CROSSON: And I just wanted to make sure that's not what you're saying, and Warner said that's not what he's saying, either.

DR. BAICKER: [Off microphone.] No one is saying that.

DR. CROSSON: Down the line, Craig?

[Laughter.]

DR. CROSSON: How did it come up, then?

[Laughter.]

DR. SAMITT: So, I would say that this is very much worthy of additional discussion. I think this -- we really owe it to this population of beneficiaries to work this, and this is from someone who has pretty much spent their career working in delivery systems or plans that care for these disproportionate percentages of vulnerable patients and members, and so I think it is less about a level playing field, but more about assuring that the adequate resources are deployed to the organizations that are caring for these vulnerable populations and they shouldn't be disadvantaged given that they've stepped up to really innovate and focus additional effort and resource in caring for this very distinct group.

And whether that's being disadvantaged because of star ratings in terms of the freedoms and flexibilities that five-star plans get, or whether it's additional resources, I don't presume to know what the right methodology is, but I do think that these types of plans

that have the SES-related implications should be recognized in some way, both in terms of freedoms and financial recognition and reward.

And, I think if our concern is about complexity related to the Medicare payment program, we're way too late.

[Laughter.]

DR. SAMITT: We're already there. The degree of complexity is already very high, and so I think if this gets it right for that subset of the beneficiaries, I think added complexity is warranted.

DR. CROSSON: Yeah. So, just -- right. If complexity is bad, then it's not necessarily true that more complexity is okay. Yeah.

MR. ARMSTRONG: Just a point, Craig, that you made, was stated far better than I said it earlier, but that was the point I was trying to make about I thought, and I wish I knew more about this, but I thought the D-SNPs actually were designed in order to create the kind of flexibility and resources to manage this particular population of patients. And so as we go through this, I think we want to understand, if that's inefficient or

insufficient and we're looking for some other way at the back end at rewarding success as an additional way of supporting the care for this population, we should really understand the net of all of that.

DR. HOADLEY: I wanted to make sure we --

DR. CROSSON: I'm sorry, Jack. Rita was next.

DR. HOADLEY: Okay. Go ahead.

DR. REDBERG: [Off microphone.] I was just --

DR. CROSSON: Just what?

DR. REDBERG: Going to make comments, but not on this.

DR. CROSSON: Okay.

DR. REDBERG: Okay. And, I think it is a really important issue and an important discussion, and I appreciate most of the comments that have been made, except that I don't think we should -- we should avoid more complex. I'd agree that our system is incredibly complex, but I wouldn't want to add to it.

But, aside from that, it reminds me a little bit of our earlier discussion about the social service expenditures in addition to health care expenditures, because if we're really looking at outcomes in health,

we're only looking at one part of it when we're looking at health care, and I think a lot of the issues that separate the low SES and the high SES are outside of the health care system and that's why we see these differences.

And it makes me think that when we do look at the, you know, comparators, how much we spend on health care and measures of how well we're doing in the U.S., we need to look not at the overall, actually, health and social services, but at the ratio we spend on health care to social services, because I suspect that countries like Sweden and the other countries that have higher -- lower health care but better life measures are spending a lot more than we are on social services and that we're spending a lot less, and I think that's where a lot of these disparities are coming from, things that we really can't address in the health care system. When people are going home to very untenable situations, it's not good for health, and they don't take their medicines and they don't come back and things don't -- so, I think that's an important sort of bigger picture problem.

But, specifically with regard to measures, because we are very committed to measures, I just want to

point out that it really is disturbing to me that all of these measures are process measures, and I understand that the process measures are weighted lower than the outcomes measures, but 44 measures is a lot of measures, and I feel like we've gotten so many measures that it's no wonder that doctors can't really take care of their patients because they're too busy checking off all these lists, and that perhaps we could have better care if we had fewer measures. You know, I'm just not -- there's very poor correlation, if any, between a lot of these process measures and actual outcomes, and so you can, you know, check off all these kidney disease monitoring, but I don't know that anyone's better off for it.

And, for example, on the example you gave us on Slide 13, the blood sugar control, which I think is considered, according to the mailing materials, to be an intermediate outcome measure, but it's not really an outcome measure. It's a measurement of blood glucose. You know, there's so much debate over what is the right HbA1c, you know, it changes all the time and we're over-treating a large percentage of the population, you know, and certainly in my Journal, JAMA Internal Medicine, we published

multiple studies that show that there are more Medicare beneficiaries who are suffering from hypoglycemia than from hyperglycemia. And, so, it makes me think we have to really go back and question our measures, because I don't know that they're measuring quality, and they're certainly not sort of related to health and outcomes, which I think is what we really want to achieve.

So, you know, we don't directly do that, but if we got feedback back to CMS on sort of less measures and more meaningful measures in terms of outcomes and less process, I think we'd overall see better quality care.

DR. CROSSON: Jack.

DR. HOADLEY: I was going to make a comment that's somewhat similar to Rita's in the sense of thinking about the -- then I was struck by something I took out of Cori's comment that I think might have passed by a little bit, which is that, to some extent, some of the measures that we're using may be biased in ways that aren't -- it's not a matter of correcting them, but maybe going back and revisiting the methodology to do the measurement. So, if we're using a survey-based thing for one of these things and there's some thought that maybe there's a response

bias, or maybe that's not the right question to ask for particular populations, let's make sure to go back and look at the list of measures for things like let's -- you know, we've gone through over the years reduce the number of process measures, weighted them less. Maybe there are still, per Rita's point, too many of those.

But, also, it's a chance to go back and look, not necessarily to add measures, but to change the way some of the data are collected to be less vulnerable, if we can figure out how to do it, to the kinds of biases that we're talking about here. So, I mean, I think that's another way to address this that might escape some of these other issues that we're grappling with.

DR. CROSSON: Okay. To wrap this up into a tight little bundle --

[Laughter.]

DR. CROSSON: I think, at the risk of over-simplifying or over-complicating, I think we do have some commonality. I think there's a general sense here that this is a real problem that needs to be addressed, and to not address it would be wrong.

I think we have some difference of opinion at the

table about the relative appropriateness of some approaches. One would be to, for example, to go into the measure set. Jack suggested examining the measures and either changing or throwing out some of the measures that are in addition to the adjustments that have already been made. Or, you know, reweighting the measures, weighting them even more and differently. You know, there is complexity in that, not only for CMS, but to try to make sure that we've done it right and haven't made the situation worse in some direction.

The other aspect of complexity, at least in my mind, is to the extent that we want the star rating system to be viewed as fair and appropriate and well thought out and scientifically credible, the more machinations that go in inside of it, you know, the more we risk people, you know, in the plan world in general saying, you know, this is rigged one way or the other and we don't like it. And, I don't know that they would necessarily pursue a different course, but I think we want to be careful we don't suggest something that fundamentally undermines the star rating system, assuming that we all believe that it's something we should keep.

You know, beyond that, there are other differences here. I mean, is it really about the money? If so, that drives us in some directions which may be more simple than others. And I've heard a couple of people think that that's the case. I've heard others, probably a larger number, say, no, preservation of this star rating system has values beyond the money, you know, to be able to compare performance over time, to be able to compare one organization against the other, whether or not it achieves the bonus that it should be, that's possible. And, so, I don't think we have unanimity of mind there.

Then there's the other question of, you know, if we -- if the fix here is to change the rating of plans who are deserving, so maybe we could agree on what that threshold would be, and we come up with a four instead of a 3.5, have we, in fact, corrupted the process itself? I don't mean made it more complex, but just simply created a situation in which a four is not really a four, it's a 3.5 with an asterisk, because I think there's an argument to be made that the quality that is produced by the plan is the quality that's produced by the plan, and it ought to be what it should be and then adjusted in some way to make up

for the deficiencies in the measure. At least, that's one position, and I've heard that position and I've heard other positions.

You know, so, I think we obviously have to come back at this again. I don't think we're ready to say to Carlos, here's what you should do. What I would hope that we could do, you know, the next time around, now that we understand this and we've begun to understand it more deeply individually, Carlos, is to come back with some options that are varied in terms of complexity -- more complex, medium complexity, less complexity -- that preserve the star rating system, or not, or alter it, and then have a discussion about the relative values of these approaches in a kind of more granular level. Is that -- how does that work for you?

DR. MILLER: If I understand where you're landing, because I also saw differences of opinion, the way we might end up here, although it's -- having one idea and everybody behind it is the clearest signal, obviously, but if it turns out that that's not where we are, then the landing place, and I think that's what you're saying, it may be that we go through these different options, still

don't come to consensus, but what we produce is there are a couple different issues --

DR. CROSSON: The pros and cons.

DR. MILLER: Exactly.

DR. CROSSON: The pros and cons, yes.

DR. MILLER: And you just say -- and that may be where we have to be, if that's the -- or the lack of consensus here.

DR. CROSSON: It might also -- I mean, is this -- when would we know, or would we know the direction that CMS may be going just to inform our discussion or not?

DR. MILLER: I'm not sure I can answer that.

MR. ZARABOZO: Well, I mean, they did post this information recently, and I think there's probably going to be more to come after that, so -- including how to address the issue, so there's more to come, I think --

DR. CROSSON: Yeah.

MR. KUHN: And presumably, they wouldn't do it until next year's letter, right, call letter?

MR. ZARABOZO: That's probably right, yeah.

DR. CROSSON: And just to be clear, I'm talking about publicly available information here, not --

MR. ZARABOZO: Yeah. Well, the call letter certainly would contain -- which is the February letter that would say, here's what we propose to do.

DR. CROSSON: Yeah. I wonder if we want to wait that long to do this reconsideration. Did you say February?

MR. ZARABOZO: February, yes. But I think between now and then, there will be more information coming out of CMS.

DR. CROSSON: Oh, okay. All right. That was sort of the question I was asking.

I think that's where we are, unless there are any other or different opinions. David.

DR. NERENZ: Just very quickly, in response to Kate's comment, you very eloquently talked about the policy dilemma. I mean, on the one hand, we don't want to unfairly either reward or penalize based on factors outside plans' control, but on the other hand, we do not want to excuse or allow truly poor quality, and the question is, how do you sort that out?

I just want to let people know that Ashish Jha and Alan Zaslavsky have written very eloquently about this,

and there's actually an analytic approach that gives traction on this point, and there's a lot of statistical deep water and we'd end up taking up Carlos's invitation to be here all night, so we're not going to do that. But, there was an article published last year. Ashish's blog post entitled, "Changing My Mind" lays it out. It fundamentally has to do with if you're looking at a gap, or a disparity, let's call it, let's say between low and high income, the question is, is that typically seen within plans or across plans?

If you see the same gap across all the plans you look at, depending it doesn't matter the mix of patients, it doesn't matter geographic location, if you see it consistently within, the same gap all the time, it suggests it's not a quality of care issue and, therefore, probably should be adjusted.

On the other hand, if you see it only in certain plans, meaning that those plans are bad for everybody, then that does suggest it's a quality care issue and probably should not be adjusted. Now, I've way oversimplified, but again, nobody wants to be here all night.

But, if either for staff or those who are

interested, Ashish has been wonderful in laying this out in pretty accessible terms to non-statisticians.

DR. CROSSON: I think that might be very helpful to look at. It still leaves us with the question of what does "adjusted" mean and --

DR. NERENZ: There are multiple forms, all kinds of approaches. It's a generic term, doesn't mean one particular mathematical model, and so it's complicated.

DR. CROSSON: All right. So, how are you feeling about this, Carlos?

MR. ZARABOZO: You know I'm retired. You know that, right?

[Laughter.]

DR. MILLER: And if you want to get out of here, you've got to stop asking Carlos questions, because he'll go on --

[Laughter.]

DR. CROSSON: Do you have enough to work with, or more than you would like?

MR. ZARABOZO: I think we have enough to work with, and we'll talk about it internally.

DR. CROSSON: Okay. All right. Well, thank you

so much for taking on this tough issue.

MR. ZARABOZO: Thank you.

DR. CROSSON: Well, okay. So, now we're ready for the public comment session. Could I ask anyone who'd like to make a public comment to come to the microphone and line up so we can see who wants to speak.

[No response.]

DR. CROSSON: Seeing no one, we are adjourned until 8:30 a.m. tomorrow morning. Thank you so much.

[Whereupon, at 4:43 p.m., the proceedings were adjourned, to resume at 8:30 a.m. on Friday, September 11, 2015.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 11, 2015
8:31 a.m.

COMMISSIONERS PRESENT:

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

P R O C E E D I N G S

[8:31 a.m.]

DR. CROSSON: Okay. I think it's time to get going this morning. Welcome back. I hope everybody had a nice evening. Welcome to our guests in the back.

This morning we're going to open up with a discussion, a relatively broad discussion and somewhat initial discussion, for the work of the Commission in the next year or so on Medicare drug spending. We're going to hear from Rachel Schmidt and Shinobu Suzuki. That rolls right off the tongue, both of them. And I must say I need to congratulate you for the clarity of this paper that we read in preparation for this. It read so easily, I put down my novel on the plane just to read it again.

[Laughter.]

DR. CROSSON: It was an okay novel. But, I mean, the clarity and the logic was terrific, so thank you so much for that.

Who's going to start out? Rachel?

DR. SCHMIDT: Yes, I am. And Kim Neuman is also a co-author on this.

Good morning. Before we get started, we would

like to thank many of our colleagues for their help on this presentation. This obviously touches across all aspects of Medicare. But we especially want to thank Craig Lisk for his help.

Over the years, many of the Commission's discussions about Medicare policies have involved prescription drug spending. In recent meetings, several of you have asked questions that seemed to be looking for broader context around Medicare's payment policies for drugs. In response, we thought it might be helpful to start out the meeting cycle with some of that context.

This is the first of two presentations that we'll give. This morning we'll talk about the magnitude of Medicare drug spending across all payment systems. We'll also describe conceptually how Medicare pays for drugs. Next month, we'll provide background material about the development and approval processes for drugs and biologics, as well as information about drug-related industries such as pharmacies and pharmacy benefit managers.

Just to remind you, here is a list of topics from some of your most recent conversations related to Medicare prescription drug spending. I am not going to go over

these in detail now, but more detail about each of these topics is available in the Commission's June 2015 Report to the Congress.

So let's look at the magnitude of Medicare's drug spending. This chart shows estimates from the National Health Expenditure Accounts put together by CMS' Office of the Actuary. These estimates are consistent with statistics on the nation's gross domestic product, and they provide greater detail about health care producing sectors of the economy. They reflect all payers for health care including Medicare.

A key thing to note is that the national health accounts use a final purchase retail concept. This means, for example, that when a hospital buys prescription drugs that it uses for surgery, drugs are an input to hospital services -- the final product. The expenditure accounts measure the value of hospital services, but they don't separately measure the drugs used for surgery. We'll show you a broader spending concept in a moment.

The national health accounts include retail prescription drug spending, such as when Part D enrollees fill a prescription at a drug store or grocery store or

when a physician's office buys drugs to administer to patients.

In 2013, across all payers, retail drug spending made up 9 percent of all national health expenditures. However, retail drugs made up a higher share of Medicare spending -- 13 percent. Medicare's retail spending in 2013 reflects Part D program spending of $64 billion and another $10 billion in prescription drugs billed separately under Part B.

Since 2006, when the Part D program began, Medicare's importance as a payer for prescription drugs has grown. This chart shows all the different payers in the economy for retail prescription drugs from the national health accounts. If you summed up all of these lines for any given year, it would total 100 percent. Before 2006, retail drug purchases paid by Medicare only made up 2 percent of total drug spending, which is shown in the blue line. Medicare's share jumped immediately to 18 percent in 2006 because of Part D, and its share grew to 28 percent by 2013. The Office of the Actuary projects that Medicare's share of retail drug spending will reach 34 percent by 2024.

You may notice that Medicaid's share -- the yellow line -- fell dramatically in 2006 as Medicare took over most of the responsibility for the drug spending of the dually eligible beneficiaries. Notice also that there's be a long-term downward trend in the share of retail drug spending paid out of pocket by patients, which is shown in the red line. Private health insurance -- the green line -- mostly provided through employers, has historically been a very important payer for drugs. It is still very important, but its share has been declining somewhat.

Oops. This slide is not great there. I apologize for how that turned out.

To get another sense of the magnitude of Medicare drug spending, we developed estimates that include not only retail drug spending but also spending for drugs and pharmacy services used as inputs at health care facilities. We based these estimates on Medicare cost reports, Medicare claims, and estimates of program spending from the Trustees' report. I'm happy to go into more detail about methodology on question.

Ultimately, the estimates are all in terms of

Medicare program spending -- what the program paid for. There's also another block of spending associated with what beneficiaries paid in cost sharing for drugs that is not a part of this estimate.

First, look at the left. Medicare program spending totaled $574 billion in 2013, and we estimate that drugs and pharmacy services made up 19 percent of that. Typically people think of 9 or 10 percent, but we think it's about 19 percent in this broader concept. You can see how we get there by looking at the right -- at least if you look at your handouts.

[Laughter.]

DR. SCHMIDT: Part D is the largest piece and makes up 57 percent of the total. This includes drug benefits in both stand-alone plans and in Medicare Advantage drug plans. If you add in separately billed physician and supplier drugs administered in physician offices and hospital outpatient departments, that brings in the other two green pieces of the pie, or another 15 percent of the total. Now, if we add in drugs used as intermediate inputs for hospitals, skilled nursing facilities, hospice agencies and so forth, along with the

same sort of spending delivered in Medicare Advantage plans, we get to the total.

To summarize so far, you might have heard before this morning that drugs make up about 9 or 10 percent of health care spending. That figure comes from the national health accounts and reflects retail spending on prescription drugs compared to all health care spending in the economy. For Medicare, that final consumption, retail concept percentage is higher; 13 percent of Medicare spending is made up of retail prescription drug spending. If we use a broader measure that takes retail spending for Part D and some Part B drugs, and also add to it spending for drugs and pharmacy services that are inputs for other providers like hospitals and SNFs, we think altogether that comes to about 19 percent of Medicare program spending.

Now Shinobu will describe the approaches Medicare uses to pay for prescription drugs.

MS. SUZUKI: Thanks, Rachel.

So I won't go into the details of each payment system. Generally, though, Medicare pays in different ways across the health care sectors. Here we've grouped them into four categories. In the first type, the cost of drugs

are included within prospective payment bundles. Payments for most institutional providers fall under this category. The second type, used for certain Part B-covered drugs, is paid separately on the basis of their ASP plus an add-on. The third is Medicare Advantage plans that receive capitated payments based on fee-for-service benchmarks and bids for their broad bundles of Parts A and B services, as well as prescription drugs. Finally, under Part D, Medicare uses a combination of capitated payments based on plan bids and reinsurance subsidies to pay for the drug benefit.

We'll go over these in more detail in the next few slides, but generally in each case Medicare's influence over drug pricing is fairly limited. In other words, typically it is the provider of the health care service or the plan that negotiates prices for drugs, not Medicare.

This chart gives you a sense of how much of Medicare's drug spending falls into each of those four categories, using the broader estimates we developed.

On the left is the distribution of Medicare drug spending for 2007, which we estimated was about $82 billion. Medicare program spending for Part D made up 56

percent, followed by 21 percent for drugs paid within prospective payment systems, 14 percent with ASP-based payments, and 9 percent for Parts A and B services delivered by MA plans.

On the right you can see that the distribution for 2013 did not change all that much. We estimate that total Medicare drug spending was about $112 billion, and Part D program spending made up 57 percent of that total. The proportion associated with prospective payments fell to 16 percent, but that mostly reflects the growth in enrollment in MA plans, which are shown as the gray piece of the pie.

Prospective payment bundles are used to pay for Part A and some Part B services. They group together services that are expected to use similar levels of resources. Examples include inpatient and outpatient prospective payment systems that group services based on diagnosis-related groups and the outpatient dialysis payment system.

For skilled nursing facility and hospice services, Medicare bases payments on per diem rates. These prospective payments are intended to give providers

incentive to manage their costs of care. For services paid under these payment bundles, drugs are used as an intermediate input to health care services. The cost of drugs in these payment bundles reflects prices that providers, their group purchasers, wholesalers, and pharmacies negotiated with manufactures -- meaning that Medicare does not have a direct influence over the prices paid for drugs included in the payment bundles.

Medicare generally pays for most Part B-covered infusible and injectable drugs administered in physicians' offices and in hospital outpatient departments separately rather than bundling them into payments for other services. By law, the payments for these drugs are set at ASP plus 6 percent. The ASP reflects the average price realized by the manufactures based on sales to nearly all purchasers. That is, although the payment rates for Part B drugs are set administratively by CMS, the use of market-based ASP data to set these rates means that Medicare's influence on what prices are paid is indirect.

Part D makes up the largest spending on drugs, accounting for over half of all payments for drugs by Medicare. As with other payment areas, Medicare has little

direct effect over prices for outpatient drugs covered under the Part D program because payments are made to plans based on bids that they submit, which reflect prices negotiated between plans, pharmacies, and drug manufacturers. The bids are essentially premiums that plans need to collect in order to provide the benefit. Medicare subsidizes the premiums through two forms of payments: the capitated direct subsidy payment and an open-ended individual reinsurance payment. While plans are at risk for the benefit spending covered by the direct subsidy, Medicare pays for individual reinsurance that covers 80 percent of the catastrophic spending. These two payments average to 74.5 percent of the total premium, and the remaining 25.5 percent is paid by the enrollees.

In addition, Medicare pays plans that enroll low-income beneficiaries most of their cost sharing and premiums. The law that created the Part D program included a provision that prohibits the Secretary from interfering with the negotiations between drug manufacturers and pharmacies and plan sponsors. It also prohibits the Secretary from requiring a particular formulary or instituting a price structure for reimbursement.

Here we list some examples of how other federal programs pay for drugs. Medicaid purchases drugs through retail pharmacy distribution channel as in Part D. Manufacturers are required by law to provide statutory rebates in exchange for coverage of their drugs under Medicaid. Most states obtain additional rebates by using placement on their preferred drug lists as negotiating leverage. The Veterans Affairs and the Department of Defense generally purchase drugs directly. Both programs have access to discounted prices that are set in law, and they both obtain further price reductions using placements on their drug formularies as leverage.

While statutory discounts allow some federal programs to pay lower prices for drugs, such discounts are not available to private insurers. Now I'm going to walk you through how private payers may obtain rebates or discounts from drug manufacturers.

One way a payer may have leverage in negotiating lower prices is by being able to move market share -- that is, successfully encouraging its members to use certain drugs over competing therapies.

Another common strategy is to use a formulary.

Nearly all Part D plans use formularies with tiered cost sharing. The tier placement or applicability of utilization management tools, such as prior authorization, can provide plans with leverage when negotiating rebates and discounts. Some payers may also use comparative effectiveness studies to not only make coverage decisions but also to obtain rebates and discounts from manufacturers. However, these strategies may not be effective when there are no competing therapies.

Our goal today was to provide background information on how Medicare pays for drugs. Next month, we will be coming back to you with another presentation that will provide background information on drug-related industries. We would be happy to answer any questions about today's presentation and would also be interested in finding out if you have any information you would like us to look at for next month that would be helpful in your discussions about Medicare drug policy issues.

That concludes our presentation.

DR. CROSSON: Thank you. Thank you very much, Rachel, Shinobu.

So, I think what we're going to do now, as we

usually do, is take clarifying questions, and we'll start with the right end of the table.

DR. NERENZ: I wonder if you could just talk a bit more about outpatient drugs, Part B drugs. The prototype in my mind is a chemotherapy infusion, but I'm curious, are all Part B drugs paid as part of a larger bundle, or are there some that are purely drug payments?

DR. SCHMIDT: Yeah, most of them are separately billable, actually, under Part B --

DR. NERENZ: So the --

DR. SCHMIDT: -- under the ASP plus 6. There's a small amount of spending that is packaged within the outpatient prospective payment system. It's packaged within the payment rates for that.

DR. NERENZ: So, the packaging is relatively small. The direct payment is relatively large. Okay. Thank you.

DR. MILLER: And by direct payment, David, in asking that question, there's two things that happen when this happens. Medicare pays for the drug, and then Medicare pays an administrative --

DR. NERENZ: Yeah.

DR. MILLER: Right.

DR. NERENZ: Okay. It was relative size.

MS. THOMPSON: Foundational. Do we understand, or can you help us understand, how is ASP -- how is the average sales price set and how is the average AWP set?

MS. SUZUKI: AWP is a list price that manufacturers set. It's not a market-based price. Usually, most payers do not pay the AWP. They negotiate prices that are different from that. ASP is a market-based price, but it reflects the rebates and discounts that are negotiated, and it could be retroactive rebates, but all of that is reflected in the final price. So, it's what manufacturers receive for the sale of a particular drug.

MS. THOMPSON: I understand it's what they receive, but how is it set? Is there a formula to the establishment of those numbers?

MS. SUZUKI: So, it's an average, volume-weighted amount.

MS. THOMPSON: So, the manufacturers are reporting that information to CMS, correct, and then CMS calculates the average? Okay.

DR. HALL: Thank you. This was a very, very

informative chapter.

It's been said in our own materials here and elsewhere that a substantial part of the increase in prices and expenditures for Part D is related to a couple of products, some of the new biologics that have come out. Hep C treatment is one that's been focused. Is there any way to break that down a little bit more, and if we remove these additional expenditures for drugs that have no competition, essentially, what are the other factors that are causing the rise in drug expenditures overall? Do you have any more detail on that?

DR. SCHMIDT: Well, so generally, I think, in some of our past presentations about Part D, we've tried to emphasize that there's almost a bimodal distribution of spending. So, the bulk of beneficiaries are taking medicines that have gone generic, by and large, and then a relatively small amount are hitting the catastrophic region and it's their use of some of the higher-cost drugs is higher, although it's still relatively small. They're using lots of other drugs, as well.

General factors behind increase in prices? I'd say the biggest thing is that there's kind of a transition

going on right now. A lot of the blockbuster drugs have already gone generic at this point and we're now into a new stage where it's more biologics entering, you know, off the pipeline and getting approval from FDA for marketing, and it's just the flow of a portfolio of drugs into kind of this new world that's more biologics that's driving spending increases, I'd say.

DR. CROSSON: Herb. Kathy.

MS. BUTO: I wonder if you could -- because the paper actually goes into detail about the different growth rates in the different sites of care, and I think you pointed out that MA, the growth rate in drug spending in MA is driven by the growth in enrollment. I also noticed that OPDs, outpatient departments, are growing faster than, say, Part D, for example, and I guess the lowest is inpatient hospital spending on drugs, as you've extrapolated or been able to figure it out.

But, could you say a little bit more about what the reasons are behind the differential growth rate, if you've taken a look at that, and sort of related to that, say something about why Medicare's retail spend is higher than private, or all other drug spending, sort of in the

National Health Accounts. So, say a little bit more about the 13 percent versus the --

DR. SCHMIDT: Right. Let me --

MS. BUTO: -- nine or ten percent --

DR. SCHMIDT: Let me start with that one so I don't forget it. It's higher than -- the 13 percent is higher than the nine percent largely because of the -- I think that -- actually, I had a different answer in mind. I mean, it's encompassing both the Part D retail spending as well as the Part B drugs, and I think the use of those biologics probably tends to be higher within the Medicare population than the population as a whole, is my hypothesis. So, that's that one.

MS. BUTO: Just a quick follow-up. So, in the nine or ten percent for the population as a whole, that also includes whatever use of biologics is going on in the --

DR. SCHMIDT: If it's going through retail channels, yes.

MS. BUTO: Okay. Because, I think, based on your definitions, it looked to me as if the all of Part B drug spending would be counted in that number, but you might not

pick up that, since private insurers pay for drugs differently. It may not be a total apples-to-apples, is what I was thinking.

DR. SCHMIDT: Yes, that's quite possible. You're right. I think not all of the -- not all Part B drugs were in there because of the small amount of packaging in reference to my first answer. But, it's most of Part B drugs are the separately billable ones, and you may be right. It may not exactly be apples-to-apples.

On your first question, the table that's in your mailing materials, yes, it's correct that I think the fastest growth rate we noted was for outpatient hospital prescription drug spending, and that's going to reflect the transition that we've seen in changing care settings, office settings into more hospital outpatient departments, by and large, I would say, as well as the use of more biologics and the higher launch prices that we've observed in recent years.

MS. BUTO: You don't -- or maybe you do think that the reimbursement differentials between OPD and physician office might help drive that change?

DR. SCHMIDT: Well, I think the transition --

MS. BUTO: You think there's a shift --

DR. SCHMIDT: It's a shift --

MS. BUTO: -- from inpatient to out.

DR. SCHMIDT: Yeah.

MS. BUTO: Okay.

DR. SCHMIDT: It's the same payment rates, right? It's all based on ASP plus 6. It's just the transition of where the care is being administered.

And, in terms of -- I should caution you on the Part A and Part B spending providing by Medicare Advantage plans. You know, we weren't able to use detailed data to estimate that, right. So, we're assuming that it's the same proportion of spending as in fee-for-service. But, yes, we saw rapid growth in that in our estimates and that's largely reflecting growth in the enrollments of Medicare Advantage.

DR. MILLER: And if you think about it -- you're at a good resting place. I hope this doesn't mess things up. You know, you get in a lot of enrollment into MA, so that's some of it. We're seeing declines in inpatient admissions. We're seeing increases in outpatient utilization, which is probably secular and the shift from

the physician setting as hospitals purchase physician practices. So, in some ways, these trends match broader trends in -- broader spending trends.

MS. BUTO: Where I was trying to go was I was trying to figure out whether the 340(b) hospital issue, where there have been a lot of shift of oncology to hospital outpatient, had anything to do with that, but maybe we can't really tell.

DR. SCHMIDT: I'd say we can't really say for sure, unless any of my colleagues sitting over here has an answer.

DR. MILLER: We have looked at this a little bit.

MR. WINTER: You might recall from the June chapter on 340(b), we did have a section in there which compared the growth in spending for oncology services, chemotherapy in 340(b) versus non-340(b) hospitals. It is growing much faster in the 340(b) hospital setting. But in terms of attributing what share of the growth they're talking about here to that phenomenon, it would be -- it would take more work. I'm not sure it's feasible.

DR. NAYLOR: So, I echo this is a terrific report. I'm wondering, Slide 10, and you -- I'm trying to

get a sense of how -- and I thank you for the reference to the work in the June report on the oncology bundling, but I'm trying to get a sense of how -- what we know about the effects of bundling as a tool, and given the indirect influence of Medicare on drug pricing, the effect of bundling on reducing prices relative to other tools available to the Medicare program.

DR. SCHMIDT: I'm not very knowledgeable, frankly, about how the bundle is built in terms of the payments for the drug versus the other services. Nancy, do you --

MS. RAY: So, to be clear, the oncology care model, that has not started yet.

DR. NAYLOR: [Off microphone.] I understand.

MS. RAY: Okay.

DR. NAYLOR: [Off microphone.] Have we -- or maybe I should start with, do we have experience with bundling with other programs, ESRD, and to the extent that we do, do we know about its relative impact on costs?

DR. MILLER: Right, and depending on how broad your question is, I think the answer is going to be we don't know. But if I follow you, and I want to see if I'm

actually getting what you're asking, so some of what goes on in Medicare is the payments end up inside payment bundles, whether they're OPD bundles or inpatient DRGs, that type of thing. And your question could be, so is that a more effective way of restraining the cost of the drug versus some other methodology, and I'm not -- I don't feel like I could directly answer that question or point to any analysis that does.

Now, we could take this offline and run it through our heads and try and come back to you and see if there is something out there that we could bring back to it. But, I wouldn't feel real confident --

MS. BUTO: Will we get any more information from MA once we analyze the encounter data, do you think?

DR. SAMITT: I guess when we talked to ESRD, didn't we take a look at the use of Epogen before inclusive of a bundle and after?

DR. MILLER: Yeah. Actually, that's a really good point. So, when Epogen was put into the bundle, the utilization started to decline. There were also some other clinical -- and Nancy's going to come to the microphone -- and what I think, if we could get her to sit down and stand

up about three or four times, I think that would be a good thing.

[Laughter.]

DR. MILLER: But, there were some clinical indication stuff that was happening, as well.

MS. RAY: I think the decline -- the substantial decline in Epo use was a function of both change in the FDA label as well as including the ESAs in the bundle.

The other thing that we did see, and this is just N of 1, but after the ESRD PPS was implemented in 2011, the drugs used for bone and mineral management, there's two primary drugs. There was a sort of little mini price competition between them, and you did see the ASP plus 6 decline after the start of the PPS. But, that is just an example of one.

DR. MILLER: So, why don't you sit tight, unless you really want to walk back and forth.

[Laughter.]

DR. MILLER: So, the other thing -- and at least one reason I cold started on that is the Epo impact was a utilization impact, and that's another thing just to keep sorted out in your minds, is that you can put something in

a bundle, and it may have a utilization effect and the use of it may go down, but the price may go up or down, or you may result in some price impact, as well. But those are probably two separate effects to carry in your mind at all times about what ultimately affects your spend, how much of it you're providing and what price it is. And the Epogen effect was largely a utilization effect, if I recall correctly.

DR. CROSSON: And I remember there was a modest reduction in hemoglobin that went along with it, as well.

DR. NAYLOR: Thank you.

DR. CROSSON: Scott.

MR. ARMSTRONG: So, a couple of questions. Actually, the last couple of questions were beginning to move into the territory I was interested in asking a little bit about. Slide 6 might help us.

First, the unnamed --

[Laughter.]

MR. ARMSTRONG: -- piece of the pie on the left-hand side is a drug spend at 19 percent of the overall Medicare spend. Are there -- what's the next -- what are the other big categories? I could probably go back to some

of our old chapters, but just trying to get a feel for how this should be weighted as a priority for our review. And in particular, do you have a sense off the top of your head for, like, what our inpatient hospital spend is as a percent of the total spend these days, and how does the 19 percent compare?

DR. MILLER: So, inpatient is probably, what, 110?

STAFF: [Off microphone.] About the same.

MR. ARMSTRONG: About the same.

DR. MILLER: Then, you know, MA is 150, 160, somewhere in there. Physician is 65, 70. Are we good?

STAFF: [Off microphone.] Yes.

DR. MILLER: Okay.

MR. ARMSTRONG: That's great. Actually, that's great. So, that just affirms -- and I have to admit, I should know this better, but that this is one of the big ones and I just think that part of the analysis you've done is really to help make that clearer in terms of overall spend.

Second, I really appreciated Kathy's questions and then Mary's. On the right-hand side, this gives us

some sense for, when you break it down into these different sort of payment categories, if you will, what the division is, and we can talk about how there have been bigger or lesser changes in some of those categories over time. And, for example, hospital outpatient has been increasing at a higher rate.

And that's interesting, but I wonder if there's a way for us to take that total spend, $112 billion, and break down the increase in spend by a different set of categories, and we were just talking about that. How much is driven by price per unit of service? How much is driven by utilization? How much is driven by the biologics versus generic pricing changes? You know what I'm saying? That is independent of these payment categories, but much more focused on the underlying impacts to the overall trend.

DR. SCHMIDT: I think that would take quite a bit more detailed data than we might readily have on hand, especially across all settings. You know, in our cost report --

MR. ARMSTRONG: Yeah.

DR. SCHMIDT: -- information, for example, for

the facilities, I'm not sure that there's that level of detail to capture the effects of price increases versus utilization of certain drugs. We might have to turn to secondary sources and that sort of thing.

MR. ARMSTRONG: Okay. And, I don't -- I'm not convinced it would really help us, but part of what I'm trying to get at is, ultimately, later in the year, our responsibility is to figure out, well, what do we do with this information? What's the best way for us to have an impact through our payment policy choices? And, if a lot of the spend in future years is driven by price versus utilization, that could really inform some of those. So, anyway, to the degree there's some way for us to get some insight into this, maybe the ESRD work and oncology work offers some of that, but that was --

And just one other point, and this is really not meant to be a loaded question. I honestly don't really know. On Slide 12 and in the paper, you do fairly explicitly point out that the law prohibits the Secretary from taking certain actions. And I'm just -- is there a real policy argument for why that is in the law? And, I just don't know.

DR. MILLER: Ray?

[Laughter.]

DR. MILLER: So, I don't know what you thought I was going to say --

[Laughter.]

DR. MILLER: -- Rachel. All I was going to say is, to his first question, could we do -- and I am going to come back to your second. But, in all seriousness, on your first question, the unit versus price question, we do -- we can, and I don't want to put you on the spot -- we can induce some of that in D, which is a big chunk of the action, and we can break that down and lay that out more clearly for you, and I want to be really careful because I don't want to give Kim a heart attack. Can we do that in B, price versus use? I think we could.

So, of the 19 percent, 13 percent of it, we could, I think, do what you said. But it's all the stuff that's tucked away in inpatient, outpatient where we would have really a hard time.

To your second question, you know, the main answer is I think there is really a philosophical argument that occurs, and it occurs time and time again, and it

occurred at the time of the legislation, whether the government directly negotiating has greater power than moving the negotiation down to a private intermediary. And so the decision at the time that the legislation was created was to say there is a negotiation power, but that negotiation power will be housed in the individual plans and that plans will negotiate the price for the government.

MR. ARMSTRONG: [Off microphone.] A market price?

DR. CHRISTIANSON: There's a little other nuance of that, which is the fact that they're going to be competitive bidding among the organizations, was going to place pressure on them to do that in negotiation part, so part of it was the establishment of the competitive market for the Part D plans, which was the justification.

DR. BAICKER: And just to add on, one, the analogy to we always wish we knew in Medicare Advantage, how the plans were negotiating different prices and bundles to manage care better, if only we knew what the private market prices would be, then we wouldn't have to go through these horrible formulas and revisions of schedules that are always off, I think the idea being if you have these

private entities competing rather than the government negotiating one monolithic price that is not necessarily going to be right, then you get both market competition and market signal. Now, whether that works well in practice is a separate question, but that seemed like the motivation.

MR. ARMSTRONG: And I don't necessarily have a point of view on what's better or worse, but it's -- again, it is what it is, and as we begin to formulate what we might be able to do to have some impact, maybe the question I would have is, Are there other parts of Medicare payment where there's a similar dynamic that we could learn from?

Again, I don't want to dwell on it too much, but if there is something about what we are expecting when the law was built, that we either have affirmed we got or we haven't gotten that would help inform what we might do going forward, I just think that might be worth at least a little bit of time.

DR. CROSSON: I actually had a similar question, and it has to do with Part D. And this is not to understate the nature of this problem whatsoever.

At the time that the law was passed, there was an estimate of what Part D would cost, and it has not proven

to cost that much. So the question is, To what extent do we understand, going back to the original assumptions? What's different? What has transpired that's different, and is there anything that we could learn about that that could be augmented or push us in a policy direction or not?

DR. SCHMIDT: Mark is laughing because many people in this room were involved with putting those estimates together.

[Laughter.]

DR. MILLER: Just for the record, speak for yourself.

[Laughter.]

DR. CROSSON: Whoops!

DR. SCHMIDT: In any event, I think that we do know quite a bit about why the original CBO estimates was wrong, and I think OAC's estimates was also wrong. But on the CBO side --

[Laughter.]

DR. SCHMIDT: On the CBO side, I think a key thing is that we had enrollments estimates that were too high. There was, I think, a relatively high assumption of participation in the low-income subsidy, higher than came

to actually happen, higher participation generally, and we had a high estimate of per capita spending. And those were the key issues. Actually, spending came in much lower when we actually saw the bids. After a year's experience, bids came in lower still, and I think then at that point, plans had a basis of claims for understanding what utilization was going to look like, what their enrollment was going to look like and that sort of thing.

And it's actually been a fairly competitive market, I would say, and that has been one factor that's been holding down the premium side. But as Shinobu and I have come to you and talked about before, there is also another part of the Part D program spending in reinsurance that's been going up significantly over time.

DR. CROSSON: So enrollment notwithstanding, in terms of the original estimate, to get back to the same point, is it primarily utilization or price or a combination of both that appears to be different than what was originally assumed?

DR. MILLER: Well, it's --

DR. SCHMIDT: Yeah. I think it's more enrollment level, so fewer bodies -- right? -- fewer numbers of people

participating in the program than was original estimate.

DR. CROSSON: Okay. So --

DR. SCHMIDT: And the per capita spend, which is a combination of utilization and price. I don't know that we can tease out which of those was the --

MS. BUTO: Rachel, do you remember what the percentage of generic use was that was assumed than the -- because was that higher in actuality or about what CBO projected, generic use?

DR. SCHMIDT: I think we had a pretty good estimate of what the GDR was at the time. I think it was the increase in per capitas that was pretty much off.

DR. CROSSON: Jack, do you have a point on here?

DR. HOADLEY: Yeah. I mean, I've written on this, and I talk a lot in what I wrote about the generic shift being more rapid and fewer new products coming on the market in the period from not just '06, but really from the time the estimates were made, which would have been '02 till almost the present. Obviously, what we've talked before about last couple of years have started to change that story a bit, but I really argue that the biggest driver of the difference between the estimates is the

generic shift and the fact that plans got to ride the wave of that. In a sense, that's price and not utilization, although it's price by product substitution as opposed to the price per product.

DR. CROSSON: Thank you. Thank you for that.

DR. SCHMIDT: Yeah. That's absolutely right. We knew what the GDR was at the time, but we didn't anticipate how quickly it would fall.

MR. GRADISON: I think that the CBO have actually gone back and taken a look at this and put out some paper on the subject, which might be helpful to summarize at some point because their estimate was significantly off. And they have also gone back and done some re-estimating, which is another subject, but of the ACA. So my sense is that they are becoming, over time, more open to publicly reviewing their own work and having people take a look at the assumptions, maybe not as much real time as analysts would like, but after the fact.

DR. CROSSON: Okay. Over here? Alice.

DR. COOMBS: I just have one clarifying question. In the handout, the paper, page 9, figure 3, there's a sliver of end-stage renal disease. I was thinking about

what Mary was pointing to regarding the bundle and the example that we were discussing regarding the ESRD bundle. Is some of that overlap and some of the other circles -- and I'm wondering, you know, how does that get parlayed out as a 1 percent?

DR. SCHMIDT: In this particular case, we asked Nancy to go dive into the claims information and look at the percentage of ESRD spending from their cost reports and claims information.

DR. COOMBS: So this came out of the bundles?

DR. SCHMIDT: Yes. Right. She pulled it out of the bundles.

DR. COOMBS: Okay. So then there's an itemized count of drugs interfaced within the bundle. So, in terms of the calculation, I think that helps out a little bit about the predictable impact of drugs on some of the bundles. This would indicate that.

DR. HOADLEY: So I have a couple of clarifying questions. One, when you were talking about the national health accounts in response -- I think it was Kathy's question -- for the infusion clinics or other physicians that are doing infused drugs, if they're getting drugs

directly from the wholesaler, is that going to show up as in the national health accounts' retail purchase, or is that actually not going to show up there?

DR. SCHMIDT: We have been trying to understand it more fully, and it's a little murky, we have to admit.

Here's my guess, but I don't know this for sure.

DR. HOADLEY: Fair enough.

DR. SCHMIDT: I think some of these sales are taking place through what are now specialty pharmacies --

DR. HOADLEY: Right.

DR. SCHMIDT: -- right? -- which I think would count as retail spending, so that's my best guess of --

DR. HOADLEY: So maybe actually a mix.

DR. SCHMIDT: Right.

DR. HOADLEY: Okay. Because, I mean, just things that when we get into the weeds here to think about which things are being accounted for in that, in that trend line -- and I was glad to hear the clarification on the Part C on the Medicare Advantage drugs. So you really are just totally generating. To the extent that we are able to find those in the claims data down the road and the encounter data down the road, we may find that the drugs used on the

A and B side could be either higher or lower than what you're projecting from fee-for-service side.

DR. SCHMIDT: That's correct. Right now, we're simply assuming it's the same percentage of program spending as in fee-for-service.

DR. HOADLEY: Right.

And then just last is just an observation. I mean, I really find the breakdown of all the drugs that Medicare is doing and the way you've done in the pie charts to be terrifically helpful, but I also was noticing in our context chapter, we still have the sort of 11 percent that's the other kind of calculation, and it may be something worth in the context chapter directly referencing this. I mean, obviously, that pie chart may belong the way it is in that chapter because of sort of definitions, but at least to cross-reference this, I think this is really helpful in getting people to understand the full story. And we should make sure it's reflected in other places where we're making that point.

DR. MILLER: So you're wanting us to be internally consistent?

[Laughter.]

DR. HOADLEY: Yeah. I wasn't going to say that.

MR. THOMAS: Just a couple of questions. On page 6, the 91 percent, do we have the trend of that number, kind of historical trend of what that percentage has been, or can we have that in future reports?

DR. SCHMIDT: We would have to go back and do the same calculation for each year. It's possible.

MR. THOMAS: I mean, I think what I'm getting at is a little bit going to Scott's point of how significant. I mean, it's 19 percent of the program. Today, how has that changed over the past decade or five years or whatever period of time you choose to look at that?

DR. SCHMIDT: So that was the point of Table 1 on page 10 in the mailing materials, was to give you a sense of the overall growth.

The share, let's see if I have that. Let me get back to you --

MR. THOMAS: Okay.

DR. SCHMIDT: -- on whether the share for 2007 has changed significantly.

MR. THOMAS: Okay.

DR. SCHMIDT: And we can look into whether we can

do other years as well.

MR. THOMAS: And then the discussion we've had previously on the lower cost alternative, is that just something that would be considered in a future report when we look at solutions, or how does that factor into this discussion?

DR. SCHMIDT: Least costly alternative, that discussion?

MR. THOMAS: Mm-hmm.

DR. SCHMIDT: Yeah. That was one of, I think, the broad topics of how we might pay, considered alternative payment methods for Part B drugs. So I don't know in the future where your conversation is going to go with respect to that.

DR. MILLER: My recollection of how that laid out is we brought a series of ideas in front of you on how to think about this. I can't remember which cycle it was or how far back it was, although we could get Nancy up here and get her to remind us, which I think would be hilarious.

[Laughter.]

DR. MILLER: And as it ticked through those things, where that conversation spun to is there was not a

lot of take-up on the part of the Commissioners of looking at that, and it kind of led to the discussion of what about looking at different models like bundling, which then led to "Well, maybe we'll take a look at it in the oncology space," because there seemed to be some activity there, and then Nancy moved off in that direction.

Now, I've kind of forgotten when we had that conversation, but it was --

MS. RAY: Last year.

DR. MILLER: Was it last --

MR. THOMAS: It was in the past year. I guess my question, going back to the materiality of this issue from a cost perspective, perhaps that would be something that we may rethink, given the magnitude of this challenge to address this cost issue, so it's something that we may want to put on our list of items to discuss as we think about how we address some of the challenges here.

DR. CROSSON: Rita?

DR. REDBERG: I also want to compliment you on the chapter. It was really helpful.

My question, my clarifying question is kind of, I think, what Scott was getting at, price versus utilization,

but I am interested if you are able to tell us the spend per beneficiary, because clearly we have had increased enrollment, and also the number of drugs per beneficiary, because my sense is both of those have gone up, you know, our bennies, our many more drugs, and the drugs are more expensive, but it would be helpful if we could understand what the contribution is of each of those.

MS. SUZUKI: We can get back to you with the detail. We published that information for Part D in the data book in June.

For other sectors, I don't think we routinely calculate that information.

DR. MILLER: It kind of goes back to the question that got driven off over here, I think. I think we could probably do that for D and B -- I'm looking at Kim -- and then the other -- and so the 13 percent, we could probably give you a good feel for that, but then the remainder that comes out of all the other little sectors probably not so much, just given the way the data is reported and where we have to get it from.

DR. REDBERG: That's a good start.

DR. MILLER: But we can certainly tease out D and

B on this, and that's a lot of the action.

DR. REDBERG: Okay. And I just wanted to second Warner's suggestion to relook at least costly alternative this year.

DR. CROSSON: Okay. So keeping in mind that this is a preliminary look at the cost thing and that, in the first round, we've had a number of suggestions about adding to the information, I want to have a round. But we don't have a lot of time left. We have identified Jack and Scott. We want to make some initial points, and then we will see how many people want to add more than we've already talked about.

Jack?

DR. HOADLEY: I really want to pick up on actually some of the things that have already come up in the discussion, and I go back to the statement you have on one of the earlier slides, which is that Medicare's influence is limited, and in turn, the influence over much of the pricing and utilization is in either the intermediary institution in the case of outpatient departments, hospitals, et cetera, or the Part D plan for that side.

But I also think what we've already been hinting at is that the influence of some of those intermediary units are also limited, less so if it's a -- less limited if there's competing products where they can put them against each other, use the tools that Rachel and Shinobu talked about in terms of formularies and things. And we saw some of that action in the hepatitis C drugs where the first year prices were high, and then although we can't always see inside the prices, but enough press reports would suggest pretty substantial discounting in the second year once there were a couple of additional products to put in the competition.

Obviously, the influence of the intermediary institutions is more limited in cases where there's only a single product to treat a particular condition, as was the case in hepatitis C in the first period of time, and I think even in the cases where there is the leverage, where there's the competitive leverage, the launch price of the drug seems to be still a significant thing. So if a manufacturer -- you know, we've talked about this occasionally. If the manufacturer knows there is going to be eventually competitive pressure to bring the price down,

they set it higher so they can get the eventual price to land where they want it do, and so they presumably have a lot of leverage. We can't look inside under that hood to really see what's going on very clearly, but that's the suspicion a lot of us have.

And so I think the challenge that we're trying to think about is how do we increase leverage for either at the level of the Medicare program or at the level of the secondary institutions that Medicare has empowered, particularly for the single-source, true single-source drugs, the ones where it's really only a single treatment, but to some extent even for other products where the whole issue of the launch prices comes in.

The problem is, at least on the Medicare side, what tools are there, and I've already said that for the plan or the institution, if there's only a single product, they don't have the same ability as formularies. The question is: Does the Medicare program or does the government more broadly have leverage? And the problem is a lot of what you are tempted to get into are areas that are outside of our boundaries, so patent law, FDA approval processes, comparative effectiveness kinds of things, you

know, things that are not as clearly inside the Medicare box.

The Secretary's authority is another possibility, and there have been proposals out there to change the law so that there would be some secretarial authority in instances particularly where there is no competition for particular drugs, and is that the kind of place where we want to give the Secretary some role? And if so, how would that role work? Because the simple view of what secretarial authority means in the context of a world like Part D where there are a lot of competing plans is kind of hard to think through.

So I would like to see us try to think about are there any tools available to us, especially within the Medicare box that we tend to talk about, or even other things that we might be willing at least to describe outside of our normal box where we might make recommendations, where we could, you know, put out some ideas on how to increase the leverage.

The only other thing I would add is I do think it's important to continue talking along the side about beneficiary out-of-pocket costs, and I made this point last

year a couple of times. But Part D, people think of as a catastrophic benefit, you know, the beneficiary's liability is capped. It's not capped. It's lessened in that catastrophic phase, but it remains 5 percent, which, when somebody's really got very high drug costs, 5 percent on top of -- what is it? -- about a $5,000 out-of-pocket cap puts a lot of money on their side. And I do think that's something we should try to think about a way to address.

Obviously, on the Part B side, it's part of a larger issue of no out-of-pocket limit for Medicare as a whole, and so, you know, that's a bigger bundle to talk about. But I did want to put that aspect on the table as well.

DR. CROSSON: So, Jack, I think what you outline is exactly what we should do, because as we've said, you know, within the Medicare program's authority, within our mandate, there are some things we can do and recommend, and there are other things that are out of our purview.

However, to fully consider those things that we can do and we can make recommendations on, it's probably appropriate for us to look at the whole panoply of tools, whether or not those are things that we can act on or make

recommendations on. And I think the intention, as you suggest, is to do that.

DR. SAMITT: Jay, can I also add that beyond the panoply of tools, I think there's one other set of players that we haven't talked about that have leverage, which is the prescribing clinician. And so if we feel that neither CMS nor the intermediaries have sufficient leverage, well, then, who has significant leverage? The prescribing clinician. And how well have we aligned interests around utilization in particular, not so much price, with the clinicians? And we've talked about this before, you know, especially with ACOs. If Part D trends or expense were included as part of the measurement or part of the incentives associated with ACOs, you may see additional focus on more effective prescribing patterns if that were included in the mix.

So I don't think we should forget that beyond the plans. We should think even further directly to the clinician.

DR. CROSSON: Jack, on that point?

DR. HOADLEY: Yeah, it is follow-up. I mean, I think that's really helpful. I was mostly focusing on the

price side, and there obviously is the utilization side. And so thinking about -- and one of the challenges we have is that Part D plans have no relationship with the prescribers, and they can only do things indirectly through prior authorizations that go to the patient's purchase, which means the patient in turn has to interact with the provider. And trying to think about that, whether it's -- we've had some of these conversation before, whether it's integrating more of the drug side into the ACO world, whether it's coming up with more on the medication therapy management, which hasn't been very effective inside Part D. But I think you're right, thinking about it on the utilization side is really a critical part of the story.

DR. SAMITT: And the reason I say that is I think we think that negotiations around price drive price. But I think what we probably see more on the commercial side is focus on utilization drives price more effectively than negotiation drives price in many respects. And so that's why this is an important thing to remember.

DR. CROSSON: And having come from, you know, a clinical life which was characterized by the integration of in this case Part D and the rest of Medicare and Medicare

Advantage and having the physician community as well as individual physicians in the practice actively engaged in those utilization decisions and policies, I can only underscore what you're saying.

Now, there's a significant amount of complexity, as you know, in terms of taking that sort of thought and model and applying it to the Medicare program in its various separate parts. But I think that's absolutely something we need to talk about.

On that point, Bill? And then we're going to go back to Scott.

DR. HALL: I'd like to expand a little bit on what Craig just said and to some extent, Jack, what you talked about and definitely what you were mentioning, Jay, about using leverage at the provider level to figure out what we want to do with these data. And I think what we were talking about here is what's the value proposition.

If I develop hepatitis C, I don't care what the price of that drug is. It's invaluable to me. And ten years ago, there wouldn't have been any chance of living. So there, no matter what the price is, the value is really quite high. And it's not just the value to me as a human

being, avoiding cancer and all the rest. It's all the expenses I'm going to incur to the Medicare system by having to care for the sequelae of that disease. So there's an example of a really high-value proposition. And so it's not that the drug is bad or the people are prescribing it indiscriminately.

On the other hand, if we take all the bread-and-butter conditions that we're prone to as we get older -- cardiovascular disease, respiratory disease, diabetes, obesity -- there, there's a lot of question about the value of what we're doing. One of the big differences from 2004 is that we know a great deal more about the efficacy of drugs, and anytime you deal with older people, the more drugs people have, the more likely they are to die. And it's not just intuitive that they're sicker, but it's that there are a lot of complications to therapy.

So somewhere if we could categorize various disease entities and classification and therapeutic approaches, I think we might be able to inform practitioners and people who are regulating practitioners on the proper use of medications. Now, that's kind of pie-in-the-sky, but it's entirely possible now, and it wouldn't

have been possible even ten years ago. So I think this is a really important lead into what we may want to use these data for.

DR. CROSSON: Thank you, Bill.

We're going to be running short on time, so Scott was one of the initial presenters, and then I have Herb and Kathy, and Sue as well? I'm sorry. Rita. Herb, Kathy, and Rita, and then we're going to stop. Sorry?

DR. REDBERG: I want to respond to something Bill said [off microphone].

DR. CROSSON: Rita, I can't hear you. Go ahead.

DR. REDBERG: Not to disagree with my esteemed colleague, but I don't share your high-value view of the hepatitis C treatment because the new drug was approved on an accelerated approval on the basis of a surrogate marker, a sustained virologic response, which is we hope, you know, going to translate into these wonderful things but wasn't actually shown, and the actual facts are only a few percent of people who are infected with hepatitis C actually go on to these terrible complications. Many people live -- 25 percent of people revert to a hepatitis C negative status on their own without any treatment at all. And the other,

of course, complicating factor is that -- I mean, I certainly see patients who have been cleared of hepatitis C and then get reinfected because they continue to use IV drugs and other problems, and it's -- or I've seen patients that have been cleared of hepatitis C, and they go on to get hepatocellular cancer.

So, you know, I'm not convinced it's the cure that we hope it to be, and certainly, you know, there's a lot of discussion that I won't go into now on whether it truly was priced at its value, because as I said, it was a 12-week study based on a serologic market that we hope is valuable, but we don't have the data to say that it does save lives or even prevent hepatocellular cancer and liver transplants.

DR. CROSSON: Okay. Thank you for that. So Scott, and then Kathy and Herb, and then we'll stop.

MR. ARMSTRONG: So just very briefly, and I won't repeat points my colleagues have made, but just affirm that the way we are thinking about applying policy that we do apply in a lot of other parts of the program to this topical area I think is a really worthwhile endeavor.

I want to just step a half-step back and thank

the staff for an incredible piece of work. The role that MedPAC can play as a nonpartisan, objective, highly respected organization for objectively evaluating a topic that we need to face in our industry in this country is very exciting for me to see us launch into this, and this first step is an affirmation of, I think, how important our contributions will be to this topic. So thank you for that.

I also just want to acknowledge that -- and I think we've alluded to this, but it's just worth saying that part of what's difficult about this is that increased drug spending is not necessarily bad, and that as we go through this in the context of our total spend, we'll want to at least see how, as we have on other topics, increases in spending here is -- where it's good and where it's bad, and that obviously gets even more complicated. But I want to just acknowledge how thrilled I am that MedPAC is moving this forward, and that a real challenge will be to get beyond this objective evaluation of what is and how does it work to what are some of the levers that we can pull to have an impact in future years.

DR. CROSSON: Thank you.

MS. BUTO: I want to just add my thanks to you. I think the work has consistently been really good in this area.

As I step back to think about sort of what is MedPAC's objective here, I think one would be -- and we tend to get all caught up in a lot of the details, but really one would be that Medicare is paying a fair price, that the pricing that Medicare -- the reimbursement rates Medicare sets is not creating unintended consequences that are bad; and then, secondly, that payment policy itself is not driving either unnecessary utilization or utilization of drugs that are high-priced when a lower-priced alternative would be just as good.

So I think we have both kind of the issue of is there a fair price that Medicare is paying, and is the formula and the reimbursement methodology a fair one. But there's also the issue of are payment policies from site to site driving the right mix of care.

And so in that spirit, and I think picking up on what Jack said, I hope we'll look at a variety of tools. And you've started down that road in this paper, but I know that in the past -- and I am very rusty on this, but, for

instance, competitive bidding was tried for Part B drugs. It failed, as far as I can tell. Just a sense maybe of why we think it failed, and is it time to revisit that approach?

I think the issue of -- you know, in a way, people haven't really talked about this, but I have often wondered at some point do Part B drugs fall under Part D contractors? Is that a good idea? Is that a bad idea? Is that going to create unintended results? So there are a number of approaches that I hope we'll open ourselves up to.

Lastly, I think since there's a lot of concern around new drugs and pricing, CMS tried something called coverage with evidence development for those drugs for which there was no predecessor or nothing that was really comparable. And I wonder if we can at least touch on that possibility as one of the approaches that could be considered if there is concern about sort of widespread use without the proper, I think as Rita mentioned, kind of clinical background to assure that it's right for Medicare patients.

So there are a number of alternatives. Those are

just a few I thought of. But I hope we'll open ourselves up to trying to think about them.

DR. CROSSON: Thank you, Kathy.

MR. KUHN: Thanks, Jay. I just wanted to kind of add my thoughts on some additional maybe design options we could look at in the future. We had an interesting conversation earlier today about the private sector negotiations, and that's a system we have. So are there more tools within that private sector negotiation, opportunities that we could look at?

One, from things I've heard and read in the past, is the formulary design additional flexibility. The fact that CMS requires at least one drug in each subclass really does limit negotiations, from what I understand. Could that open things up?

Comparative effectiveness, what more is PCORI doing in this area and are there ways to interject more comparative effectiveness into the policies that we have here?

A little bit outside of our scope, but limited antitrust waivers. Part D plans only can negotiate among themselves. They can't come together at multiple plans, as

I understand, to negotiate to get more market leverage out there. Is that something worth looking at in the future?

And then, finally, coming back to the issue of Medicaid, and I don't know whether this is more administrative pricing or whether this is more market forces, and I'd like to hear the pros and cons on that. But the fact that dual eligibles do not have access to Medicaid pricing when Medicaid pricing is lower than the Part D opportunity out there seems like that's an opportunity of anywhere, from what I've seen, from $3 to $5 billion, opportunity that would be not difficult to capture. But is it administrative pricing? Is it market negotiations? Kind of how would that fit into the overall structure we have under Part D? That's something else to be looking at.

DR. CROSSON: Well, thank you, everybody. We have a lot of good ideas here, I would say. So I think I'll have to talk to Mark, but we'll probably spend the entire October and November meetings on this topic.

[Laughter.]

DR. CROSSON: Just kidding. Just kidding.

Rachel and Shinobu and Kim, thank you very much,

and everyone else who worked on this. We're going to -- we've used up a little of our time, but we'll try to catch up, and we're going to move to the next topic. Thank you.

[Pause.]

DR. CROSSON: We will move on to the next topic, which is a new topic for the Commission, and it has to do with freestanding emergency departments, which have begun to appear in the United States in larger numbers and at a faster rate. Zach Gaumer and Jeff Stensland are going to present. Zach, are you going first?

MR. GAUMER: Yes. Okay . Good morning, everybody. Today we will be talking about emergency department services and specifically ED services provided at stand-alone facilities, but before we start, I want to thank Dan Zabinski, Anna Harty, and Amy Phillips for their contributions on this project.

Today, I will be summarizing the context for this research. I will provide some background information on ED visits and stand-alone facilities, and arrive at a few policy questions for you to consider in your discussion.

The reason we are talking about this subject today is that some of you expressed interest in the past.

Specifically, Cori, you noted interest in ED visit trends, and, Craig, you expressed interest in the stand-alone ED facilities at one point in the recent past.

[Laughter.]

MR. GAUMER: This research is relevant for the Commission in two primary ways. First, the trends we observe here may cause concern about whether our payment systems encourage providers to serve patients in the ED setting rather than in the lower-cost urgent care center settings. Therefore, this is a new version of the site-neutral issue. Second, these trends may cause concern about whether stand-alone EDs materially improve access in the communities where they locate.

So, first, the emergency department facts. In recent years Medicare ED visits have grown moderately. In 2013, there were approximately 21 million hospital ED visits under Medicare. From 2008 to 2013, the number of these visits grew 1.6 percent per capita per year. The growth in ED visits does not appear to be due to an aging of the Medicare population, as the age of beneficiaries has remained fairly stable.

Also, on a per capita basis. the growth in ED

visits was variable by metro area, as Dallas, Houston, and Atlanta and a few other metropolitan areas had more rapid growth than average.

In contrast to volume growth, Medicare spending for ED visits grew more rapidly. These visits accounted for approximately $6.1 billion in spending for the outpatient ED claims and the physician ED claims, and from 2008 to 2013, spending for ED visits grew 7 percent per capita per year. Now, these figures do not include spending ancillary services provided during these visits or for the spending associated with ED visits that eventually become IP admissions. And so you can look at that 6.1 billion with kind of a positive sign next to it. If you add all that stuff in, it would be significantly larger.

The growth in ED visit spending may be associated with the growth in the reported severity of ED cases. From 2008 to 2013, the severity of ED visits increased for both outpatient and physician claims. With physician claims, we observed nearly a 30 percent increase in the volume of level 5 ED visits. Those were the highest-severity visits. Within the outpatient claims, we observed an 82 percent increase in the volume of level 5 visits and nearly a 40

percent increase in the volume of level 4 visits.

These changes may signal an increase in the aggressiveness of coding by both physicians and hospitals. In addition, the inconsistency between the physician and hospital ED visit coding at each level suggests that the coding practices of these providers are very different, despite the fact that they use the same five ED codes

Now, moving on to the facilities, the number of hospitals reporting that they had an off-campus emergency department, or an OCED, increased 76 percent between 2008 and 2015. We have identified 387 OCEDs that are currently operating. They are affiliated with 323 different hospitals, meaning that approximately 6 percent of all hospitals have an OCED, and 30 of these hospitals have more than one OCED.

Hospitals that operate these facilities tend to be urban, they tend to be large hospitals, and they tend to be part of larger health systems.

OCEDs exist in many metropolitan U.S. areas, but Dallas, Houston, and Seattle have several.

Information we have gathered from hospital representatives and the media suggest that there continues

to be significant interest in developing OCEDs, particularly for hospitals associated with large hospital systems. We anticipate more growth will occur in late 2015 and 2016.

In the course of our interviews, hospital officials told us that OCEDs tend to locate near to their affiliated hospitals and they vary in size.

They also stated that they tend to develop these facilities in urban or suburban areas and areas that tend to be fast-growing, relatively affluent, well insured, and create convenience for patients. They stated that their decision to develop an OCED is often driven by competition for market share and because it can be cheaper to expand ED capacity off campus rather than inside the hospital.

This business model is very consistent from facility to facility. OCEDs offer 24/7 ED services, lab services, and imaging services such as CT scanners, ultrasound, and x-rays. Most importantly, they do not offer trauma services. The most common medical conditions they treat include respiratory distress, head injury, sprains and fractures, UTIs, and abdominal pain.

Information we've gathered from OCEDs and their

representatives as well as ambulances suppliers suggests that compared to hospital EDs, these facilities capture more patients via walk-in and fewer by ambulance transport. In fact, ambulance suppliers told us that they will only transport a patient to an OCED if they are certain the patient is not a candidate for inpatient admission. This suggests that patient severity at OCEDs might be lower than at hospital EDs.

These facilities are permitted to bill Medicare if they are deemed provider based by CMS. Among the various requirements, they must have state licensure and adhere to Medicare's conditions of participation. They also must be fully integrated with the hospital they are affiliated with and located within 35 miles of that hospital.

Medicare views these facilities as an extension of the hospital emergency department, and therefore, like hospital EDs, they bill Medicare under the outpatient PPS for facility services and also under the physician fee schedule for physician services. Unfortunately, because they are viewed as an extension of the hospital, their claims are not separately identifiable in Medicare data.

Private insurers also view OCEDs as extensions of the hospital ED and pay them as in-network providers.

The growth of OCEDs raises three particular questions.

First, do existing reimbursement systems encourage providers to expand ED capacity and steer patients to the higher-cost ED setting? Interviewees from OCEDs stated that ED visits are currently profitable, especially for privately insured patients. In addition, interviewees stated that small OCEDs can sustain themselves financially on as few as 20 ED visits per day.

The second question is, Do beneficiaries know when ED visits are appropriate and understand the associated financial consequences? A RAND Study from 2010 concluded that between 13 and 27 percent of patients served at hospital EDs could be served at urgent care centers or retail clinics. As a result of choosing the emergency department over these urgent care settings, these patients may be unnecessarily exposing themselves to higher liabilities.

Third, does the development of OCEDs materially improve access to ED services in the communities they

inhabit? Interviewees from hospitals stated that in developing OCEDs, they focus on areas with population growth, sound payer mix, and gathering market share, rather than on areas that just lack access. However, the few OCEDs that do exist in areas with poor access may demonstrate that this facility model can be a viable model in isolated rural and urban areas that possess relatively sound payer mix as well. On the other side of the coin, OCEDs located in areas with existing capacity may be duplicative.

The other type of stand-alone ED facility are independent freestanding emergency centers. These facilities currently are not able to bill Medicare, and their story is relevant to MedPAC's work. There is a lot of information on the slide in front of you, but it all essentially boils down to three takeaway points.

First, IFECs have grown rapidly in recent years in a few metropolitan areas, mainly in Texas. These facilities have largely the same business model as OCEDs, except for the fact that they can't bill Medicare and narrowly rely on privately insured patients for revenues.

And then the most important of these points is

that in 2015, some of these facilities, specifically in Dallas, Phoenix, and Denver, began affiliating with hospitals or building their own hospitals in order to bill Medicare, Medicaid, and private insurers as provider-based EDs. Therefore, we think it is likely that at least a portion of IFECs that are currently out there will become provider based and will begin billing Medicare in the near future.

Okay. Before we move on, I wanted to demonstrate for you the relationship that exists between the location of IFECs and more affluent ZIP codes in the Houston metropolitan area. Among the 60 IFECs in the Houston metro area, 66 percent of these are located in ZIP codes with an average income above $53,000 per year. These are the ZIP codes with the two darkest shades, and they are the two highest quintiles of the five categories. This map does not include OCEDs, but if it did, they would largely exist in the same ZIP codes.

Now I want to put these two types of stand-alone ED facilities into the broader context for you and summarize their relationship to other providers they compete with.

Row 1 on the table above indicates that there are three types of facilities currently providing ED services: hospital emergency departments, hospital-based OCEDs, and the independent freestanding emergency centers. Urgent care centers, physician offices, and retail clinics do not provide ED visits.

Row 2 identifies that IFECs are the only entity of the six that do not bill Medicare.

Row 3 is informed by our interviews with various stakeholders, including CMS, ambulance suppliers, and many other facilities. This row illustrates in general terms the relative severity of all cases served at each type of facility. The three ED facilities handle a significant number of higher-severity cases, but of course, hospital EDs handle cases that are the most severe, such as trauma and cases that are destined for inpatient care.

In addition, all six types of facilities treat a significant number of low-severity cases, and this is the key point, that there is overlap between these entities in terms of serving low-severity cases.

We would like to gather your views on directions this research could take. To guide your discussion, we

have generated a list of possible directions. The Commission could consider ways to track OCEDs in claims data. The Commission could explore incentives in Medicare payment systems that encourage the growth of ED capacity, and as a part of this could consider whether CMS should explore making differential payments to off-campus ED facilities. The Commission could explore the growth in ED visit severity and coding practices, and finally, the Commission could explore the effect that the growth of OCEDs has had or may have on beneficiaries in terms of whether they understand when ED services should be used and changes that could occur in their out-of-pocket liability.

Thank you for your time, and I welcome your questions.

DR. CROSSON: Thank you very much, Zach.

I just want to start with one question. In terms of the interviews that you had, did you get any sense that in these marketplaces that these independent emergency rooms, even though they don't accept trauma, are essentially leading more profitable patients away from trauma centers, which have an important role in the community, or is that not the case?

MR. GAUMER: Well, we interviewed folks that represent the OCEDS, the off-campus hospital-based facilities, as well as individuals that represent the independents, and although they have very similar business models, I would say that that applies -- what you have said applies more to the IFECs in that their main line of revenue or source of revenue are the privately insured, and they target going into markets where they can get the privately insured. But I would say yes to your question.

DR. CROSSON: Okay. Thank you.

Yeah, Jon.

DR. CHRISTIANSON: This is, I think, just a real quick question. On slide 12, on the note, you have the OPPS, which doesn't appear anywhere on the slide, but the slide, you have HOPD. Are those the same things? Are you using the same nomenclature?

MR. GAUMER: Yes.

DR. CHRISTIANSON: Okay.

MR. GAUMER: Thank you.

DR. CROSSON: Okay. Clarifying questions? We went over there first the last time. We're going to start over here, so we'll start this way.

DR. HOADLEY: I do have one. On the policy -- the last slide, you talked about the impact on out-of-pocket liability. Did I miss it, or did you talk at all about sort of what the current situation is for out-of-pocket liability? This is all just 20 percent Part D cost sharing?

MR. GAUMER: Yeah, that's right. And I should clarify that. So, for Medicare beneficiaries, the issue here is that if they go into one of the freestandings or they go into the OCED and their service -- say it's a lower severity type of a case -- and their service is billed as an ED visit, that will cost more for the program, and that will cost more for them because 20 percent of an ED visit is higher than 20 percent of like an E&M visit or an outpatient visit at an urgent care center that can't bill as an ED.

The difference here -- and this is what you read in a lot of the press articles that are coming out about these facilities. For the privately insured patients, if they go to one of the independent facilities that are out of network, then they get often his with a significantly higher out-of-pocket cost than they would otherwise expect

or plan on, and that can be hundreds of dollars.

DR. HOADLEY: And so for the ED visit for the Medicare patient now, that is going to be billed -- whether it's the off-campus version or the on-site version, that's going to be billed under the ED E&M codes. If it's an urgent care center, that's treated as an office?

MR. GAUMER: So there's a very similar distinction for the urgent care under Medicare. Urgent care centers can be provider based and be deemed provider based --

DR. HOADLEY: Okay.

MR. GAUMER: -- and therefore get the hospital outpatient payment and the physician payment, but if they are not deemed provider based, then it's really just for Medicare a physician payment ball game.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Clarifying questions. Craig?

DR. SAMITT: So, on slide 12 -- and this may be a bit of a tag-on to that -- the row where you talk about general severity of cases --

MR. GAUMER: Yeah.

DR. SAMITT: -- this simply came from

observations or interviews. So claims do not allow us at this point to distinguish between these, thus to your question about should we be evaluating these separately? My understanding from your presentation is that at this point, we can't look at claims and determine what types of cases specifically and what severity exists between hospital EDs and the OCEDs.

MR. GAUMER: That's absolutely right. So, to the first part of that, what you see on the third row here are examples or illustrations of the world as we understand it based upon the interviews. We're not able to drill down in the claims data and figure out what the case mix is for each one of these types of providers. Specifically, the OCEDs, which are not separately identifiable in Medicare data, that would allow us to do that. Yeah.

MR. THOMAS: A real quick question on a similar area. What sort of insight do we have into severity of visits in urgent care centers that are seeing Medicare patients? Do we have data on that?

MR. GAUMER: We didn't look at that for this. I think that -- I'm going to jump out here and say, I think that we could look at the claims for urgent care centers

that are provider-based urgent care centers because there is -- and I'm going to get into the weeds for a second -- there is a place of service code on the claim that allows us to look to see which patients are being treated at those facilities. And, I'll look at Dan here. Is that accurate, Dan?

MR. ZABINSKI: [Off microphone.] I think that's correct, yes.

MR. GAUMER: Okay.

MR. THOMAS: It might just be interesting, as we look at this continuum of what types of services do we see and billing do we see in urgent care centers, versus these off-campus EDs, versus, you know, primary -- primary care is a little different, but I guess after hours or what not primary care services, because it's really a continuum that's being provided, so --

DR. MILLER: I want to put a marker down. We'll have to look at the data and make sure that we can do this, because I'm not sure I've thought about it this way. And, also, if we want to present the full urgent care picture, we'll want to be able to show them what is in the OPD and also in the fee schedule, and I'm not as readily clear that

there's a marker in the fee schedule that we can pull --

UNIDENTIFIED VOICE: [Off microphone.] There is.

DR. MILLER: There is, okay. Well, then maybe we can do it. But also keep in mind that in this continuum, we'll be missing the very animals we're talking about today. So, in some ways, we can give you the two ends of that distribution, but not the middle of it.

DR. CROSSON: Clarifying questions. Rita.

DR. REDBERG: A very interesting chapter. I wonder if you could just explain to me what it means to be provider-based.

MR. GAUMER: Sure. CMS has an approval process -- let's see, where is this here -- an approval process for becoming provider-based, and that's done by the CMS regional offices. There are a slew of requirements that these facilities have to meet. I won't try and name them all. But, for the sake of this presentation, I think the most important ones to remember are that the state that the facility is in has to have essentially licensed the facility and they have to be integrated with the hospital that they are affiliated with in terms of their financial calculations, in terms of quality of care efforts that they

have, and in terms of their clinical staff.

So, a good example of that is if the hospital contracts with emergency care physicians for their on-campus emergency department, the contractors have to be the same for their off-campus. The contracted physicians have to be the same. So, they have to be quite integrated clinically.

The other key piece here is the 35-mile radius. CMS wants the OCEDs to be within 35 miles of the mothership hospital. But, there are a bunch of other requirements that I'm kind of skating over here that CMS would probably want me to say.

DR. REDBERG: Okay. And one more?

DR. CROSSON: [Off microphone.] David.

DR. NERENZ: Just, first, a quick response. The essence of this all, I think, is it's part of the hospital, part of a named hospital, as opposed to freestanding. And all the stipulations are basically marker conditions for that.

MS. THOMPSON: [Off microphone.] And it's billed under Part A.

DR. NERENZ: Yeah. Okay, my clarifying question

actually ties to Warner's. If we can go to Slide 5, please, I want to clarify what the take-home is here. In your talking about it, you talked about aggressive coding, perhaps upcoding could be a phrase, and so what we're seeing here in terms of time trend we might judge to be a bad thing. But, also, you could see the same pattern of numbers if initiatives designed to keep low-intensity cases out of the ER were working. Medical homes initiatives, expanded primary care hours, urgent, retail clinics would produce this exact same phenomenon. So, do your data allow us to tell which of these, or is it a mix of both? I want to know, is this a good set of numbers or a bad set of numbers?

DR. STENSLAND: I think when we looked at this, you could say, is it good or bad, and if we saw, oh, the share of the visits that are level four and five grew, but the overall number of visits shrunk, then we could say, oh, we're getting rid of these ones and twos. But we don't see that. We see the shares of fours and fives growing, and the overall number of visits per capita are growing despite no aging of the population, and so that indicates it's probably more of a coding thing than that the ones and twos

are going away because the volume overall is increasing.

DR. NERENZ: Perfect. Thank you.

DR. CROSSON: Bill.

DR. HALL: In terms of the independent freestanding centers, you mentioned there are 17 for-profit entities that claim ownership. Are some of these physician groups?

MR. GAUMER: No.

DR. HALL: Are the majority physician groups?

MR. GAUMER: I don't think that they are physician groups. It appears to be -- you know, these are really all in Texas --

DR. HALL: Right.

MR. GAUMER: -- and, you know, the largest is Adeptus and they have over 50 different facilities. That is -- you know, I think I would interpret that as just a for-profit corporation. But it doesn't appear that the others are physician-driven organizations.

DR. MILLER: Can I just bring one thing, just before it gets too far down the line. I want to go back to Rita's question on provider-based. There are lists of requirements that are to be in place, and I realize this is

not directly your turf, and so I just did a little consultation. But providers can attest to that, and then the second thing is they can start billing with the assumption that they've met them, and they could be at risk for somebody then looking behind it.

So, I don't want to leave you with the notion that there's this long process and everything is checked and gone through. It can sort of -- there's lists of things that are to be true, but you can attest to it or even just start billing and be provider-based, and presumably, you have met all of those requirements.

So, I just wanted -- it's a little freer than there's a big stack and somebody's looking really carefully.

DR. STENSLAND: And maybe to clarify on Bill's question, there are some, like Zach had talked, like big companies, like even a publicly traded company that's owned by the stockholders, that do these. But, there's also some that we talked to where the emergency physician owned the entity that would be -- that had the ED and was billing the facility fee for the ED.

DR. CROSSON: Bill Gradison.

MR. GRADISON: Could you help me understand, please, why independent ambulatory surgical centers are eligible for Medicare reimbursement and independent EDs are not? And if that's something you want to work on, what I'd really like to see, if we do more work on this, would be a side-by-side of those two, just to try to figure out what's going on there. Would the Secretary have authority to cover these, or would it require legislation? This sort of combines my immediate question and my suggestion for the future.

MR. GAUMER: We'll look into that.

MR. GRADISON: [Off microphone.] Great.

DR. CROSSON: Herb.

MR. KUHN: Three quick clarifying questions. So here on Slide 5, the observation that you made in the report as well as orally here today was the variation we're seeing between the intensity on the physician side and maybe something different on the hospital side. And when I was at CMS, we didn't see that as a bad thing, and the reason is, is that if you have a patient that has complex medical decision making by the physician but less hospital resources, of course the physician would code maybe at a

four or five and the hospital would code at a two. That makes perfect sense. Versus a patient that might need a lot of nursing services, but the physician's role is far less, so the hospital resources are far higher and the physician resources are far less.

So, I don't necessarily see this as a bad thing, and I don't know if that's how you were presenting or not, but I think there's a lot of explanation why you see that variation out there. I don't know if you have any thoughts on that or --

MR. GAUMER: No, I think that makes a lot of sense, and we were looking at this as you have these five code levels and they both have the exact same set of descriptors that the hospital coders and the physician coders are using, and, you know, kind of presenting the information as --

MR. KUHN: Here's what we're seeing.

MR. GAUMER: -- here's what we're seeing, why does this exist, and kind of offer it up to you guys --

MR. KUHN: Okay.

MR. GAUMER: -- to come up with explanations.

MR. KUHN: And, I guess, the second thing, you

know, ever since the beginning of the physician payment system, coding between threes and fours and fours and fives, we always know is a perennial issue, you know, just an issue out there. And so if we're seeing a movement in the ED, or the emergency department area of moving from threes to fives or moving up the scale, are we seeing that elsewhere in other settings where physicians practice, or is this really an outlier, or is that just a general trend, we're seeing more intensity of coding across the board?

MR. GAUMER: Okay. I think I can offer one little example here. A couple of years ago when we were looking at observation care -- sorry to bring that back up again --

[Laughter.]

MR. GAUMER: -- we did see differences in terms of cases being coded by physicians and hospitals, you know, as whether or not they were coded as inpatient stay or an observation. There might be some natural reason for that, as well. But, we do see differences occasionally in those --

MR. KUHN: So, in those settings versus the physician office, we're seeing --

MR. GAUMER: Yeah.

MR. KUHN: Okay. Thanks. And then the final one I had was this issue you raised of emergency transport and the emergency transport ambulance services not wanting to transport to these freestanding facilities if they think it's going to result in an admission. And, I'm making the assumption that's because they don't want to do a second transport, and I guess from that facility then over to the hospital. Is that second transport reimbursable? Is that why they don't want to do this, or kind of -- I'm just trying to understand a little bit more behind their thinking there.

DR. STENSLAND: I think a lot of times, they just think that that's what's best for the patient. Like, if this patient needs to be admitted, or obviously they say, if this patient is having a heart attack, we're going to take him to someplace with a cath lab rather than take him to the freestanding ED.

There is a Medicare payment issue when it comes to the re-transportation. If you went to -- let's say I had a hospital, we'll just call it the Mercy Hospital, and you went to Mercy Hospital's freestanding ED, which was

billing under the same provider number as the main hospital campus --

MR. KUHN: Right.

DR. STENSLAND: -- and then if you get transferred from that freestanding ED to the main hospital campus, well, what happens then is the freestanding ED has to pay for that transport. That same provider number can't bill --

MR. KUHN: A second time.

DR. STENSLAND: -- a second time. But if you go to a freestanding ED and then you get transported to somebody else's hospital, the other -- then you'll get billed for that transportation by the --

MR. KUHN: By the second --

DR. STENSLAND: -- by the ambulance service.

MR. KUHN: Got it. Thank you.

DR. STENSLAND: They can both -- they can bill for the freestanding ED visit and the admission, where if it's the same campus, then the beneficiary is going to make one payment for the deductible. If it's two different entities, the patient will make two payments, one for the coinsurance on the ED visit and one for the deductible.

DR. CROSSON: Kathy.

MS. BUTO: Can you -- maybe you touched on this, but do the EMTALA requirements, you know, the requirements that hospital emergency departments have to take unstable patients regardless of ability to pay, do those requirements apply to all these freestanding facilities, as well?

MR. GAUMER: Yes, they do, and it's a state licensing issue more than anything, you know. The state requires that they adhere to EMTALA --

MS. BUTO: Okay.

MR. GAUMER: -- and we hear from all the IFECs that we talk to that they have to stabilize before they do anything, just like a hospital ED would.

MS. BUTO: Okay. And then the second question is whether the independent freestanding are totally, are they all for-profit? Are there some that are not-for-profit, or is it really being driven by for-profit entities?

MR. GAUMER: I don't know. I think that there could be some nonprofits in there, but I'm not certain. Do you remember?

DR. STENSLAND: I think everybody we've -- all of

them that we've talked to are for-profit entities, but in some cases they'll partner with a nonprofit hospital. So, this will -- and then it might become an OECD, you know, because then they can bill under the for-profit hospital -- or the nonprofit hospital's billing number.

MR. ARMSTRONG: I forget when it was. In the last couple of years, we did a study on avoidable emergency room visits and avoidable hospital days. Am I remembering that correctly? I just wonder if we shouldn't dust that off and see if markets where we have more of these freestanding EDs change the broader avoidable ED visit rates, because it's -- anyway, it just might be another perspective in on how big of a problem is this and what do we want to do with it.

DR. CROSSON: Warner, clarifying?

MR. THOMAS: Yeah. I just have another quick clarifying question. On Slide 12 on the IFECs, we say that you can't bill Medicare. Is that for a tech fee? I mean, will the physician -- can the physician still bill Medicare for seeing a Medicare patient?

MR. GAUMER: Okay. So, there should probably be an asterisk here on this "no" on the second row. So, they

cannot bill Medicare for the facility fee, hospital outpatient department. CMS says that the physicians cannot bill Medicare for the physician services. But I think that what we heard from some of the IFECs was that there's some ambiguity there. They said they are not in control of the physicians that they contract with that are doing their own billing and they suspect that sometimes physicians do bill Medicare by putting in a place of service code as something like a hospital ED or an urgent care center, that kind of a thing. It doesn't make a lot of sense, and there's some ambiguity to this. But, CMS tells us that the physicians should not be billing out of the IFEC.

MR. THOMAS: Okay. Thank you.

DR. CROSSON: Okay. So, I think we have a number of suggestions from Zach and Jeff. It seems to me that they kind of fall into two categories, two elements of the issue here. One has to do whether or not the existence of these facilities of both types actually end up increasing the cost to the Medicare program of services that could be delivered less expensively. And the second one is whether or not their existence or the way they're marketing or whatever increases the beneficiaries' cost. And I think,

you know, my sense is both of these are problems.

So, I'd like to just have -- and, again, we're a little short of time, but have a round on those two issues, the relative importance of those, and some suggestions for the staff as to what's the first or second thing to go after, and we'll start with Alice, who is the person who had volunteered.

DR. COOMBS: Thank you very much. This is excellent. I did a little survey in my own regional area regarding some of the questions that were posed, especially in the chapter, and in terms of the IFEC, I think the piece of it that really is important is the determination of need regulatory state infrastructure, such that the reason why Texas and some of the other states have free ability to kind of navigate that for the IFECs is because the regulatory determination of need infrastructure is not there.

So in Massachusetts, there are a couple of sites which have these free-standings, and what they've done is, even though they're a large group, they've linked one of them to a hospital so that that one is considered to be an off-campus ED, and so that's the way they get around it.

All the other sites are non-Medicaid and Medicare treatment centers. So if there's a Medicaid/Medicare who wobbles into that office, they've got to be referred over to the one that will refer to an ED. So that's some of the manipulation, navigation, if you will.

In terms of talking to the ED physicians, I was very curious about the level visits and how they match up. So Level 5 visits would be something that was requiring a lot of intensity, someone with acute strike, acute MI, rushing off to the cath lab. And, honestly, they said, at most they might see three to four a day at most. That's a busy, busy day.

So I was looking at the demographics. It seems like the Level 5, to go up that much and to be that percentage in a clinical setting, if you were to divide by days, it seems like it's an increased amount, and we have the third busiest ED in the Massachusetts area. Just looking at the numbers alone, it would seem like upcoding was probably more likely than to say that the demographics and severity of illness changed for that reason.

So the why part of this is, Is it because of access, entrepreneurial coordination, market forces,

referring institution? And the last piece that I don't think we've dealt with, in the referring institution, if an institution wants to align themselves with an IFEC because their surgical volume is low and that's a goal, guess what? That's a strategy. And so what we have found is that referrals for surgical patients to the hospitals is very easy because that's where hospitals will value services, because if surgical volume is low, obviously it's an important piece of the operational infrastructure for hospitals, which, you know, as anesthesiologists we see that.

The question I had with all of these is, of course, looking at the unanticipated increase in cost with ED visits at missions and things of that way and the practice of defensive medicine at some of these facilities, where doctors might not have the threshold to send a patient home but refer them because fear of lack of follow-up thereafter, because these places are not calling people the next day and saying, "I want you to go to this clinic." So I think that there might be more defensive medicine. It's just one of my biases in a setting like this, such that cure may be driven upstream with admissions and more

ED visits, despite them not necessarily being affiliated with a hospital. That's a piece of it that you have to understand can affect the cost and quality of a patient in terms of going to the wrong place.

So of all these things, I think looking at the outcomes in terms of admissions and ED visits, but also I was thinking along the lines of this is analogous to LTCHs in many ways, sort of, in terms of proprietary involvement and expansion in areas where you have higher average incomes, not necessarily access. I talked to Sue about this, and I'll be interested to hear what she says. It's only 8 percent in the rural areas. It's not like we're going to the places where, you know -- it's the Starbucks pattern, if you will. I mean, I shouldn't say that, but it's a pattern where you're going to have the people that you want in your clinic.

And so I would say that some of the actions that we use for LTCHs might be a similar kind of road map for this entity.

DR. CROSSON: Thank you, Alice. You point out a good point, that, you know, in terms of this affiliation dynamic that's going on, which I think we presented as in

the interest of the free-standing emergency department in order to be -- emergency facility in order to be able to bill for Medicare and Medicaid services, I think one of the points you're making is that in many cases it's also in the interest of the hospital because it serves as a mechanism to have more admissions and more procedures and the like.

And if we follow the Starbucks model, then pretty soon we're going to have one on every block, as best I can tell.

[Laughter.]

DR. CROSSON: So maybe this is a worse problem than we thought. Forget about that drug cost thing. Let's work on this.

Okay. So let's start down this way and go around, and I would say again, to help the staff here, where on the question of what do we need to do about the long-term impact on the cost of the program, and then also are there ideas about how to protect beneficiaries in this regard.

DR. HOADLEY: So I think these are all interesting perspectives to study, and what I'm trying to do to sort out is sort of like the question Scott often

asks, sort of where are the bucks here and sort of -- and whether these OCEDs are a big enough phenomenon to be worth as much attention as drugs or, you know, even some of the other -- or more specifically within this list, the broader pattern of sort of coding and severity, which strikes me could be sort of in a dollar sense a bigger impact thing if there's something screwy with how coding is going on.

So, I mean, the analyst in me wants to know, you know, the first one here, you know, let's figure out how to track data, let's get this on the claims form somewhere so we can track them. And I do wonder if that could be a simple thing and how burdensome it is to sort of answer the first question here. It might be worth doing regardless, but in terms of sorting out, you know, thinking about where the dollar impact would be would be helpful.

On the beneficiary side, you know, to me it's a little like some of the site of service things where what you really come down to and all the complexities that Zach sort of laid out, I mean, the beneficiary unwittingly pays very different amounts, depending on where they end up. Obviously in some cases, they can make a conscious choice, but these are emergencies where in many cases they're

landing somewhere because the ambulance took them or because it's the closest or other kinds of sort of factors that aren't economically driven, and it does seem like one of those things where it's unfortunate that they may pay a potentially quite substantial difference in out-of-pocket liability just depending on these circumstances of how they land in one particular place or another.

You know, again, this sort of analogy that our site-of-service differentials, maybe this is something where we ought to think about either just in terms of the beneficiary or more broadly in terms of payment there ought to be some leveling if you're getting the same service, why should you -- why should more dollars be flowing in one situation than another?

MR. THOMAS: Just a couple of points.

I think, first of all, there's -- I think we've gone through one model here of, you know, looking at Houston and kind of the -- you know, putting sites kind of all over, and I think that certainly is probably more prevalent. You know, we've also seen in situations actually have gone through converting a rural facility to a free-standing ED because it ran a census of eight or ten

patients and essentially shut the inpatient down and converted to a free-standing ED because it was 20 miles away from another hospital. So I think we'll probably see those opportunities as well, so I want to make sure whatever we do, we don't shut down those opportunities, because I do think that is a model that we ought to be looking at going forward that would have a more comprehensive outpatient center as a hospital and not necessarily run an inpatient census.

I think the other component is I think what we're seeing here is one of the reasons these are so successful is because of access to emergency services. I think you see a lot of big ERs with just such a long wait, no fault of anyone because, you know, we see it in some of our own, but there's just such a demand for it, and I think that's why you're seeing more folks that are opting for these smaller centers that essentially have easier access. I'm not saying it's right. I'm not saying it's the best thing economically. But I just think it's a fact of the situation for patients.

I would encourage us to look at this as a continuum, and to look at this as a continuum starting with

telemedicine that we brought up, you know, yesterday; you know, how can we basically facilitate telemedicine being a better option for our beneficiaries so we can help diagnose and then steer them to what we think the most appropriate facility is, whether that be a primary care practice, an urgent care, an ED, whichever that is.

So I would start looking at telemedicine, looking at our urgent care services, and then looking at ED, not just looking at one or the other and looking at it as a silo, because it really is a continuum of access.

As a point, you know, we have extended access in every single primary care clinic we have into the evenings, and on every weekend, including Sundays, and we have had no impact on our utilization of emergency services. Even though we see a lot of people using these after-hours services, it just seems that, you know, people use EDs. And I'm not saying it's right. I'm not saying it's not costly, because I understand it is. But, you know, we really thought when we expanded every location to 7, 8 o'clock at night, every weekend, and we'd have an impact on utilization of ED -- haven't seen it.

So I would just ask us to look at it as a

continuum, and I would really put telemedicine on the front of this, because I think it's a way to steer people to the appropriate level of care.

DR. MILLER: Can I do a quick commercial on your first point, the whole notion of rural, ED, hospitals close to each other? That's a real important point, and that is something that we're going to try and come to this cycle. And when we're talking about this, I mean, I think the notion of an ED model in that instance is a whole different ball game.

MR. THOMAS: And I actually think if we could create incentives for smaller facilities that have a census of eight or ten to convert to this type of model and try to create some financial incentive, I think we'd see more folks do it. But right now, they keep hanging on with a census of eight or ten, and we all know that's just not sustainable long term.

DR. SAMITT: One of the things that was striking to me was, you know, your comment about how the primary driver of the development of these is population growth and payer mix, and it may be less about improving access. So I believe this warrants additional analysis. I'm concerned.

I don't know how material the issue is, but this is very much a site-neutral issue to me. If free-standing EDs are developed to provide improved access where access is poor, that is certainly understandable and warranted. But if we're seeing cases in free-standing EDs that alternatively could be seen in urgent care settings, then this is wasteful. You know, we should be enhancing our focus on urgent care if those cases can be seen there.

Likewise, beyond just the visit, I'm concerned about excessive imaging and anything else that would go into these free-standing ED visits that may make them more profitable, but also equally unwarranted.

So I think we should find a way to distinguish the claims between these facilities and EDs and begin to study appropriate utilization of these facilities as the immediate next step, which no preconceived notions as to what we'll find. We may just find that they truly are ED services. But if they're urgent care services, I'm concerned.

The one other thing that I would say is I don't think we should avoid a focus on urgent care facilities as well. The latest craze is the development of free-standing

urgent care. And I was surprised by the notion that the payment is OPD rates for urgent care facilities when these could be done in primary care physician offices for the most part. So I don't know if it should just be free-standing EDs that we focus on. I also believe we should focus on the movement of free-standing urgent care and our next analysis, maybe next year, should be on that, because I think that's the next impending wave.

DR. REDBERG: I'll just briefly comment because Craig said a lot of what I was thinking very well. But I do think we should consider site-neutral payments because it does seem, particularly for the reasons these are growing, these are not going to address the overflow from primary care or the lack of primary care. And I was surprised to hear what Warner said because certainly when I am attending, a lot of the patients I see that are coming in through the emergency room for non-emergent issues are coming because they were unable to reach their primary care or unable to be seen by their primary care doctor. And I don't know whether the increasing access now or increasing insurances, what kind of changes I think we're still watching, but certainly I don't think we should be paying

more for someone to be seen for a non-emergent issue in an emergency room setting, both for the ambulance transport -- and I'm not sure, if an ambulance transports a Medicare patient to an emergency room for a non-emergency, does Medicare still pay the ambulance transport? Which is a whole different issue because people don't always know, although I was struck by the fact that the ambulance said clearly -- some of them they didn't at least consider it an emergency enough to ever to consider inpatient admission. And I do think we should -- it would be good to have the OCED claims separately so that we can analyze them.

DR. CROSSON: Thank you, Rita. So just to confuse things, since I've gone this way twice, I'm going to start this way.

MR. ARMSTRONG: Very briefly, I would just affirm I think the same pay for comparable services kind of principle is really relevant here. I won't repeat other points people have made, but would just say that part of what we're wrestling with is payment in fee-for-service, and just for a moment, I just would reflect on the fact that in an integrated system like the one I work in, we don't contract with these. It messes up the coordination

of care and the way in which our patients are really part of an integrated, well-managed system. And we just ought to kind of, I think, think about that.

And then, second, we are looking at payment -- and it might be interesting to find out what ACOs are doing and how they're thinking about this, you know, through that lens.

And then, second, it's really interesting, Warner, to hear your points and to be reminded that it really is, when you can look at the benefit design and you can look at telemedicine and 24-hour consulting nurse services and in-ER consultants reviewing for admission criteria, that whole sort of spectrum of different ways of helping create an integrated, well-coordinated managed system, all have to kind of be aligned around the same common goals. And we can only do so much, but it might just be worth reminding ourselves of some of those things as we look at these specific payment policies.

DR. CROSSON: I just want to make one quick comment here. You know, this is my eighth year on the Commission now, and I can't tell you how many times on so many different topics at some point someone -- sometimes it

was me -- makes the comment that Scott just made, which is fundamentally to me -- you know, we wouldn't have the complexity of this issue and these perverse incentives going on if only we had integrated systems that were paid on a population basis.

Now, I realize that we don't have that, and we have a lot of work to do to improve the system we do have. But I do think somewhere down the line it is in the purview of the Commission to ask ourselves, you know, in a longer-term basis what it really would take to fundamentally start moving the country in that direction to the extent that's possible. And I don't know whether we can do this, you know, as a broad brush stroke or make sure that as we work through some of the more specific issues, we are always thinking about that potential direction and not coming up with policies that move in the opposite direction. That's just my editorial.

DR. NAYLOR: Hear, hear.

MS. BUTO: Hear, hear. I agree.

I realize this is more of a clarifying question, but are these entities for the most part physician-owned or are they hospital-owned for the most part?

MR. GAUMER: I think they are mostly hospital-owned facilities. The OCEDs are wholly owned by the hospital. The IFECs are mostly for-profit.

MS. BUTO: Owned by physicians.

MR. GAUMER: No.

MS. BUTO: Or for-profit entities.

MR. GAUMER: For-profit entities, and as Jeff indicated, there are some that might have some physician ownership in there.

MR. KUHN: Two points. On the first question up there, on tracking OCEDs, I think we ought to be doing that. As I think about it, from operations from CMS, I think an off-campus modifier would be easy for CMS to put in place. I think what would be difficult if we tried to know the exact location of the facility that was billing because then you have to have a separate billing number, and per Jeff's earlier response on emergency transport, if you have a separate billing number, does that create opportunities for gaming? You know, all that kind of stuff. So I think there's a way we can track it -- it's just what level of specificity -- and avoid unintended consequences as part of that.

And the other issue I'd like to kind of speak to is this issue of a little bit of what Warner teed up, and that is, you know, the incentives are driving us to convert and shed inpatient capacity that are out there. Warner gave a good example of what we're seeing in some rural areas, and we're seeing that as well. That makes sense.

If you look at Maryland, that has gone to a global budget. My gosh, they're shedding inpatient capacity as fast as they can, and one of the tools that they're using is these free-standing emergency departments. And so it's a tool in terms of what they want to use in order to kind of move in that direction that's out there. Some of those are part of integrated systems. So I think as we go through this, we need to understand, you know, there's different types of flavors that are going out here in terms of these facilities that are out there.

And, you know, at risk of kind of teeing this one up, I just would mention something Warner didn't mention, but we're at the ten-year anniversary of Katrina, and Warner has been on a lot of news stories about what they've done in New Orleans, and he and his team have just done a terrific job on that. But one of the tools they did in

rebuilding New Orleans was freestanding EDs. So, there is a real legitimate reason for some of these out there and I think we've just got to be careful how we parse it out.

DR. MILLER: That also gets to the comment that -- you know, this just occurred over here -- it may make complete -- it may be entirely different if they flourish in a population-based payment system. That may make complete sense. And the program's orientation to it may be much more -- much more indifferent in that environment.

DR. CROSSON: Bill.

MR. GRADISON: Picking up on what Craig said and my earlier question about ambulatory surgical centers, what I'm trying to think through is what forces, if any, are there that are moving or seeming to move activities out of the integrated hospital into freestanding units. What common denominators are there? What other services are there that don't come to me but might come to others of you that might move in that direction in the future? Is there any relationship of what we're talking about to the movement of some low-intensity services from high-priced tertiary care institutions, often teaching institutions, into community hospitals, which could do just as good a job

at a lower cost? It's the economics of this, I'm just trying better to understand.

One minor sidebar and a suggestion is to take a look at Georgia. There are a number of rural hospitals there that are having a really hard time of it financially, and I believe I'm correct that the state, with the encouragement of the Governor and others, has created legislation to make it possible for some of these entities to shrink down to a stabilize and transfer type of facility. Again, I don't want to trust my memory or full understanding of the facts, but my best understanding is no county has taken up on it yet, which may suggest that the problem is economic, not health care alone, that if these hospitals fail, it's because of the economics and the high concentration of low-income patients and that the ED would suffer the same problems as the hospital, even though it was operating on a much more limited basis and focused basis.

DR. CROSSON: David.

DR. NERENZ: Hopefully, just a side issue, but it speaks, I think, to point two about the incentives. In the chapter that we had, in Table 1, you illustrate the

different payment rates for the different settings and it's basically a factor of three-to-one for the ED versus physician office. Part of that three-to-one ratio, if I understand it, is not just more intense clinical care, it's just other things -- stand-by capacity, Katrina response capacity, whatever it is.

And as we think about this going forward, I wonder if we want to even step into the territory of some different payment stream for that capacity that is sitting there all the time as opposed to the individual visits, and that would allow the payment for the visits to be more comparable, but still not cut away the support for the stand-by capacity of the other mission elements. There's a reason why what we have is what we have, and I may not know that well, but I suggest that as something we could consider.

DR. CROSSON: Sue.

MS. THOMPSON: I, too -- I'm really excited about the opportunity to take this information into the context of the rural discussion that we look forward to, because I think while we do not see these independent freestanding facilities in the rural areas today, the work that's before

us, and I think the struggles these Critical Access Hospitals may be having -- are having -- we are going to see a lot. So, there's a lot to be learned, I believe, from the work you're doing, so I appreciate this as background.

I'm curious to know, as we continue to have discussion, are you seeing CT scanners, MRIs, PET-CT, all those kinds of expensive modalities going up, and not necessarily for today's discussion, but I'm interested to know if there's learnings from what we're seeing in these freestanding facilities today that we can maybe think about as we talk about the rural issue going forward.

And then, secondly, back to the coding and questions about is there upcoding going on, in that period of 2008 to 2013, we also saw a lot of electronic health records either come into place or we got a lot better at using them, and with that, there was a lot more capture of the detail of the clinical presentation of the patient, which may have presented a much more clear picture of what we had been seeing all along but had not been capturing. Not sure, wondering about is that a factor that may have contributed to those numbers.

MR. GAUMER: That was something that came up in some of the discussions that we had with folks around -- in the interview process, that one or two of the different criteria of the coding could have been fairly easily handled with the new electronic medical record in doing patient history and that kind of thing. I think you're right.

DR. CROSSON: Okay. Thanks very much. I think I would simply sum up by saying, Houston, we have a problem.

[Laughter.]

DR. CROSSON: And thank the Commission for the useful comments. Zach and Jeff, I hope you've gotten enough information to move along here. Thank you very much.

[Pause.]

DR. CROSSON: Okay. Our final presentation is going to be on payments from drug and device manufacturers to physicians and teaching hospitals. This is an issue that the Commission was active on a number of years ago, I think leading to the process that we have in place to track that and make that information publicly available. I think as a consequence of that and our continuing interest in

pharmaceutical costs, we're going to review the current status of that information. Ariel Winter and Anna Harty will be presenting, and, Ariel, it looks like you're going to start.

MR. WINTER: Thank you. Good morning. Before we begin, we want to thank Kevin Hayes and Shinobu Suzuki for their help with this work.

So here are the main points we'll be covering today. We will be going over some background on this issue, describing the public reporting program, which is known as Open Payments, presenting results of our preliminary analysis of data from 2014, and then talking about some next steps.

So, as Jay mentioned, back in 2009, the Commission recommended that the Congress mandate public reporting of physicians' financial relationships with drug and device manufacturers. The goal, one of the main goals, was to help Medicare and other payers and the general public better understand the scope of these financial ties and how they might affect practice patterns and health care spending.

In 2010, in PPACA, Congress created a public

reporting system. CMS implemented this program in 2013 and called it Open Payments.

As we expected, the media have been using this database to shed light on physician-industry ties, and I will list a couple of examples. ProPublica found that the drugs associated with the highest amounts of promotional payments to physicians tended to be newer drugs that treat similar conditions. New breakthrough drugs that cure disease or significantly extend life were associated with smaller promotional payments. The New York Times found that half of the physicians who received the most money from the manufacturer of Lucentis billed for a higher amount of Lucentis than their peers. And the Wall Street Journal has used this data to highlight hospitals and physicians who received very large payments from the industry.

And later on, Anna and I will be presenting the preliminary results from our own analysis of this information.

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 advance practice nurses and physician assistances, and it also excludes institutional organizations other than teaching hospitals.

Manufacturers are required to report most financial interactions; for example, speaking fees, royalties, meals, research grants, 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. So far, CMS has released payment data that cover the last five months of 2013 and all of 2014, and the data can be searched or downloaded from a public website.

Anna will now describe the results from our preliminary analysis of the data.

MS. HARTY: The Open Payments database contains three main files. The research file 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 study, or the drugs and devices that are studied.

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.

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

This chart shows the proportion of payments in 2014 that fall into each category. The total payments sum to about $6.5 billion. If you look to the orange sections on the right, you will see that research payments make up

about half of the total value of payments. Within the research payments category, $2.5 billion went to physicians and $705 million went to teaching hospitals.

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, just over $2 billion went to physicians and $543 million went to teaching hospitals.

The blue section shows physician ownership or investment interests which, at $703 million, make up the remaining 10 percent of the total value.

Around 80 percent of the total payments went to physicians, while the other 20 percent went to teaching hospitals. About 607,000 physicians and 1,100 teaching hospitals received payments. Of those physicians who received a general payment, the average payment per physician was $3,325. Of those physicians with ownership or investment interest in a drug or device Company, the average value of interest per physician was about $164,000. We didn't 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.

Eighty percent of physicians receiving payments were MDs osteopaths, and 20 percent were dentists, optometrists, podiatrists, or chiropractors. Seventy percent of the MDs and DOs who billed Medicare during 2011, '12, or '13 received payments from drug or device manufacturers in 2014.

For the next three slides, we are going to be focusing on general payments file.

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 the total payments. The top 10 percent of physicians account for 91 percent of total dollars.

MR. WINTER: We also examined general payments by the type of payment, and this table shows the information for physicians. There's a similar table in your paper that looks at the teaching hospitals.

Promotional speaking fees and honoraria accounted for about one-third of general payments to physicians, but only 6 percent of physicians who received any general payment received this type of payment. This category does

not include fees related to speeches that are for continuing education.

The average amount per physician in this category was about $19,000. Royalty or license payments accounted for about one-fifth of general payments and had the highest average amount per physician, about $227,000, but only about 2,000 physicians received one of these payments.

Food and beverage accounted for 11 percent of total payments but were received by about 568,000 physicians, or 94 percent of all physicians who received at least one general payment, and this indicates that the practice of providing meals to physicians is widespread.

We also examined the distribution of general payments by specialty for MDs and DOs. We linked the specialty code that appears on Medicare claims to records for MDs and DOs in the general payments file, and we were able to identify specialty for 92 percent of the records that accounted for 84 percent of the dollars on this file. And this table shows the top 10 specialties.

Orthopedic surgery accounted for 23 percent of payments for which we identified a physician specialty, with an average payment per physician of $20,000.

Cardiology accounted for 7 percent, with an average payment per physician of almost $6,000. Internal medicine and family practice each accounted for 6 percent of payments but had relatively small average amounts per physician. Further down the list, neurosurgery and endocrinology had relatively high average amounts per physician.

And we will conclude with some next steps that you may wish to discussion.

So the Commission may want to suggest improvements to the Open Payments program. There are technical changes that would improve usefulness of data, for example, indicating in the database whether it was a GPO or a manufacturer that made the payments, as well as the type of manufacturer that made payment, for example, a device or a drug manufacturer.

There are also potential changes that would require a change in statute, for example, requiring manufacturers to report payments to other health professionals and organizations.

We also have some ideas for future analyses. We could examine the relationship between physicians' prescribing behavior and the payments they receive from

manufacturers. We could also explore trends as more years of data are released.

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

DR. CROSSON: Thanks, Ariel and Anna. A very interesting beginning, I think, of a process to look at this.

I have one question I'll start with myself. So with respect to other health professionals who are not required to report, is that true irrespective of whether that individual is self-employed and practicing independently or is in fact an employee of a physician or group of physicians or a hospital?

MR. WINTER: That's true in either case that you said.

What could be happening is if a manufacturer buys, let's say, lunch for an entire practice, and there could be NPs and PAs in the practice who partake in the lunch, but their names will not show up in this database. It will only be the names of the physicians in the practice.

DR. CROSSON: Okay. Clarifying questions. Let's

start here. Alice?

DR. COOMBS: I looked at the graph in the paper, and I was having a hard time for the food because --

DR. MILLER: Are you hungry?

[Laughter.]

DR. CROSSON: Is this another Starbucks thing?

[Laughter.]

DR. COOMBS: No, because I think the doctors are being cheated. They just get coffee.

Well, what I wanted to know is that do you have actual names of doctors listed as having received a meal? Because when I go to conferences now, I mean, if I have my badge on that says ASA or Society of Critical Care and I talk by a booth and they have a coffee, they say, "Oh, you're from Massachusetts. You can't come here," because of the rules in Massachusetts.

But I'm wondering how --

DR. BAICKER: So Alice would like a cup of coffee.

DR. CROSSON: It is about Starbucks.

[Laughter.]

DR. COOMBS: So I'm wondering how they really

reconcile this. I mean, you only have 750,000 actively practicing doctors in the country. That means everybody has been fed. I mean everybody is actively practicing. So I'm just trying to reconcile that.

MR. WINTER: So, in the hypothetical, the example you gave where if the manufacturer gave money to an organization for a conference or to sponsor a booth at a conference and a physician walked by and took a meal and the manufacturer has no way of knowing the identity of that physician, that payment is not reported. If it is only reported -- if the manufacturer or the GPO is aware of -- either pays -- gives that meal directly to a physician or does it indirectly but is aware of the identity of the physician who gets the meal. So these are more likely cases where they are taking physicians, buying them dinner, buying them lunch, for an individual physician or a group or a practice, that sort of thing.

Clearly, it is widespread. In the more limited cases that are captured in the data, that is, that practice is widespread.

DR. HOADLEY: Thank you. This is very useful. I was trying to get some different ways of thinking about the

numbers.

On slide 10, you have what I think -- the bottom right is the overall average payment per physician across everything. It would just be useful, I think, to sort of express that as a share of income, even if you just have to use average kind of incomes to get a sense.

And then when you talk on slide 9 about the top 5 percent are getting this much of the payments, again, it would be kind of interesting, even if you just sort of are doing it as more of a back-of-the-envelope type of calculation of what share of income those high receivers are getting, because again it helps to tell the story. If somebody is getting an increment of 1 or 2 percent, you interpret that one way. if somebody is getting 30, 40 percent of what's their normal income in additional gifts, that's going to tell us a different story, so it's just a way to help to enlighten what the numbers are meaning to us.

MR. WINTER: I think that would be easier to do for the average or median physician perhaps by specialty --

DR. HOADLEY: Something like that, yeah.

MR. WINTER: -- or groups of specialties, but at

the top of the distribution, I think that would be tougher to get. I just don't think the data are that granular to look at, what's the income of the top fifth percentile of physicians. I'd have to talk to Kevin and Kate more about that. But I assume by income, you mean sort of total income for --

DR. HOADLEY: Right.

MR. WINTER: -- revenue from their practice and everything else.

DR. HOADLEY: But even if you look how much total payments in this dataset the average physician in the top 5 percent is getting, you say they account for 86 percent of the dollars -- that's just a different arithmetic -- and then look at that relative to the median physician and whatever. I mean, just -- again, give us just a sense of the magnitude.

DR. CROSSON: Cori.

MS. UCCELLO: So there's a website that you can go to and type in a doctor and find out all of their payments, so I looked up some of my doctors.

[Laughter.]

MS. UCCELLO: And one of them had a lot of food,

and I was actually wondering, "My God, it's like every other week. How is this" -- and some of them were -- I mean, it was like $20, $5. And so I couldn't tell if some of this was even just sending stuff to the office that was for an office because I know in my office, sometimes some of our contractors or whoever will send like a basket of chocolate or something.

DR. MILLER: Say more about that.

[Laughter.]

DR. MILLER: For the record, just keep talking.

MS. UCCELLO: So I just thought that was -- I thought it was kind of interesting, looking up people.

I hate to do this, but you know that this is who I am. So, on page 8 -- slide 8, the average ownership investment interest per physician, 163,000. Slide 10, the number on the right-hand column for ownership interest is 53,000. So I'm just trying to reconcile what that is.

MR. WINTER: Right. You raise a good point. This is a question we asked CMS about.

So the payments on slide 10 are from a file called general payments, and there is a separate file for ownership and investment interest. And there is a category

in the general payments file called ownership interest, and what is going on there is that reflects cases in which a manufacturer gave a physician a stock or some kind of interest in the company. And you could think of that in lieu of paying them a consulting fee, "We'll give you a share in our company." But the ownership file includes both of those cases where a physician received a share of a company but also cases where a physician bought shares in a company or founded a company and they own it or they're partners with someone else in the company, so it was a much broader set of the payments in the ownership and investment file than just the row you see here.

MR. THOMAS: A quick clarification, and it's really tied into Jack's comment, but on page 9 where we have the top 5 percent, top 10 percent, I know Jack asked to kind of look at it as the percentage of median. I would just like to know the average payments in those buckets versus where you show the average payments for all physicians. So if we could provide that in the future?

MR. WINTER: Yeah. We didn't calculate the average for each bucket, but I can tell you what the number is of the fifth percentage, and that's about $5,900. So

that would be at the bottom of that bucket, would be $5,900, and the top is, you know, millions of dollars. And we can do the average and come back to you with that.

MR. THOMAS: Yeah. And I think getting back to it, just what is the average payment per physician for the top 5 percent, for the top 10 percent.

MR. WINTER: Sure.

DR. CROSSON: Clarifying questions. Coming up this way.

[No audible response.]

DR. CROSSON: No more clarifying questions. Okay.

So we are going to start the discussion now about where we would like to go with further information, and Rita has volunteered to start this discussion.

DR. REDBERG: Thank you. I wanted to make a few sort of general comments. Thank you for the analysis.

I think we're moving in all ways, I'm hoping, in medicine to transparency, transparency of clinical trial data, the clinical trials registry, and I think this is an important part of it. I think it actually is interesting because it relates to the drug sending discussion we had a

little earlier this morning, and Craig mentioned that the really important part is prescribing clinicians. Well, we know the reason there's so much money invested in physicians is because we do make most of the medical decisions in control of the drug and device spend, and we also know there is a very strong relationship between the money spends on physicians, you know, the meals, even a pen, and their prescribing behavior. And certainly, when you said a lot of the payments go for the expense of the "me too" drugs, from a company point of view, that's a good investment, because if I have five different drugs I could prescribe and one is cheap and one is more expensive, to me it doesn't -- but if I'm getting payment from a certain company, that could influence behavior.

And I'll say I listen. I used to listen on the way to work to a lot of these CME tapes and when you have to disclose at the beginning, and everyone I heard on these CME tapes, they would say, "These are my disclosures, but it has no influence on what I am going to say." I have never heard someone say, "This has an influence on what I am going to say."

[Laughter.]

DR. REDBERG: However, obviously, companies are getting a return on their investment because they know it does have an influence on what we prescribe and how we practice medicine, and so it's really important.

I should point out the obvious, that patients are really unaware of these, and maybe Cori went and looked it up. But when doctors are -- for example, orthopedic surgeons were at the top of that list. You know, it's known that a lot of orthopedic surgeons will recommend devices that they happen to be an ownership interest, or they have a relationship with the company. They may truly believe that is the best device for that patient, but the patient is unaware of that, and I think -- you know, I don't think that leads to the best medical decisions, and certainly not to inform medical decisions.

In terms of the research payments, you know, there's a lot of discussion over whether that is or isn't an influence. I would just point out, in the, again, 30 years since I've been in medicine, most funding for research has shifted from the NIH to industry funding and that does have an effect because the sponsor has a role in the kind of question that is being asked, or you can't get

an answer if you didn't ask the right question. So, what you're comparing. Are you comparing to control and not doing anything? Are you comparing to current treatment? And then who owns the data? Sponsors, you know, there's varying policies depending on the academic medical center, but sponsors have a lot of influence over how the analysis is done, whether the results are published. You know, we know that negative results tend not to be published as much as positive results do, and that all affects, again, the way we practice medical care.

And the other thing about research payments is that there are these things called seeding trials that, I think, often go under the research payments, but when a new drug or device first hits the market, in order to -- it seems in order to familiarize doctors or develop relationships, companies will do these research trials, or sometimes they're post-market surveillance trials, but there's a per payment per patient for enrolling patients and using the new drug and device, and all of that appears under research, but it really starts to overlap with marketing. When you see trials that have many centers and one or two patients per center, you know, that's often what

we think is going on.

The other thing I would say is the samples that are excluded from use, you know, where I practice at UCSF, we banned samples many years ago. Again, I first thought, oh, it's great that there are samples, and then I realized that there were never samples of those generic drugs. There were never samples of the inexpensive drugs. All the samples were of the new expensive and often the "me too" drugs, again, to try to get a market. And, so, they're excluded, but they clearly still have an effect.

So, I think continued sort of making sure, of course, that we've gotten all this right, getting more details, as you suggested on the last page, about who's making the payments and the type of manufacturers is good. I think we also need to go a little further in making sure that patients are aware and that doctors need to disclose if they have a relationship with a drug or device that they are prescribing. Thank you.

DR. MILLER: Can I ask one thing quickly? When she mentioned the -- and I can't remember the vocabulary, but the payment to the physician to put a patient in a post-marketing trial, would that show up in this database?

MR. WINTER: That should be showing up in the research payments file.

DR. MILLER: Okay.

MR. WINTER: But they don't distinguish whether it's phase one, two, three, or four, so we don't know if it's a post-market trial or not. But, they're not required to. They might, but they're not required to.

DR. CROSSON: Okay, so let's -- remember, we have kind of two questions here. What potential changes to the existing program would people think might be recommended? And, secondly, what further analyses would you like to see from staff. And we'll move up from Rita, starting with Warner.

MR. THOMAS: Two comments. One, I think we should continue to reinforce the importance of transparency around this, because I know a lot of organizations that went and looked up their own physicians and found that they didn't know payments that were going to their own physicians. So, I think that is really important. And I think it also, getting back to Cori's point around the patients understanding that. So, I would just encourage us to continue to focus on the transparency, reinforcing that

and making sure that that's something that the more detail we can have on what these payments are, what they're for, I think the better off we are.

The other thing I'd like to just put on our radar screen, and it may not have the same magnitude, but I think it's rather large, are the payments that go to the reps, especially around device organizations, who are in the ORs of hospitals and what not. And we find that, in some cases, the reps are being paid more to assist in a procedure than are surgeons who are being paid to do the procedure, and that is not transparent at all in the process and that may be something that could be interesting, and it's a hidden cost of the program, quite frankly, because it's in the cost of the device that's being purchased by the hospitals. So, just maybe something to put on our radar screen.

DR. CROSSON: Okay. Cori.

MS. UCCELLO: Yeah, I agree with the idea of examining more closely this relationship between prescribing behavior and these payments. I mean, I couldn't -- looking at that Slide 10 and looking at the different payments, like this royalty license and the

ownership interest, those are huge numbers, and I just -- I was just trying to figure out, well, are these red flags or not? They seem like it, but I don't know what to do with that. So, just kind of helping me think through that would be helpful.

DR. CROSSON: Jack.

DR. HOADLEY: Yeah. I, I think, agree with Cori's comment and I agree with the other comments. I do think, again, the relationship between the prescribing behavior and the payments is really interesting, and the Lucentis example that was done in the media, you know, is a real interesting example of that and one that, I think, is pretty revealing. Trying to frame what that analysis might look like is challenging. I mean, I think it may be more interesting to do for very selected drugs than to try to do something across the board, although it would be interesting, maybe, the more overall, the more payments you get, you would generally prescribe more. I think that's less likely to be revealing, though, than picking on something like Lucentis or identifying some other cases, not necessarily among expensive Part B drugs, but even among some of the Part D drugs that are of more

questionable value and see whether their use is accelerated by the doctors who are getting payments.

DR. CROSSON: Alice.

DR. COOMBS: So, my line of work has to do with being in the operating room and seeing a lot of reps and the impact of reps. But, to be honest with you, a lot of surgeons feel uncomfortable doing some of the procedures without the rep being present for fear of opening the wrong kit. Opening the wrong kit is a big deal. And, so, I don't know how to reconcile this whole issue, but I know there's a -- even before the operating room, whether or not you do a troch nail or you do a more involved procedure, doing titanium, all that decision making happens a lot of times with the rep outside of the room. So, once you get into the operating room, the rep is there to ensure a level of safety with using the devices that are being used for -- I shouldn't list any ones, but for pacemakers and testing the pacemakers. The reps are essential for the whole process.

One experience I did have, without too much identifying data, was a guy who came in to, quote-unquote, "observe cases." "I just want to come in and observe cases

all day." And while in the endos, we suggest that we use -- you sure you don't want to clip that? You sure you don't want to -- and that kind of behavior actually changes the provider, even though the provider doesn't get any -- he doesn't get anything in return for that. But it does influence behavior. When that rep came around again, you know, there was a way in which the rep wasn't involved with this quote-unquote "observation," because I think the observation rep that comes in to observe a case has more influence than just them observing the case, and so I think that's problematic.

I think we have a major problem, because we went over this whole thing about how drug companies influence doctors, but, you know, I pick up a New England Journal or I pick up a JAMA, and guess what, all through the magazine is this advertisement, and sometimes you'll read that as opposed to something else and there's influence there, too. So, I mean, we all have been a part of this in terms of influence.

DR. CROSSON: Kate.

DR. BAICKER: I think it's great to have these data so readily accessible and the technical fixes that you

mentioned. I haven't tried to use the data, so I don't know what fields are missing or could be populated with information that's already collected, but certainly anything that could be populated better to make it more usable, we should be recommending that that information be merged in and most easily used, and those seem like great suggestions from people who are expert in trying to use it.

It seems like there's bigger return to that, which might clarify some of the big dollar payments that Cori mentioned, than trying to parse more finely how many people in the office got a cup of coffee. Did Alice get a cup of coffee, because I do not want her to have coffee.

[Laughter.]

DR. BAICKER: You know, that -- I think finer and finer slicing of that comes at higher and higher cost with less and less return, whereas understanding where the bigger dollar amounts are going, from whom to whom, is where the return likely is in the data.

DR. CROSSON: The Starbucks metaphor is just running wild here.

[Laughter.]

DR. CHRISTIANSON: I was going to say pretty much

the same thing that Kate said, and we're kind of depending on you to tell us -- you're working with the data -- what fixes should we be recommending that will allow you to do a better analysis, get at some of these issues and so forth. So, I think that's important, but as Kate said, I think the next round, I mean, we've got a feel for what's here. You guys have got a feel for what's here now. So, let's try to come up with a set of things like that that we can recommend.

MR. ARMSTRONG: I just briefly would affirm this data is interesting and we ought to make sure it's usable and we believe it, and if it can be enhanced, we should do that.

I'm still wrestling, though, with, so, what else-what do we do? Other than make the information available, what else do you do with this? I think, you know, one extreme -- Rita mentioned this -- that's true in my system, we don't allow any of this to happen. We don't let samples into our buildings or reps into our buildings or payments of any kind. And, I suppose that's one extreme, that we impact payments to providers who show up on any of these lists. I doubt that's easily implemented, and there's

probably a lot of ground in between. But, it just seems to me that's really the question, is, well, what do we -- how does this influence payment policy, if at all.

And then to someone else's point, we need to ask, is it even worth spending that much time on, given so many other really big things we have, despite how it just seems wrong, you know, that this is happening.

DR. NAYLOR: I think this is a really important issue, $6.5 billion, when we're paying $65 billion each year in outpatient costs. I mean, that's ten percent. So, I think it's really important. It's important for all the reasons everybody else has talked about, largely because while we have now a tool, largely the beneficiaries are unaware of what is happening.

I would support all these suggestions, that we think about the transparency being responsibility for everyone who receives Medicare payment, and that would extend to nurse practitioners and PAs. And I would also support the additional analyses. I am not sure I would limit the analyses to the top five or ten percent. I would be very interested in looking at the extent, and this builds a little bit on earlier comments, when we have a

group of providers for whom it is a substantial jump in their compensation, however that's defined, I think that is as important as looking at just the five or top ten percent.

I also think this idea of what are the next steps is really important, and there's a huge body of work around the relationship between these kinds of incentives and behaviors and decisions by institutions to stop it. And I'm wondering if showcasing, you know, those that have really stepped up to the plate, given the acknowledged linkages between this spending and behavior. Certainly, the analyses that you're doing will also bring that to the fore. But, I think this is an exceedingly important area. It's not unrelated to the Medicare drug spending. If we learn that people are using more, prescribing more because of these relationships, it could affect the bigger bottom line.

DR. CROSSON: Kathy.

MS. BUTO: Yeah. This issue really bothers me because it totally undermines the argument that, you know, medicines have value and the value should really be the determining factor of how they're prescribed. So, I think

this is a real issue of credibility and trust.

I'm assuming that we will look at the relationship between physician prescribing and payments from manufacturers. I think some literature has already been developed in this area, and I would ask that maybe for the next go-around we get a little synopsis of some of the findings of -- because I think there has been a clear relationship shown.

And then in addition to that, I think it's important for us to understand, particularly if you look at it by specialty, where the growth in Medicare spending is associated with these specialty services that are tied to drugs and devices. So, I think it would be helpful to have that connection to Medicare per se.

And, the last thing I would mention, and I hate to do this because I don't think it's a great piece of law, but the Stark ownership and referral rules, which have had -- I think we once described them as Swiss cheese because they're more defined by the exceptions than by the actual rules. There are ownership and referral rules that are in Medicare now, and so I -- I mean, I guess I'm of the belief that there is something that Medicare could do to move in

the direction of more appropriate referral and transparency issues, and maybe it's worth looking at that. Maybe it isn't worth looking at it, because it's such a labyrinth. But, there was an effort made to -- for those who are not familiar -- to reduce the ownership where there's the possibility of referrals, for example, in radiology practices and so on and so forth. So, this is kind of analogous to that, but not totally, because it involves specific categories of medications and devices and so on.

MR. WINTER: If I could just respond to two of the points you made, one is that in our 2008 and 2009 chapters on this topic, we did examine and summarize the literature on the influence -- the link between physician interactions with drug manufacturers and their prescribing behavior, and we can certainly update that based on more recent literature for the next time.

The other point I want to make is that as part of our set of recommendations in 2009, we also recommended that Congress mandate public reporting of physician ownership of any entity that billed Medicare, so hospitals, ASEs, dialysis facilities, independent testing facilities, and so on. And that recommendation is still out, has not

been adopted. But, it does relate, and I think your comment about physician ownership --

MS. BUTO: Of course, physicians, I mean, manufacturers don't actually bill Medicare. So, I think we have to think through how would that work or what would the reporting be. But, anyway, I think your point is well taken.

MR. WINTER: And physician ownership in a manufacturer is part of the data that is now being reported as part of this database.

DR. CROSSON: Herb, no. Bill.

MR. GRADISON: We've talked a lot about provider behavior, and I certainly support the efforts to get more information about that, or update the information from earlier.

We haven't, at least in my view, talked enough about patient behavior, that is to say, what does it take to influence the patients? I don't mean we haven't talked about it at all, but I'd be -- and I'm sure there have been studies of this, maybe by psychologists or behavioral scientists maybe more than people in medicine, directly in the practice of medicine. But, another way to say that is

how can information best be presented or made available to influence behavior in the direction we would like to nudge it, and I'd kind of like to know a little bit about that.

In the interest of full disclosure, I was surprised when I was having a pacemaker installed to see some guys in blue outfits that were under the employ of Medtronic, as I recall it. I was also very glad they were there, to be honest. And I have a vague recollection -- vague because I think I was partially sedated -- that when I was having some back surgery, there were some guys from Medtronic there, too, even though that surgery had nothing to do with it.

[Laughter.]

MR. GRADISON: So, I say, you know, this is a mixed situation. It could be that some patients are sort of proud of their physicians getting invited to conferences where they're talking about the newest device or -- and I don't mean to sound naive. I'd like to know more about which way this works in terms of influence on patient behavior.

More specifically, I would be very interested in anything you could learn about how other countries are

handling this, especially a country like Canada, where the physicians are in private practice rather than in the government employ. I think if they're in government employ, it might be kind of a different situation, although that would be interesting. But, just in terms of casting a broad net, I'd be interested in -- I don't usually raise this question about what other countries are doing, but I think in this instance, it might be interesting.

DR. HALL: So, just full disclosure, I like to take notes at these meetings and I have two pens here. They don't bear any names of any drug company. I paid 75 cents each for them at the Rochester airport on the way down here.

[Laughter.]

DR. HALL: On the other hand, every time I come into this meeting, somebody drops a blue pencil or pen up here that apparently is from the Ronald Reagan Building, which probably explains my perfect attendance record for the last four-and-a-half years at this meeting.

[Laughter.]

DR. HALL: More seriously, I think we should have zero tolerance for this sort of thing, especially since

virtually every specialty society in organized medicine has very strict mandates against this type of behavior, of accepting gifts from pharmaceutical companies. The technical support is a special thing, but it would have to be looked at carefully. And virtually every academic center, and I think most reputable hospitals, have -- also seem to have zero tolerance.

And it's possible that your statistics show that it's one of these five percent/80 percent rules. Five percent of Medicare patients are responsible for a huge amount. And I suspect that that's where the money is going to be to look at that.

But, this is a serious problem, even when it's only the appearance of impropriety, and I think we're doing a good service to medicine by keeping a close tab on this.

DR. CROSSON: David.

DR. NERENZ: As this goes forward, I just would ask you and sort of all of us to always keep right in front of us what the connection is between this set of issues and Medicare payment per se. You know, on the surface, we could say this isn't our problem. These are not Medicare payments. These are manufacturer payments and it's not our

business. But, the reason we're talking about it is that we see that there's a connection.

But, I guess I always want that connection to be made explicit as a reminder, but also perhaps as a guide to analysis, because it seems like there are two kinds of connection with the causal things running in two different ways. Either we want to understand more clearly what's the relationship between these payments and Medicare payments, what's driving behavior change. You know, we know some of that already, but perhaps there are other questions.

But I think even more interestingly, but I don't see it yet as clearly, is going the other way. What about Medicare payment change per se could influence any of this, because that presumably is our purview and that's where we would take some action. And I guess that's where I would want to see this going, some way or other.

DR. CROSSON: Warner.

MR. THOMAS: Just real briefly, commenting on Alice's commenting about the reps. My claim is not that they're not important. My point is that the payments to them ought to be transparent like the payments are here to physicians, and I think that that would be telling, and I

think that there are many organizations that are working hard now to figure out other models, to move to more of a rep-less model because of the significant cost of the system, so --

DR. HOADLEY: Just real quickly, we've heard several examples here of institutions that don't allow these payments. It might be useful to get a sense of what's the story across the country. How many practices don't allow it? Is it mostly just a handful of institutions? You know, I think Bill said a lot of the physician societies have suggested they shouldn't be done. Sort of get a sense of what the -- and if there's any literature that says how much impact that's had.

DR. CROSSON: Okay. Ariel and Anna, I think you've gotten broad support here for both of your large bullet points and the areas you've suggested and so we look forward to hearing from you again later.

I see no further questions or comments. I think that means that we're finished with the agenda and now we have time for the public comment part of the meeting. So, if there are any individuals, representatives here from the public who would like to make a comment at this time,

please come forward to the microphone so we can see who is interested in speaking.

[Pause.]

DR. CROSSON: Okay. Seeing -- oh, there you go. Let me just make a couple of comments before you begin.

First of all, as I think most of you know -- we certainly know on the Commission -- the MedPAC staff make every effort before the meetings to hear from representatives who are at interest. There are a number of mechanisms for this, both input onto the MedPAC website as well as individual contacts with Mark and his staff. So this opportunity here is not the only opportunity nor necessarily the best opportunity to provide that input.

What I'd ask you to do -- turn on your microphone. But what I'd ask you to do is state your name and your organization, and you'll have two minutes to present. And then when this light comes back on, we'd ask you to stop. Thank you.

MS. SANDEL: Thank you. My name's Rhonda Sandel. I am the president of the National Association of Freestanding Emergency Centers, and for full disclosure, I also own and operate several freestanding ERs in Texas.

The National Association of Freestanding ERs advocates for both the independent model and the hospital-associate model of freestanding emergency rooms. We feel that all freestanding emergency centers should have the right to be reimbursed by CMS for the services we provide. That's both the independent and the hospital model. I believe if independent models were able to receive payment for services provided, you would see many more of these facilities open and operate in underserved areas.

Blue Cross/Blue Shield has already performed its own study and published the data that they recognize that the freestanding model, both the independent and the hospital model, are a less expensive alternative to the hospital-based emergency room, both for the payer and for the beneficiary. It's on their website.

Freestanding ERs are not cherrypicking from the hospital emergency room. In Houston, where you see more freestanding ERs than any other place in the country, all hospital visits have increased greatly, both in the freestanding model and the hospital model. The numbers are up.

ACEP supports this with their own study that

we're at an all-time high for emergency room visits across the country, despite numerous freestanding ERs opening across the country.

There's certainly a place for urgent cares, but I think it's very difficult for you to drive patients to the urgent cares. And I think part of our issue is that urgent cares are nothing more than an extension of a primary care physician's office or services with extended hours. But both primary care and urgent care services are open for very short hours of time. Therefore, when patients have their emergency, your beneficiaries, where do they go to? They go to the hospital emergency room, or they go to the freestanding emergency room. That's the issue that needs to be addressed, is the hours. If you want to push someone to urgent care, they've got to have some extended hours.

That's all. Thank you very much.

DR. CROSSON: Thank you very much.

MS. SANDEL: Absolutely.

DR. CROSSON: Appreciate that.

Now, seeing no other individuals at the microphone, we are recessed until next month. Thank you so much.

[Whereupon, at 11:38 a.m., the meeting was adjourned.]