MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 7, 2013
11:19 a.m.

COMMISSIONERS PRESENT:
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AGENDA

Refining the hospital readmissions reduction program
- Jeff Stensland, Craig Lisk, David Glass 3

Public Comment 100

Competitively-determined plan contributions
- Scott Harrison, Julie 101

Effects of adherence to Part D-covered drugs on
Parts A and B spending
- Shinobu Suzuki, Joan Sokolovsky 150

Addressing Medicare payment differences across
settings: Ambulatory care services
- Ariel Winter, Dan Zabinski 193

Public Comment 252
MR. HACKBARTH: Okay. Good morning. Let me begin with an apology to people in the audience. Sorry for the delay in the beginning of the meeting. We had to redo the schedule yesterday based on the snowfall that never came, and for a while we were really concerned about getting Commissioners here for the meeting in time for the early start, and that is why we moved it back. But in the event, it proved unnecessary.

Our first item today -- oh, and by the way, we have no recommendations that we'll be considering today, no draft recommendations. We have made our final recommendations for this cycle. The next step in our process is the June report. But there will be no recommendations in that report on which we have not yet voted.

So the first item for today's meeting is refining the hospital readmissions program, and who is leading the way? Jeff, take it away.

DR. STENSLAND: All right. So last September we talked about the new hospital readmission reduction program, and today we'll discuss the status of that program and three
refinements that could possibly improve the program.

First, a bit of history. The Commission recommended a hospital readmission reduction policy in 2008, and that recommendation came out of a discussion of trying to increase providers' incentives to work across silos to improve quality and cost. And it was actually part of a package of recommendations, and this included a gain-sharing recommendation for physicians to work with hospitals, also a recommendation to test the concept of bundling where there would also be joint responsibility for the full cost of the 30-day episode, and the other part was this readmission penalty.

In the end, all three recommendations push hospitals to look beyond their doors and coordinate care with other providers.

A key motivation for the readmission penalty is that readmissions are a poor outcome for patients.

The second motivation is that they result in substantial amounts of unnecessary Medicare spending. A 10 percent reduction in readmission rates would save over $1 billion a year. And while it is feasible to reduce readmissions, there was little progress prior to 2008. And
hospital executives told us that everyone wants lower readmission rates, but it was difficult to place a priority on funding readmission reduction programs when there are competing needs for that money for other programs that could actually generate revenue rather than reduce your revenue. So the incentive was not there to direct funds toward reducing readmissions, and the new penalty has changed that.

Finally, before I get into the details of the readmission penalty, I want to point out that it can be complementary with other policies that exist out there. For example, imagine if you had an ACO run by a group practice. I would have an incentive to reduce readmissions, but it would want some cooperation from the hospital that is not necessarily in the ACO. Now this aligns their incentive because the hospital also has an incentive to commit resources to reducing readmissions.

And there is another Commission recommendation out there to have a penalty to reduce readmissions for the SNF, when a patient goes to a SNF and then is readmitted to the hospital. And if you have that penalty in effect, too, then you would have an alignment of all the incentives. The SNF would have an incentive, the hospital would have an
incentive, the physician group practice and the ACO incentive, and they could all be aligned to create better care for the patient and avoid those readmissions, which patients have clearly shown that they consider a poor outcome.

Now for some of the details of the policy. The current readmission reduction policy was enacted in 2010, so hospitals knew that their readmissions in 2010 and 2011 could result in penalties when the penalties started in 2013.

The penalty is initially based on three conditions: AMI, heart failure, and pneumonia. The policy will add at least four more conditions in 2015, including COPD, CABG, PTCA, and other vascular procedures. The Secretary, however, can add more conditions in 2015 if he or she thinks it's appropriate.

In 2013 -- that is, this year -- the average penalty is 0.3 percent of base inpatient hospital payments or roughly $125,000 on average for each hospital facing a penalty. The magnitude of the penalty is capped at 1 percent of operating payments in 2013, 2 percent in 2014, and 3 percent in 2015 and after.
The magnitude of the penalty has been large enough to capture the attention of hospitals. And hospitals have reported taking a broad number of initiatives to reduce readmissions.

For example, they're reducing complications that occur in hospitals, such as hospital-acquired infections. Second, they've identified patients at most risk for readmission and have targeted their efforts on that population, including patients who have been frequently readmitted in the past.

For these targeted patients, there are several efforts to reduce readmissions. There are transitional care models, Project RED, Project BOOST, for example. They all can provide patient education (such as teach-back) and self management; some schedule follow-up visits and medication reconciliation before discharge; others make follow-up calls or visits with the patients after discharge in their home. They can all lead to better communication between the physicians, post-acute providers, and the hospital.

The policy appears to be having some effect. Recall that hospitals had an incentive to reduce 2010 and 2011 readmissions after the policy was enacted. We examined
changes in risk-adjusted readmission rates from 2008 to 2011 using a 3M measure. We found a 0.7 percentage point drop in readmission rates by 2011. And last week, CMS reported that readmission rates fell further from 2011 to 2012 by a similar amount.

These declines coincide with a flurry of activity and anecdotal reports we hear from hospitals that they are able to reduce readmissions. Now, it may not be easy and the changes might not be dramatic, but it appears that they have started.

While the current program appears to be having an effect and should continue, there are some refinements that could make the program more equitable across hospitals. Specifically, we discuss refinements to address these four long-term issues with the current policy that I listed on this slide. The objective is to increase the incentive to reduce readmissions, continue the downward trajectory of readmission rates, and fix the computation of the penalty to be more equitable across hospitals and more equitable for the industry as a whole.

Now we will go through those four issues.

The first issue is random variation. The concern
is that small hospitals may be more subject to penalties due
to having greater random variation. Currently, to address
this problem, CMS shrinks the reported values toward the
national mean, as we discussed in your mailing. The problem
with this solution is that it reduces the incentive to
improve performance and can distort values that are
presented to the public.

One possible solution is to use an all-condition
measure. This would expand the number of observations and
reduce random variation.

We could continue to use three years of data.

And, finally, if some hospitals are still
concerned about receiving a penalty due to random variation,
we could allow the hospitals to report individually, but to
combine their performance within a system of hospitals for
purposes of computing the penalty. This would reduce random
variation and would also create peer pressure and create an
incentive to share best practices within their group which
is collectively generating a penalty or avoiding the
penalty.

This slide shows the increase in the numbers of
observations if we switched to an all-condition measure.
I suggest you look at the first row. This is the 10th percentile of PPS hospitals. They have 60 heart failure patients and 60 pneumonia patients on average over the three-year period. For hospitals with 60 cases, the expected number of readmissions is only about 10. So if random variation caused just two additional readmissions, this would shift the readmission rate by 20 percent, and this is just too much random variation. What CMS currently does to deal with this issue is a process of blending the hospital's actual readmission rate with the national average. This is also called "shrinking the score to the mean."

The problem with the current method is that for a small hospital, the vast majority of their score is based on the national mean, not their own performance. And any change they actually make in their readmission rates will not have a large effect on their score. So the danger is hospitals may start to think their own performance does not have much of an effect on their publicly reported readmission rate or their penalty, and that may lead to them being less willing to expend financial resources to reduce their readmissions.
A better solution than just adjusting everyone's score toward the mean is to use more observations. In this slide, we show that if we move to an all-condition measure with three years of data, the numbers of observations even at the 10th percentile would increase from roughly 60 heart failure cases to 1,170 discharges in the all-condition measure.

While two random readmissions could make a 20 percent difference in the rate when a hospital just has 60 admissions, it would only make a 1 percent shift in their readmission rate when we're looking at the full 1,170 readmissions.

So the first refinement we've talked about is moving to an all-condition measure with data collected over three years. This largely eliminates the small numbers problem, and the benefit is this reduces the need to shrink all values toward the mean that is currently done.

The second issue we'll talk about that could also be helped by moving to an all-condition measure is dealing with something called "the penalty multiplier," and Craig will now talk about that.

MR. LISK: Moving on to our second issue, the
computation of the readmission penalty, in this graphic we have algebraically simplified the penalty payment formula that appears in the law. The penalty is a function of two pieces shown in the boxes above.

The first box is the estimated cost of excess readmissions. For example, if you were expected to have 10 readmissions and you had 12, you have two extra readmissions on a risk-adjusted basis. If the base operating payment for that DRG at your hospital is $10,000, your excess cost of two excess readmissions is $20,000.

The second box is the penalty multiplier. This is set equal to one divided by the national readmission rate for the condition. For example, if the readmission rate is 20 percent, the multiplier is five. A multiplier greater than one makes the penalty larger than the revenue generated from the readmissions, creating a strong incentive to avoid readmissions. So in our example here, we said they have $20,000 in excess readmissions; their penalty would be $100,000.

Some would argue that a strong incentive is needed because the penalty only applies to three conditions. To get institutional change from a penalty that only applies to
a limited number of cases, the incentive will have to be large. The readmission penalty as currently constructed, though, creates two problems.

The first problem is that the penalty remains constant as the industry readmission rates improve. Second, the penalty multiplier differs for each condition. If the national readmission rate for a condition is 5 percent for one condition and 25 percent for another, the penalty will be five times as great for the condition with a 5 percent readmission rate. The multiplier will be 20 in that case.

Third, under the current policy, over half of all hospitals are always going to be penalized for each condition covered under the policy, as the penalty is calculated on a hospital’s performance relative to the average. And that continues to change over time. So what are some possible improvements to the policy to address these issues?

First, you can set a fixed readmission target that is set below the historical average readmission rate. You could set it at the 40th percentile of the current readmission rate distribution, for example. In this way
hospitals have a goal that, if they achieve it, they can avoid receiving a readmission penalty.

Second, you can set the penalty equal to Medicare's costs of excess readmissions over the target. This effectively is like setting the penalty multiplier to one for all excess readmissions across all -- for all types of conditions. So we don't have that differential between the different conditions anymore.

So let me demonstrate the problem with the current readmission penalty. In this chart we show hospitals sorted into readmission deciles based on 3M's potentially preventable readmission measure, which is the first column in this chart.

In the second column we show the average readmission penalty for hospitals under the current readmission policy, and as you can see, the average penalty is 0.31 percent of base PPS operating payments.

As you can see, the penalty also increases with each readmission decile, increasing from 0.02 percent in the first decile up to 0.73 percent in the 10th decile.

So what happens now, though, if all hospitals reduce their readmissions for the three conditions covered
by the readmission policy by 10 percent? Well, as you can see in the third column, even though all hospitals reduced their readmissions by 10 percent, they will continue to receive a penalty of roughly the same magnitude in aggregate -- 0.31 percent before the reduction and 0.30 percent after -- and this relationship holds across all the readmission deciles.

So now let's turn to see what happens under our potential refinement where we, as Jeff talked about, use an all-condition readmission measure. In this example, we are using 3M's potentially preventable readmission measure. Two, sets a prospective target at the 40th percentile of the potentially preventable readmission rate, which is 12.2 percent. That's noted by the arrow in the chart.

And, three, sets the penalty equal to the average base operating payments for potentially preventable readmissions that occur over the target.

What we see when we do this is that hospitals in the 1st through 4th deciles, looking at the second column, receive no penalty as their readmission rates are below the prospective target. Hospitals in the 5th through 10th
deciles will receive a penalty because their readmission rates are above the target. And the average penalty across all hospitals with a 1 percent penalty cap will be 0.48 percent.

But what happens, though, if readmission rates drop by 10 percent across all hospitals? This is what we show in the third column. If the readmissions decline by 10 percent, what you will see is that the average penalty falls to 0.21 percent. Hospitals in the 1st through 6th deciles now receive no penalty, and the penalty is now lower for hospitals in the 7th through 9th deciles. So with a prospective readmission target, penalties decline when readmission rates improve.

The principal objective of this refinement is to encourage hospitals to reduce readmissions so they can avoid receiving a readmission penalty.

In the last column, we show that the savings from reducing readmissions can result in larger savings than what is achieved through the penalty, 1.15 percent of base operating payments on average with a 10 percent decline in potentially preventable readmissions across all hospitals.

Moving on to our third issue, the third issue is
that hospitals serving poor patients tend to have higher readmission rates. This could be due to poor patients having fewer resources outside the hospital. To bring these readmission rates down, hospitals may have to expend more resources on these low-income patients.

Outcomes for minorities also differ. But the story is less clear. African Americans tend to have higher readmission rates, but also have lower mortality rates. The effect for other minority groups, however, can go in different directions. However, if we control for income, the effect of race on readmission rates is smaller.

Because we have this relationship between readmission rates and income, we find that the penalties under the current policy are higher for hospitals treating more low-income patients. There are two possible refinements to address this issue in the readmission policy.

First, you could add SES to the risk adjustment models used for determining readmissions. However, NQF, the Yale team that has worked on readmissions, and CMS have concluded that including SES status in the risk adjustment would end up hiding disparities in performance in the risk-adjusted values, which is not desirable.
A second option would be to leave SES out of the risk adjustment models, but in computing the penalties, compare hospitals to peer hospitals based on their level of SES. So in this refinement we are considering, we set the target readmission rate for each hospital equal to the 40th percentile for hospitals in their peer group, in this case based on its SSI deciles. We're using Supplemental Security Income deciles for Medicare patients.

No hospital that meets the peer group prospective target would get a penalty in this case, and the average penalty within each peer group would be approximately equal. If this approach were adopted, you would still report hospital readmission rates without adjusting for socioeconomic status.

So what happens if we make this refinement? The first column of this chart groups hospitals into deciles based on their share of Medicare beneficiaries on SSI. The actual SSI patient shares is shown here. The second column shows the average readmission penalty by decile under the current readmission policy. You will note that the average penalty rises steadily as SSI patient share increases, starting in the lower 20 -- 0.2
percent range up to 0.4 percent range at the top for patients with over 18 percent SSI share.

When we move to a system that compares hospitals against their peers, we show that the average penalty is close to average across the distribution, 0.49 percent at the bottom decile, from 0 to 3 percent readmission rate, up to 0.54 percent in the top decile -- all close to 0.5 across all the deciles. You can see it's very even there.

Now, if the readmissions decline by 10 percent, we see that the penalties within peer groups will also go down. Remember that under the current readmission policy, the average penalties really will not change with a reduction in readmissions.

So, with that, David will continue on to talk about mortality.

MR. GLASS: Thank you, Craig.

The fourth issue is that mortality and readmissions can be related, and an inverse relation raises concern that if readmissions are reduced, perhaps mortality goes up, although, of course, correlation does not imply causation.

There are two hypotheses on how an inverse
relation might happen.

Hypothesis 1 is that some hospitals may keep very ill patients alive, but after discharges those same patients tend to be readmitted more often. And there is the converse of that argument, that very high mortality leaves very few patients to be readmitted, but the positive form is the one usually suggested.

Hypothesis 2 is that some hospitals may just have more liberal admissions policies and they tend to admit more patients and readmit more patients and, because they admit less ill patients, have lower mortality.

This slide shows a simple example of each of those hypotheses.

At the top we compare a low-mortality and high-mortality hospital. They each see 100 patients and admit 10. In the first hospital only one patient dies; in the second two die. Hence, the lower mortality rate of 10 percent in the first and 20 percent in the second. However, perhaps that one patient who Hospital 1 saved is then readmitted. Then the first hospital has two readmissions and the second hospital has one with the resulting readmission rates. As the first hospital's mortality rate
goes down, its readmission rate goes up and there is an inverse relationship.

Under the competing hypothesis in the bottom example, the high admitting hospital admits 12 patients instead of 10 and readmits three instead of two. The same number die. The result is the high admitting hospital has a lower mortality rate and a higher readmission rate, again, an inverse relation. And we think as we look at the data we see some support for the second hypothesis.

The finding that has caused concern is that the CMS heart failure mortality measure has a high negative correlation with all three readmission measures used in the policy, which are CHF, AMI, and pneumonia. We find this, Yale found this, and other studies find this. The data are shown on page 24 of your mailing, and there is a statistically significant negative correlation of about 0.2 across the board.

The other two mortality measure, CHF and pneumonia, have either non-significant or much lower correlations with readmissions.

CMS heart failure mortality also has a significant negative correlation -- we found minus .25 -- with the 3M
readmission measure we have been using earlier. One explanation of this would be the second hypothesis we discussed: that CHF admissions may be more subjective and some hospitals simply admit more CHF cases, which drops their mortality rate, and then readmit them more often as well. AMI we expect would be less subjective, and it shows no significant correlation. And perhaps some of the clinicians could tell us about how subjective pneumonia might be; it has significant correlation with AMI and CHF readmissions but not with the all-condition measure.

So this topic clearly deserves more study and perhaps the development of a joint measure of mortality and readmissions. However, for our purpose today, we point out that when using a more inclusive mortality measure -- an AHRQ measure of mortality for five conditions, and the all-condition readmission measure -- the correlation diminishes and is no longer significant.

In other words, the penalty would not be targeted to low-mortality hospitals. This is another reason we think moving to an all-condition measure may be a useful refinement to the policy.

In summary, we find that the hospital readmission
reduction program which started last October appears to be working. It is creating some incentive to reduce readmissions which is better for beneficiaries and will save money for Medicare. As such it represents a major improvement.

However, we also find that there are four major issues in the current readmission policy that will need to be addressed in the longer term, and we have presented some refinements to address these issues.

Moving to an all-condition measure helps with the small numbers problem and makes it more possible to evaluate hospitals on their individual performance.

Decreasing penalties as the hospital industry as a whole reduces readmissions creates a better incentive for hospitals to work together to reduce readmissions and thus could result in greater program savings.

Creating peer groups based on low-income share and judging performance within those groups makes penalties similar across hospitals serving different SES groups and does not penalize hospitals that serve low-income patients disproportionately. And using an all-condition measure also limits issues regarding interactions between readmissions.
and mortality.

Finally, remember the goal is to reduce readmissions. These refinements increase the incentives for individual hospitals and the industry as a whole to reduce readmissions. And the savings from reducing readmissions to the program may be much larger than any penalty if the incentives created are strong enough to get real action to reduce readmissions from a large number of hospitals.

First, we note that almost all of the policy refinements discussed will require a change in law rather than an administrative action by CMS.

In your discussion, we would like you to consider if the refinements we have discussed are moving in the right direction.

Should the policy move to an all-condition measure? We have illustrated using the 3M potentially preventable measure, which is used by several states and private payers. Yale has developed an all-condition measure for CMS.

Is setting a target in advance a good idea? We have illustrated setting a target of having readmissions at the 40th percentile of the previous year's readmission rate
distribution. Is it reasonable to compare hospitals to their peer group rather than to all hospitals? We have illustrated peer groups based on the percentage of Medicare patients who receive SSI payments as a proxy for low-income, low SES patient share.

We look forward to your discussion and would be happy to answer any questions.

MR. HACKBARTH: Okay. Thank you. And thank you, Jeff, for your introductory comments, putting this discussion in the context of past MedPAC recommendations, including the initial recommendation to have a link between payment and readmission rates.

As I have watched the debate on this unfold, initially it seemed like a lot of the debate was how good are readmissions as a measure of hospital quality, and that was one of our reasons for being interested in this. As Jeff indicated in his comments, this is a bad result from a patient perspective.

But the other part of the rationale was to begin breaking down the silo of accountability, and the thinking that, "Oh, I'm only accountable for what happens within my
four walls," and actually get people to think about, "Oh, what happens when the patient leaves my institution?" That was a major goal of ours that at least was lost initially in some of the debate about this. I have seen it more prominently mentioned now in some of the more recent literature, and that is a good thing.

I had a clarifying question about the all-condition approach. My hunch would be that the likelihood of readmission varies by condition, that it is not evenly spread across all conditions. If that is true and we're using an all-condition measure, then a hospital's readmission rate will be influenced in part by their mix of cases. So that's just a reaction. Tell me what you think about that.

MR. LISK: The all-condition measures adjust for that, so you're already adjusting for the fact that the expected rate for someone with heart failure is 24 percent versus someone who has a hip or knee replacement is 10 percent, and the expected is relative to those. So it's all adjusted for within that.

MR. HACKBARTH: George, do you want to lead off with clarifying questions?
MR. GEORGE MILLER: Sure. Thank you.

The chapter was very well done. I really enjoyed the reading, and it certainly provided a good beginning for conversation, so I certainly want to applaud you on the work. And I think -- well, let me do a clarifying question first. I think we're going to in the right direction. I will say that.

I'm just wondering if in doing the analysis, did you go down in comparing and use the term "liberal hospital admission policies," did you look at different times of day, different times of the week for why some were readmitted? And did you look at the difference between hospitals if they employed the ER physicians versus if it was contracted? And then taking a little granular, at least at my place we know by the admissions who the ER physician was. So I don't know if you took that into consideration in doing some of the analysis, or did you just take a broad brush?

DR. STENSLAND: We haven't done that detailed analysis. We'll have to think about whether we can do it.

MR. GEORGE MILLER: Yes. Just curious. I'll come back for round two.

DR. NERENZ: Thank you. I definitely think this
is moving in the right direction. I commend you for the steps. We'll get to that later in the second round.

Two clarifying questions.

First of all, in Slide 15, I was quite surprised in comparing the second and third column. It seemed like in spirit this issue of comparing to peer groups is designed to relieve what Column 2 seems to indicate is, I'll call it, an unfair burden on hospitals serving high proportion. But my interpretation, if I'm correct, is that everybody's worse off in the adjusted model. All those Column 3 numbers are higher than the corresponding Column 2 numbers. How can that be?

MR. LISK: We didn't set it in terms of being absolutely budget neutral here in terms of -- we just picked off 40th percentile and what would happen here. We could adjust it to be the same amount, but what we did here is just set it at the 40th percentile, as an example. So we could have done some other maturations to get it to be the same, but the principle of that number in the middle, if we lowered it down to where the average penalty was 0.31, it would be similar to that.

But, remember, the penalties -- it's actually
going to end up expanding, the cost is going to end up expanding, too. So --

MR. GLASS: There are two competing things going on. Since we're doing all conditions, that raises the penalty. The other lever you can pull is do you go with 40 percent, 50 percent, 60 percent? If you change that, then you can make the average whatever you want, in other words.

DR. NERENZ: Okay, that --

MR. GLASS: So you can change -- this is just illustrative.

DR. NERENZ: Okay. That helps. Because, clearly, the point that seems to be what this was designed to do is to have those numbers in Column 3 be very much alike. I appreciate that.

MR. LISK: Yes.

MR. GLASS: Yes.

DR. NERENZ: The fact that they're all higher than number 2 surprised me a great deal.

MR. GLASS: Right, that's because we're doing all conditions, and we set it at the 40th percentile rather than the 50th percentile.

DR. NERENZ: Fine. Okay. So that would not
necessarily be --

DR. MARK MILLER: Just one more pass at this for you and for also the public. What David was saying there and Craig was saying there at the end is the calibration here can be set to whatever you need to hit. So if it's budget neutral, you can make the bottom-line numbers equal. This was just all-condition and 40 percent.

DR. STENSLAND: And I think when CBO would go to score something like this, they would have a baseline, and their baseline would say, What do we expect readmissions to do over the next 10 years? And if they expect readmissions to go down, say, by 10 percent over the next 10 years, then we're in the last column by the time it's 10 -- and then we have a lower penalty. If they expect readmissions to be just flat, then we'd actually have a higher penalty under this. But I suspect they would expect some decline in readmissions since we've already seen some decline. And the way this is set up now, I wouldn't be surprised if that 40th percentile target would be about budget neutral, because it's basically saying, well, if things stay constant, you would pay a little more; if things actually get better, you're going to pay less; and we're not sure how much
they're going to get better. So actual expected penalty is probably somewhere between the third column and the fourth column. It's not just the third column. Does that make sense?

DR. NERENZ: Okay. Thank you. That helps.

The second question. This would now go to Slides 4 and 5. On Slide 4 you've listed a number of things that hospitals are doing, and actually on page 4 in the chapter, you've got a few more. All of these things cost money. They take time, they take resources. And as I understand the program, there are no new resources built into this, so these are resources taken from somewhere else. The question is: Do we know anything now about the costs of these activities? And then as I extend into Slide 5, this does report some smallish positive effect, but I'm wondering if there is now the ability to compare cost and benefit, and particularly to do some comparative analysis to see whether is this the best possible use of the resources that are being devoted to this as opposed to, for example, pressure ulcer prevention, sepsis prevention, and other kinds of things, because, you know, it's kind of zero sum in terms of time and budget available within the hospital. Do we know
any of this?

MR. GLASS: Well, reducing the complication is one of the things we listed, I think, which would be the --

DR. NERENZ: Well, then another question. Do we know how much variance in the readmission rate comes through that pathway?

MR. GLASS: No, I don't think so. No.

DR. STENSLAND: I think that's a good thing for us to look into, what is the cost, and the cost isn't directly paid for in any way directly. But that cost is computed into the overall hospital cost, and so when the payment adequacy discussion comes up every year, that could be factored into that discussion, because it will affect the overall cost and the overall margins.

DR. NERENZ: Yeah, I think I'm a little more interested just in what the tradeoffs are within the hospital. I'm just curious what we know about that.

MR. HACKBARTH: And, Dave, I think you're raising an important question on this issue. This is one of the reasons why I hope the ultimate estimation here is to move to bundling of payments. And there what you've done is you now have a larger pool of resources that can be reallocated
and used to high-priority, high-value purposes as opposed to
this more narrow approach. And, again, that goes back to
the context that Jeff mentioned at the outset.

When we first looked at this, we looked at
bundling and said, you know, that has a lot of appeal to it,
but it's not going to happen overnight, and it's going to
take some time to work out how to best design it. And what
can we do in the shorter term that will help address the
issue of readmissions, but ultimately could be supplanted by
bundling and a more flexible approach?

DR. NAYLOR: Just building a little bit on Dave's
comment, you know, this program does co-exist with multiple
investments, huge investments being made in care
transitions, in hospital innovations and health care
innovations. And so you can never disentangle how much the
effects of the policy changes are from the multiplier of
programs relative to this. I think contextually that's
important to comment on because once those resources go
away, it'll be really important to monitor what we're
seeing.

But the two questions I have are around the
relationship between mortality and readmissions, and I
understood the recent work showing weak associations between mortality and readmissions, certainly for AMI and pneumonia, and only a weak association between heart failure. And so that's -- it's a paper you cited, Krumholz in JAMA, and so I'm wondering, because whether or not other possible measures that seem to be connected with readmissions -- and, obviously, you're highlighting one of them, SES, but symptoms and functional status were considered as possible -- so I guess my first question is, you know, Is the evidence really clear about this association between readmissions and mortality given the most recent data?

MR. GLASS: We think it is for CHF, for heart failure. On page 24 of the mailing materials, we have a little table showing it.

DR. NAYLOR: So does it depend on the measure? I mean --

MR. GLASS: Well, yeah, I mean, there does seem to be something there for that one particular thing, and, you know, if the clinicians could tell us, is that somehow more subjective? Is there more leeway in deciding on --

DR. MARK MILLER: Dave, this is the way I would say it. When this first relationship hit the literature and
kind of people started talking about it, it was, I think, exclusively predicated on what was observed for CHF. And so then there was sort of this prevailing view: readmissions and mortality move in a different direction. 

When you look at other conditions, as you're zeroing right in on, it doesn't hold.

And then the last thing I would say is we've raised some questions -- and maybe some other folks, but I know internally we've been talking about this. Is this a mortality readmission tradeoff or are both of these results kind of governed by an admission pattern? And that -- DR. NAYLOR: Right. I mean, Krumholz's work shows that there's this group of people for whom there is poor performance on mortality and poor performance on readmissions. So I was just wondering whether or not the science has evolved to really challenge us, those associations.

Lastly, frailty. Did you consider beyond SES given the real challenges of people that are coming in with heart failure plus cognitive impairment plus functional deficits who are high utilizers, whether or not that, as we think about refinement, should be also a consideration?
MR. LISK: I mean, to the extent that within the -
both all-condition readmission measures there are CCs that
kind of get at people with a couple co-morbid -- multiple
co-morbid conditions or a higher level of patient severity
which would probably take those into account. So in the 3M,
it's four levels of severity so those patients would be in a
higher category with a higher expected readmission rate, for
example, because of those factors. So the risk adjustment
kind of tries to get at those issues. Whether it gets at it
perfectly or not, you know, that's debatable.

DR. MARK MILLER: But the very direct, if I
understood your question, is what about things like
functional status.

DR. NAYLOR: Exactly. I mean, I think Joan Teno's
recent piece about frailty distinct from multiple chronic
co-morbid conditions and the kind of way -- and functional
status is -- I mean, I think it's a two to three times
higher readmission rate for those with frailty relatives.

DR. MARK MILLER: And what I wanted to answer very
directly is I don't think those have entered into the
adjustment factors in what we're talking about here, and I
want to be a little bit careful about this comment. I think
in the bundling discussions, we are working on some stuff in that direction.

MR. LISK: We are.

DR. MARK MILLER: So we may have something to say about that down the road.

DR. NAYLOR: Okay. Thank you.

MR. HACKBARTH: Let me just pick up on Mary's question. I think this is important. And just to be clear, I'm sympathetic to the idea of using a comparison group based on SES. Certainly the goal here is not to handicap, harm institutions that care for a disproportionate number of low-income people. But it really isn't what we're trying to adjust for. We don't think the meaningful factor is income. We think that's correlated with other things that may affect readmission rates. And is this the best correlate to use? So another might be geography, you know, even down to the zip code level, that might signify the sort of community resources that exist.

Mary is going in still another direction, you know, patient-specific characteristics that may contribute to readmissions. Could you just talk a little bit about why this
correlate and why not some other correlates, or even more
direct measures of things associated with readmissions?

MR. LISK: Well, frailty, for instance, we don't
have any measure for every patient that comes out of the
hospital. So the only thing we have, if you want to take
that type of information, is from -- if they went to a post-
acute care provider, you might be able to capture something
there, but we don't have it for every patient who leaves the
hospital. So that's a major reason for not being able to
deal with that one.

In terms of the geography thing, that's another
approach that's different than what we've done with using
the SSI. But we do see a pretty strong relationship with
the SSI as a measure, and that is measuring the poorer
folks. And in terms of the resources for those folks -- and
a lot of other studies have talked about what difficulties
poorer folks have in communities. But you're right about in
terms of certain community resources. So some communities
may have Meals on Wheels that help make sure that those
patients have good food and nutrition; whereas, in other
places they may not have it, and those patients may suffer
and not have good food and are more likely to get
readmitted, for instance. So some of that is those community resources that differ.

DR. MARK MILLER: You have to be careful there too because if you just take geography, depending on what level, you can be capturing practice patterns which may be higher readmission rates, and then in turn you'd be adjusting them downward for those reasons. And so all of these get pretty messy pretty quickly.

MR. GRADISON: I've got a couple of technical questions. I'll reserve some policy questions for later. First, an observation. I think this is kind of curious. My understanding is that a readmission counts as an admission and, therefore, that in the computation of the readmission rate, the more readmissions you have, the lower rate you're looking at next year. Is that -- it's minor, but I just want to make sure I understand that correctly.

MR. LISK: It depends upon the readmission measure you're using, and I -- it depends upon the readmission measure you're using here. In terms of the current --

MR. GRADISON: Well, the current policy.

MR. LISK: In terms of the current policy, in terms of how the formula actually works, the readmissions do
count towards the count of cases, but it doesn't reduce your
readmission rate because the readmissions are not counted in
the readmission rate. So it's initial admissions without a
readmission that are considered in calculating the
readmission rate.

MR. GRADISON: Okay. Thank you.

One other point. This goes to -- on page 5, towards the bottom, we're talking about the importance of
the readmission penalty having to be larger than the sum of
the marginal profit the hospital gets from additional
Medicare readmissions. That's true. But I think there's
another element that goes into this, and that's, in effect,
the incremental costs incurred by the hospital in trying to
reduce its readmission rate, and I think you might want to
take a look at that, because my sense of how this would
actually work over time is that the incremental cost of the
reduction or trying to reduce readmission rates would
steadily rise over time in the sense that you do the easier
things first, and the least expensive things. And I'll come
back to that later from a policy point of view.

I do want to ask a question, and it comes to
points made on page 10 about the VA hospitals and the
critical access hospitals. Do you have any information on readmission experience in those two groups of hospitals that are otherwise excluded here?

DR. STENSLAND: So the critical access hospitals are excluded in two different ways. The one way is they're not subject to the penalty, and their readmission rates are roughly similar -- you know, some studies say a little below, some studies say a little above, but it's on average about similar.

The other thing that is a little bit of a quirk in the policy and we're not quite sure why it is in there is if someone is at a PPS hospital, say in the big city, they get discharged and go back to their home in their small town, and then they get readmitted to the critical access hospital, that readmission to the critical access hospital doesn't count against the PPS hospital's readmission rate.

MR. GRADISON: And, by the way, how about the reverse? What if the -- I couldn't figure that our from the paper.

DR. STENSLAND: If they go from the --

MR. GRADISON: Critical access hospital to a PPS hospital.
DR. STENSLAND: It would count as a readmission for the critical access hospital, but the critical access hospital doesn't suffer any penalty. There's no penalty there for it.

MR. GRADISON: Okay. So the second admitting hospital isn't dinged for it.

DR. STENSLAND: Right. It would be publicly reported, but --

MR. GRADISON: And how about numbers on the VA? Do we have any information on readmissions?

DR. STENSLAND: No. It might be out there. I'm not aware of it.

MR. GRADISON: Okay. Thank you.

DR. MARK MILLER: Jeff, when you answered the CAH question, those are readmission rates without the shrinkage adjuster in there or with, when you were saying they were about average?

DR. STENSLAND: They're about average without the shrinking.

MR. GRADISON: This is a policy issue, not a number issue, but I would think there would be ways to bring the critical access hospitals under this, even though
they're not paid in the same way. Okay. We can do that later. Thank you.

MR. KUHN: On Slide 14 you made the observation that both CMS and Yale indicate that the SES risk adjustment model might hide disparities, and I'd like to kind of understand that a little bit more. And the reason I'm curious about that is I guess in the last couple of days, the New England Journal of Medicine published a perspective piece that talked about the readmission policy. And one of the observations the authors made is that there is growing evidence that those safety net as well as large teaching hospitals tend to be more highly penalized than other hospitals, and they reflect on that that it's probably because they have a larger proportion of complex patients as well as the SES issues as a result of that.

So if the evidence is showing us this kind of directionally, give me a little understanding kind of on their policy rationale why they discounted this.

DR. STENSLAND: Why they would discount it [off microphone]?

MR. KUHN: Right.

DR. STENSLAND: Well, there would be a concern
that what if there is, say, different resources in the poor communities or different resources in communities with high shares of African American populations, and those different resources are really adversely affecting the care people receive and they are resulting in higher readmission rates. If we put those variables into the regression model, the regression model would come out with results showing, oh, the readmission rates are equal, and people wouldn't even know that there are these differences that are associated with these disparities maybe in income or community resources. And so this approach would say, well, let's leave those, at least those income variables out of the model and run the model so we're aware that there are these differences maybe in resources and the effective readmission rates; but then not take away the money from these places that happen just to have high readmission rates just because they treat a lot of poor folks by adjusting the penalty formula. So you can kind of do it in two different ways: either adjust it up front, and then it's kind of adjusted deep inside the black box and you never know really what's happening with those poor communities; or let's take a look at what's happening with the poor communities, but not
penalize them more than the wealthier communities if they have the higher readmission rates.

MR. GLASS: So from the beneficiary perspective, the beneficiary might like to know that Hospital A has a much higher readmission rate than Hospital B. Whatever the reason, they might like to know that when they're choosing a hospital. So you don't necessarily want to hide it.

And also, there's this feeling that you're kind of just tolerating higher readmission rates for poor patients if you put it in the risk adjustment --

MR. KUHN: Yeah, and of course, that makes that the assumption that all these communities are homogeneous, but I understand that argument as part of that.

MR. HACKBARTH: Yeah, so, Herb, the piece you're referring to is the joint and jaw piece that appeared this week --

MR. KUHN: Yeah.

MR. HACKBARTH: When I read that, it wasn't clear to me how they might react to this approach as opposed to putting it in the formula using a comparison group approach. Do you have any insight on it?

DR. STENSLAND: I think they would be open to this
approach as being a reasonable way to address that problem, because in that article they specifically showed our tables using these SES deciles. So their illustration of this problem uses our approach of the 10 SSI deciles.

MR. KUHN: Yeah, and the real key here is, you know, how do you make sure that you have equity in the system and then make sure you're not pulling resources out of these communities that desperately need them, because then it becomes a self-fulfilling prophecy. You just get worse as part of the process. And I think that's an observation you made earlier, Glenn, as well.

MR. HACKBARTH: Yeah, and the way I interpret this approach is that what we're trying to do is achieve that policy goal while also not depriving the patient potentially of information that he or she might find useful. So it's agree with the goal, but just take a little different tack on it.

MR. KUHN: And one other quick question. Also in their piece, they made the observation that the number of hospitals penalized are much higher than the original models predicted. Do you know why they made that particular statement? Or are we seeing data that supports that? They
just kind of made that statement, but I just wasn't aware where it came from.

DR. MARK MILLER: I read that this morning, too, and I got to tell you, I mean, I read through it, and most everything that I read I followed. That point was a little confusing to me because they refer to this 5 percent outlier number. And what I would suggest here is let us look at it before we pop off in public on what we think they might have meant. But I remember hitting that point in the article and going, "I don't understand why this is being said." So if we could, unless somebody's got it wired, I would suggest we come back on it.

DR. COOMBS: So thank you very much, Herb. I was thinking along the same lines, especially dealing with the fact that, you know, the disproportionate hospitals may have a greater challenge in terms of being able to meet certain fiscal benchmarks, and then there's the burden of the excess penalty that is superimposed on that.

One of the questions I had was, is there any kind of analysis on the number of beds per -- hospital beds per given area, correlating that with penalty? Because I think that's another issue, because if you look at the table on
Page 13, Table 3, and you're looking for consistency, and I noticed you guys had some -- grasp with the correlation was very weak.

I'm wondering if there's another confounding variable that lends itself to a better understanding with the readmission rates in the sense that if you're in an area, you might not necessarily be in a rural area. You might be in an area where the density of hospital beds are much lower and it's not necessarily rural, but it may -- you know, like in inner New York there's a lot of crowding of hospitals in a small amount of area, and if that's been shown to have an impact on readmission rates.

MR. GLASS: I think there is something on occupancy, isn't there, Jeff, some relation? I notice that there's a lot of hospital beds available. I think that admissions rate and readmission rate goes up.

DR. MARK MILLER: The table you're referring to is in the paper?

DR. COOMBS: Yes, I'm sorry.

DR. MARK MILLER: Okay. No, I just want to make sure what we're looking at. So it's Table 4 in the paper?

DR. COOMBS: Page 13, Table 3.
MR. GLASS: Probably hospital group, the table by hospital group.

DR. STENSLAND: We can look at that, but there is some literature showing areas with high admission rates, initial admission rates also have higher readmission rates, suggesting there's some practice patterns, and you see that, that certain cities tend to have higher readmission rates than other cities. People out west tend to have lower readmission rates where they generally tend to admit less, and sometimes out east in some other cities where they tend to admit more have higher admission rates and readmission rates.

DR. COOMBS: And one last question and that was, we haven't talked about this and maybe it's something that's obvious, just the piece about Visiting Nurse Association support. Are there any phases where someone had brushed with an intermediate care facility with some of these readmissions? So say, for instance, if someone has a short stint leaving the hospital and then they bounce back, say two weeks after being at home.

DR. STENSLAND: I didn't.

DR. MARK MILLER: Give us another pass at it. I
Dr. Coombs: I was just speaking of a patient that we had in the ICU. Someone goes home immediately from the hospital or maybe they go to a short-term rehab facility, and then they go home. You know, the pressure is for length of stay to be squashed considerably, and the natural inclination would be that maybe there's some of those patients that fall through the crack because we're pressured to actually get to this optimal length of stay, and those patients may have a short stint at an intermediate care facility as well.

And so, that those numbers may result in a readmission in a short period of time, and I'm wondering if that's something that has been teased out. Or if, maybe, less of those patients who are being readmitted actually go straight home and they're not quite necessarily ready to be at home. And if they're bouncing back for reasons that could have been actually handled at home.

Dr. Mark Miller: So I'm taking your question as do you see any variation in readmission rates depending on what the first site of care is following the hospital? That's your question? Okay. Now, I don't recall us looking
at it that way, but...

DR. STENSLAND: No, we didn't. And if that's the question, we don't have any information. If your question is, is there a connection between length of stay and readmission rates?

DR. COOMBS: Not only that, but is there an intermediary help system for that patient? Because that's really huge, isn't it, in terms of revision?

DR. STENSLAND: I don't think -- Mary could probably discuss the intermediary help system much better than we could and how that reduces readmission rates, so maybe I'll wait for her to go around.

DR. COOMBS: Well, see, my question was, if we actually looked at that, if that's one of the pieces that we actually looked at.

DR. STENSLAND: Just through the literature which often does show some benefit, and a lot of those programs we've discussed have some system. Mary's system, other people's systems of either getting that initial visit as soon as they leave the hospital, someone going actually out to their home to help coordinate their care and smooth the transitions.
There is a fair number of studies that have some moderate success with that, and I'm already feeling like I'm stretching too far into Mary's territory, so I'm just going to be quiet.

DR. HOADLEY: Yeah, I had two questions. One is, do observation stays count either when you're looking at admissions or at readmissions?

MR. LISK: No.

DR. HOADLEY: And is there any -- been any look at whether there's anything going on that could be greater use of observation stays in order to avoid a readmission or anything like that?

MR. LISK: I mean, there is an incentive here in the policy to use observation stays to potentially avoid an initial admission that potentially could end up with a readmission, or as -- if the person's admitted, to use it to avoid the readmission when the person comes back to the hospital.

DR. HOADLEY: Right.

MR. LISK: So there is an incentive in here, but that's not part of the policy as it currently stands.

DR. HOADLEY: Is there any way to look at that
analytically?

MR. LISK: Yeah. We have not directly looked at that, but that is actually something that could be examined. It's a little more complicated because then we have to go from Part A to Part B bills and stuff like that.

DR. HOADLEY: And my second question, the use of three years of data. I assume that was done, you know, to a great extent to get more into the mix. If you go to the all-condition measure, first of all, is there any concern that three years kind of mutes the ability to see the response, and if you go to the all-condition measure, is there any ability -- does it seem reasonable to reduce that amount of time, or is that a dynamic that's worth thinking about?

DR. STENSLAND: I think that's kind of a judgment call. When you look at, okay, you know, what is the variation with these different numbers of observations? I really think you need the three years. Some other people would think no, maybe we can take more variation and just do one year. I think in some of the Yale work on the new all-cause measure they've had, they've just used one year, but then they continue to use that round of effects model which
shrinks everything to the middle which has some issues. So there's some various trade-offs there.

One possibility, if people really -- the incentive is really, I think, the same because you know that if you reduce your readmissions in 2013, you know you're going to have a lower penalty or no penalty for three straight years. So you still have that same incentive. Some people would like it to be closer so that if you get -- things change now, it affects your results right away. That is a trade-off.

Maybe if you wanted to get more complex, you could have a more complex policy where you said, for smaller hospitals, you need three years. If you're really big and you have 10,000 admissions per year, maybe you can have one year of data.

DR. HOADLEY: One way of looking at that trade-off is, do you want to shrink towards your hospital's mean over three years or do you want to shrink toward the national mean over one?

DR. SAMITT: Great job on the chapters. Thank you. Two quick questions. Page 15. What struck me was the last column on the right, and even under the new system with
the 10 percent reduction, there's this phenomenon for the share of beneficiaries all the way in the lower right. So what's going on there? It looks like there is a much greater increase in penalty, even with these modifications, when the SES is significantly higher.

MR. LISK: I think that may be a function of that distribution where you have the over 18, and even the 13 to 18 is a highly skewed distribution. So we're looking to the average within that distribution because of the skewness. I think that may be part of what's going on.

You know, we've done it by deciles. You probably could have some sort of continuous adjustment instead of the deciles or something like that that might mitigate that some. But like this decile group, because then you have a clearer picture of where you stand, but I think it may be that skewness of the distribution that's contributing to that.

DR. SAMITT: Because ideally a solution would solve that as well so that there isn't inequity there.

MR. LISK: It's -- it's substantially reduced in terms of the difference from what is under current policy.

DR. SAMITT: Okay. My second issue is about the
all-condition readmissions. I certainly understand why it's being recommended where we're trying to solve a couple problems. I guess my question is, does it cause new problems when we shift to an all-conditions measure? You know, the current policy using three conditions is a much more typical common admission, a more typical condition.

If we move to all conditions, would we see a greater skew that creates greater penalty for academic medical centers or organizations that would attract higher complexity illness for less common conditions that would face readmission? So I don't know if you've looked at that. I just wouldn't want us to come back and say, All right, we solved some problems by doing this, but we've created new ones.

MR. GLASS: Well, I guess it's a question of whether the risk adjustment picks it up or not, and that's hard to determine.

DR. SAMITT: Okay.

MR. GLASS: Presumably if it's risk adjusted, if you have the much more risky patients to begin with, that is taken into account. But whether it completely does that or not, I'm not sure.
MR. HACKBARTH: Mike.

DR. CHERNEW: So that leads into my first question which is, in the materials you mention that the risk adjuster is based on HCC categories. Do they do that separately for the three conditions? Are those three separate risk adjustment models that they're running? And do we think when we move to the all-cause measure, or even with the ones that we have, that the risk adjuster will be good enough to address what we'd like it to address?

MR. GLASS: Which one? There are two models?

MR. LISK: Well, actually, the current -- yes, the current models are separate for pneumonia, heart failure, and AMI.

DR. CHERNEW: But when you move to the all-cause, you're not going to run them separately for all cause, I assume?

MR. LISK: No, actually in terms of -- we can get down to the details of what Yale does versus 3M. I don't know if we want to get to it here, but they do do some -- they define it in for, let's say, for Yale into five categories; for 3M, we're looking within DRG specific.

DR. CHERNEW: The real question was whether we're
comfortable with the risk adjuster as we move to a broader
set of conditions. And I see some basic nods, so that's a
yes, for the record.

DR. STENSLAND: I think we're basically
comfortable, but that's not to say it couldn't be improved.

DR. CHERNEW: I think understanding where we think
the errors in the risk adjustment might be could be
important, like academic medical centers and things.

The second question just simply is, is the
mortality a 30-day mortality rate?

MR. GLASS: Yes.

MR. LISK: Yes.

DR. BAICKER: My questions follow up on the ones
that Herb and Craig brought up about using the SES or SSI-
based cohorts as a benchmark for evaluating, and I
understand the motivation to not want to punish facilities
that are serving more complicated, more expensive patients
that happens to be correlated with income and race.

You mentioned in the slides that controlling for
SES or controlling for income still leaves a race residual.

First question is, does controlling for SSI still leave a
race residual? Is SSI just a better measure of income than
income? Or do the same issues persist there?

MR. LISK: We're using SSI as our measure of income.

DR. BAICKER: As income, okay.

MR. LISK: It's our measure of income.

DR. BAICKER: So it's not that you have a continuous measure and you're using a poverty binary.

MR. LISK: And really, for the highest -- that looks like the highest decile of hospitals treating African-Americans, that's where we still see an affect. But if you look at it without SES, you see kind of a continuous affect. When you control for SSI --

DR. BAICKER: By SES, you mean SSI?

MR. LISK: SSI, yes. It flattens out, but you still have a spike up for the highest, the hospitals with the highest share of African-Americans. So that's hospitals with over a 30 percent share, for instance.

DR. BAICKER: So part of my motivation in asking that question was that I understood the dueling concerns about not wanting to punish providers that were treating more complicated patients or more expensive patients with higher readmissions, et cetera. And on the other hand, not
wanting to say that it's okay if those groups have worse outcomes.

I wonder if this control -- comparing within SSI deciles, to me, seems like it has all the same problems, just slightly obscured in that comparing within SSI, deciles is really just a different functional form from throwing in SSI as a control, and maybe it works better as a functional form or maybe it works worse, but it has the same issues embedded in terms of that.

Is it okay for these SSI -- you know, higher SSI deciles to have worse outcomes -- we're just not penalizing them for it -- versus saying, we want to be sure that we're not masking this to the public.

So I'm trying to understand whether you think conceptually there's any difference between looking at SSI deciles versus controlling in some flexible, functional form for SSI, and whether the same solutions in terms of one set of reporting to people that doesn't mask this versus another set of calculations for penalties might apply to more flexible, functional forms for controls as opposed to just the deciles. That was a complicated question.

DR. MARK MILLER: No, no, but I followed it, and
what I would say is that, you know, for the first half of your question -- and what I'm going to do is, there's a measurement in the methods question, and then there's a policy question. I would say what has been put together here is decidedly a different policy.

On the methods sense, I could interpret what you're saying as, Look, you can either methodologically adjust it as part of your risk adjustment, or you can do these cohorts, but either way you're sort of giving them a buy. And up to that point, I completely agree, and I think we all agree. A nod would be appreciated.

But the second part of it that I would say is -- and, you know, there's the hiding thing which you were tracking on, so I know you're all over that. But what I think is important about the cohort approach is, when you put it in a cohort, what you will find is that there are some people with lots of poor folks who don't have high readmission rates, and you're saying you're going to be judged against those.

So from a policy perspective, there's still some force on that hospital to say, I need to clean up my act if I'm way out on the right-hand tail of this group.
DR. BAICKER: Wouldn't the exact same statement be true if you were controlling for SSI? I just am trying to —

DR. MARK MILLER: I think you end up without a penalty.

DR. BAICKER: It's a different functional form.

DR. CHERNEW: Exactly. I think the question is what your penalty is relative versus what you're being reported as, and the cohort approach —

DR. MARK MILLER: Take it over, Mike.

DR. CHERNEW: No, I'm just going to get it wrong. I think the cohort approach was designed to have the penalties reflective of the SES, but not mask your admission rate when you report it to the public. So if you were to adjust it and report an adjusted admission rate, the reporting number to the public would be adjusted.

But if you don't adjust for it and just — we're trying to do just the -- I would say, they're trying to adjust the penalty, but not the actual adjusted number, if that makes sense.

DR. BAICKER: So then just to -- I want to make sure that I understand the methodological niceties. It
seems like what you're trying to achieve is having two
different things reportable, two different outputs, one that
does not, you know, mask these differences for reporting to
the public, and the other that takes them into account when
doing the penalty calculation.

I understand that distinction. I would think you
could make that distinction in lots of different functional
forms that you're using and that there's nothing magic about
this cohort method as opposed to other controls where you
could report partially adjusted outcomes with or without
that adjuster taken into account.

So that it's not -- it's just a functional form
difference. We're not changing anything fundamental.

DR. MARK MILLER: I understand, but if you put a
functional form into, you know, the regression work that
ultimately goes into the reported readmission rate, I still
think what you would be saying is, Here's your full
unadjusted readmission rate. I put some functional form in.
Here's your adjusted one. And that would be less than --
otherwise it has no effect -- what your raw readmission --
and, of course, none of it is raw, it's risk-adjusted --

DR. BAICKER: Sure, sure.
DR. MARK MILLER: -- but not for income. And it would still kind of bring that number down and, in a sense, say, Some of this difference is going to not be reported. DR. BAICKER: I think we're saying the same thing. I just want to be clear that in reporting those two different numbers or in using those two different numbers, one that adjusts and one that doesn't, that's the way we're handling this sticky-wicket of differences by SES, whether it's measured by SSI or any other variable. It's that difference in reporting that's the way we're handling it, not the fact that we're looking in cohorts, because looking in cohorts versus putting in controls, it's all the same. DR. STENSLAND: I think there is a difference because you can do it two different ways. You're saying, Well, let's just put it in there and run two different regressions, basically. DR. BAICKER: Or run one regression, but report results that are either partially -- that are either fully adjusted for the model or only adjusted for the parts we want. DR. STENSLAND: Yeah, but you're basically then, because we want to publicly report the one that doesn't have
the SES adjustment in there, that would be one review models of outcomes. The other model is when it's in there, you'd have a different outcome. So I think that is one difference.

The way we're doing it, there's really only one number out there, because we're coming up with, this is your readmission rate and you're compared to this cohort of people, but you only have one number. So I think if we ran two different models or a model with and without SES, then you have two different numbers floating out there which could create some --

DR. BAICKER: Although the two different numbers are really just the one number and the difference between that and your cohort, in essence. So there's still two things going on. There's you and there's your cohort that adjusts for everything within that bin.

I just don't want it -- I just don't want us to be misled about -- not misled. But what I want is to be clear on what it is that we're doing in terms of whether we think it's okay to take these variables into account or not.

DR. MARK MILLER: And with some real license in going through the detail here, I think I agree with you that
you adjust inside the model, you do this cohort thing up to that point. Yeah, that's the same thing. You're sort of giving consideration to a hospital that has a bunch of poor folks. Up to that point, I completely agree with you. I think that the two places where we feel that it's different -- and for the record, our policy is magic. I want to be clear on that point.

DR. BAICKER: Excellent. Withdraw my question.

DR. MARK MILLER: Yeah, right, because that's all I've got at this point.

[Laughter.]

DR. MARK MILLER: -- is the transparency of the number and, you know, whether it's one or two, whatever the case, and the continued pressure to change if you end up -- you know, the penalty of somebody with very few poor people may be bigger than the penalty for hospitals that have a lot of poor people. But within here, we still think there's some pressure to change their behavior. That, we think, is fundamentally different about the policy, not the measure.

DR. BAICKER: And that's where I feel -- and I'll stop with this iteration and we can talk about it more off-line. But I'm with you on the first part, that it may be
easier to interpret this way and to have the one number where there's this difference in going on sort of in the background from the cohort, rather than two numbers might be more transparent. I'm with you there. But then the second part of your statement made it sound like there was a more substantive difference in terms of the pressure that was exerted, and there's where I don't see the difference. But I would think that there's -- if you're taking your SSI share into account in a regression framework as opposed to in these cohorts, you're still competing against others who have the same SSI share. It's holding SSI share constant. That's the whole point of putting it in the regression. So I would think that the fiscal pressures would be similar, but that -- I have no problem with this in terms of transparency and if it's an easier way to report it and calculate it, great. But let's not think that we're adding extra pressure throughout the distribution. Then we would be with an equivalent adjustment model.

DR. CHERNEW: Right. Can I just say, I think there are probably other ways to try and accomplish the same goals that are worth discussing. I think the cohort
approach is a simple way to try and accomplish things that
don't get accomplished by the simple functional forms they
use.

So when you open up the set of things you could
do, we probably could address it in other ways. There are
other problems with the cohort approach. You create seam
effects and other types of things that go on. So it's worth
discussing, but if you compare it to the existing way of
just sticking to the model linearly, then you don't have the
right functional form that we were trying to address.

MR. HACKBARTH: Peter.

MR. BUTLER: I'm not that anxious. This kind of
broadly fits into the pay-for-performance category except
it's don't pay for poor performance, as opposed to pay for
performance. I do get a little bit of a headache thinking
we have value-based purchasing blossoming, we have a
hospital-acquired condition, we have meaningful use turning
from carrots to sticks, all of which, by the way, are likely
to have some of these same kinds of explanatory variables
that we're going to want to address if there are unintended
consequences of where the money is flowing. Okay, that's my
only editorial comment.
My question is quite a different one. There's a cap on individual institutions of 1 percent going to 2 percent going to 3 percent. I'm a little unclear if we recommend or say, you know, let's make sure that the improvement is credited, so to speak. What is Congressionally required to be changed versus what is within the discretion of CMS to grab hold of some of these thoughts and execute them? Because the nature of what we might want to lay out could be significantly different depending on whether we're dependent on Congress voting on this versus the Secretary.

MR. GLASS: Almost everything is in law. The formula is in law.

MR. BUTLER: The amount that needs to be taken out would automatically be the higher level unless they take some action and say no. Right now it's .3 percent, for example, in one year. Is there a -- what is the Congressionally mandated amount of dollars?

MR. GLASS: Oh, no, I don't think -- the formula is in law. The formula for computing the penalty is in the law, not the -- there's not a target, I don't think, for how much money comes out.
MR. LISK: The only thing that's in there related to that is the 1 percent cap for the first year, 2 percent next year, and then 3 percent afterwards, so 3 percent of base operating payments, and then the expansion of the policy to the four other conditions is what is in law that the Secretary must do. But the formula is very prescriptive in terms of what is -- how it's calculated and stuff.

MR. BUTLER: Okay. So I'm still a little lost then on the formula in the sense that, let's say, all the readmission rates went down to 10 percent nationally. Would we potentially be in a position where it wouldn't have any penalties at all then?

MR. LISK: No.

MR. BUTLER: Or the formula automatically generates additional penalties?

MR. LISK: The formula continues to address -- it's penalties, and in fact, for certain types of institutions, if you're -- if you have no chance of getting there, if you're already really high on readmissions, you have probably no incentive to reduce your readmissions because you're going to be like spinning your wheels in the process.
MR. BUTLER: That's good. Because then my only point -- and I'll forego Round 2 which we may not have anyway -- is to make it clear the distinction between what automatically happens by law versus what the Secretary might be able to do with reformulating the methodology.

MR. HACKBARTH: Late start or the snow day phenomenon. Boy, we're a gabby group today.

[Laughter.]

MS. UCCELLO: We are going to have round two, right, or not? Okay. Well --

MR. HACKBARTH: Scheduled for 8:30 tonight, at this rate.

[Laughter.]

MS. UCCELLO: I had the same questions that Kate had, although I think she put them much better than I would have. So this comes under the "be careful what you wish for" request, but if there are additional conversations about this, I would like to be kept in the loop.

DR. HALL: I'll be brief. David and Mary and Glenn alluded to the fact that there may be other things going on in the health care system that might be alleviating the problem of excessive readmissions, mainly bundling,
moving to Accountable Care Organizations, et cetera. And your own data suggests that there's some inexplicable drop there that hasn't been explained necessarily by legislation. What do we know about some of the pioneer Accountable Care Organizations where there are some data? Are we seeing a difference in 30-day readmissions that might inform us a bit?

DR. STENSLAND: I don't remember readmissions, but the overall number of admissions, there wasn't much of a movement.

DR. HALL: That might be worth looking at, I think.

DR. REDBERG: So I came in with two, but now that it's gone all around, I have a few more, but I'll just stick with these two for now. So one is on Slide 16, you know, on the hypotheses. I just want to suggest, and it's related to the question, another hypothesis which is kind of the opposition of Hypothesis 1 is that the reason there's no relation -- it's inversely related is because patients that take very -- hospitals that don't -- that take poor care of their patients, they die, so they have low readmissions but a high
mortality rate.

So related to that, though, what is -- and you can answer this offline, too -- is in the risk adjustment, because right now, I only know that SES or some things are not. But I'm not clear on what is in the risk adjustment. But it does argue, certainly, for going toward a more bundled measure of readmissions and mortality, at least for heart failure, where it does seem to be -- of course, I guess if we go to the all condition measure, we'd have to look at whether that was overall true or not true for all condition.

MR. GLASS: That is -- on page 24 of your mailing material there, it shows that when you go to the all condition measure and the more inclusive mortality measure, the effect goes away. It's no longer a statistically significant.

DR. REDBERG: Even for heart failure? I couldn't --

MR. GLASS: Oh, no, no, not for heart failure, but for -- as a --

DR. REDBERG: Oh, okay.

MR. GLASS: -- if you go to the total mortality
total, then that goes away.

DR. REDBERG: Okay. You can answer it some other time about what is the risk adjustment.

And the other question I had, of course, is on page 13 in the mailing materials, do you have some feeling for why major teaching hospitals were in the high penalty area? Do you think -- was it related to the kind of patients they take care of or the kind of care or --

MR. LISK: They are high -- they, on average, treat more -- they have a higher SSI patient share, which is consistent with what we show here, and so more low-income patients could be one factor. There could be other factors, probably, too, but --

DR. REDBERG: They would be higher than government hospitals, because that had the lowest penalty.

MR. LISK: The reason here is this is also adjusted -- this is actually the actual payment effect.

DR. REDBERG: Oh.

MR. LISK: So those hospitals are already receiving high DSH payments --

DR. REDBERG: Oh.

MR. LISK: -- so a lot of the numbers we presented
to you today are just base operating payments, so we don't show the effect of DSH payments or IME payments on what the penalty would be. So these numbers here on Table 13 are showing that effect. So the government is lower, in part, because they get a lot of DSH money.

DR. REDBERG: I see. Thank you.

MR. HACKBARTH: Okay. We'll do a quick round two, he says, hopefully.

[Laughter.]

MR. HACKBARTH: A question based on Dave's round one question about the resources that go into this. One of the ideas that you laid out for dealing with the small numbers problem was giving hospitals the option of pooling and being evaluated as part of a pool. And Dave's comment struck me as, well, maybe some of the necessary resources to deal with transitional issues and the like could be handled more efficiently on a pooled basis than an individual hospital basis. So why not give all hospitals an opportunity to say, we want to be evaluated as a pool?

DR. STENSLAND: Makes sense.

MR. GEORGE MILLER: [Off microphone.] -- system, and if you're not part of a system, the small hospital, you
don't have that opportunity, so your point is very well taken.

MR. HACKBARTH: George, round two.

MR. GEORGE MILLER: Just quick for round two. I want to say I like the idea of eliminating the penalty, but the question would be, what would be the national rate that we'd use, so I'll just put that out there, expressing a concern.

And to Herb's point about the JAMA study and what the CMS and the Yale measures, aren't there planned readmissions and are they included? I think the JAMA excluded them, but the CMS/Yale did, and if I remember correctly, 43 percent of the JAMA said they did not come through the ED, but the Yale/CMS model had nine percent, which led me to believe that the different models had a different planned readmissions than the other. And so the CMS/Yale model used the lower. So I would think that would change the data and change the impact.

And then back to Kate's question, why not use dual eligibles instead of SSI in your formulary?

MR. LISK: On the planned --

MR. GEORGE MILLER: Yes.
MR. LISK: The different models treat planned, potentially preventable, differently. The current readmission measures used right now basically include all cause readmissions, so even planned readmissions are included in most cases, except for a few exceptions in AMI. But the new Yale/CMS all condition measure does eliminate a selected set of planned readmissions.

MR. GEORGE MILLER: Why?

MR. LISK: Because they are planned, so they're going to be readmissions that are going to be -- so it's someone who has --

MR. GEORGE MILLER: But there may be a good reason for --

MR. LISK: -- for surgical. So, no, they're not going to be counted as a readmission.

MR. GEORGE MILLER: Oh, you're not counting them?

MR. LISK: No. When you have the planned --

MR. GEORGE MILLER: Okay.

MR. LISK: So the readmission measure is -- so the title readmission measure is for unplanned readmissions, okay? So planned readmissions are excluded.

DR. MARK MILLER: This is a really important point
worth repeating for the public, just not so much George at this point. We're trying to be really careful to say two things. All conditions, avoidable or preventable, whatever your word is, we're thinking it's really important that hospitals, that there should be some effort when you construct the measure to remove those readmissions that are expected to occur or not really open to being prevented.

And I just say this very carefully because the word "all cause" gets thrown around and that generally is put it all in there, and we're saying, don't put it all in there.

DR. NERENZ: Okay. Let me just repeat my "yes" answer to your question to us about is this going in the right direction. Yes. I am most significantly focused on the question of the social demographic, socio-economic adjustors and the fact that we are proposing a way to do that, I think is a very, very important and good thing. I would -- so, yes, I like that.

There may be additional things even beyond this just to keep in mind as this continues to go forward. I'm thinking this may tie into Kate's earlier comment about the factors that are most directly in a causal path, so to
speak, about why a readmission occurs. I draw your attention to low literacy, limited English proficiency just as two examples. I know that you don't go there first because we have limited data at the individual patient level, but on those factors or other similar, we have data at the community level.

So now tying back to Glenn's comment, if we are willing to consider the concept of building some adjustment or cohort identification based on community-level factors, then I think some other opportunities open up and I would suggest that you look at those. I think that might take us even farther down the road.

DR. NAYLOR: So a 2008 recommendation that results in a policy and now leads to refinement, kudos. And this paper and your presentation, for someone who actually knows a little bit about this, just highlights the complexity of the issues. You did a fantastic job of making that clear.

So on the recommendations for refinement, I think pursuing all condition preventable is really a very important target, not just from the capacity to increase the observations, but because we're seeking policies that get us to all system redesign and not just focused on specific
conditions, but we know people come back with heart failure 50 to 60 percent of the time for something else. So I really like that.

I also, in my comments, I think SES is a very important -- and the way that you're attempting to model that, but building on Dave's comments and my earlier questions, whether or not we can continue to work on the refinements about what it is that helps us to understand who's complex and where other adjustments might be made.

And on the issue of mortality, I have lots of questions and concerns about that, but hope that we will think about quality, other quality measures rather than mortality. They are measured differently, mortality, zero hospital admission to 30 days and readmissions discharge. And so I think that there are other options there. Thank you.

MR. GRADISON: I want to raise a question about one of the objectives that's listed on page 14. I have serious questions about starting off, at least, with the idea that it should generate savings that are equal to or budget neutral. We don't generally do that. Remember our hospital recommendations the other day actually talked about
an increase, which would not be budget neutral because we felt the hospitals had been dinged enough already towards the end of last year. And I'll tell you, I really think that this would be counterproductive to start off with this objective.

The point has already been made, and I want to repeat it because I think it's very important, so long as -- unless you assume that all hospitals eventually get to zero in terms of potentially preventable readmissions, there are going to be some above the mean and some below the mean, or average, whichever way we do it. That means that for some group of hospitals, it's not going to make any sense financially for them to incur incremental costs to try to reduce the rate of readmissions because they're not going to have a chance to reduce the penalty. And I think that's a very -- I mean, I think that's sort of self-defeating.

I mean, the more direct way to do this, if we are able, if we are actually able to identify potential situations where readmission can be avoided, then I think the straightforward thing is that the penalty ought to be basically we won't pay you for the readmission, period, and everybody gets dinged to the extent that they fall within
that category. The response may be, well, we're not that sure and it's judgment, but the judgment enters into anyway in terms of the numbers of whether an admission is actually potentially preventable. So we may come to a point of wanting to be budget neutral, but I wouldn't start that way.

And I think it would be helpful as we move forward on this to know a little bit more about how the scoring was done under the ACA. My hunch is -- let me put it this way. It's possible that this was written in order to obtain a score, whereas other methods of doing it might not have been as sure to be scored in that manner, and I'd like to know more about the history of this because I think it sheds some light on how Congress actually got to writing it the way that they did. Thank you.

DR. MARK MILLER: Just to follow up on at least a couple things that you said, and I'm going to say this, but I may have misunderstood what you're saying, so just heads up.

One of the things, and this is back in the day when we were talking about this a few years back, we were very focused on the notion of calculating a rate for the hospital, because there can be some play, and there is some
judgment on an admission by admission basis and not applying the policy for a specific admission, and then the notion of how the penalty affected -- you didn't lose your entire payment, necessarily. Your rate had to be fairly out of line with the entire distribution.

I thought I heard you saying, and this is where I want to be clear, if a given readmission is determined to be avoidable, don't pay, and I think that's --

MR. GRADISON: Fair enough. Yes, I did say that, although it could say you pay 50 percent. I think that something less than the full amount that they would otherwise get. We're limiting this to prospectively paid hospitals, at least that's the current practice, so there is a number that one could take a look at and say, well, we'll pay you less.

DR. MARK MILLER: And that was the second point I wanted to definitely get to, and I realize that we may have set this up in a confusing way, certainly unintentionally. When we're using budget neutral in this context, we're saying that the Congress took an action that actually results in savings. They executed a penalty, and we're saying we're not going to eliminate those savings. In a
sense, we're saying, we're not trying to over-achieve more savings or under-achieve those savings. We're trying to remain consistent with what the Congress has already put in place.

MR. GRADISON: My objective here, and this is something that's been bothering me for many, many years about Medicare policy in my old life, and that is budget -- generally speaking, my experience is that budget policy drives health policy and not always in a very wise direction, and that's really where I'm coming from and why I'm raising the question. We may in the end want it to be budget neutral. But to state at the outset that this is one of our four criteria, four principles that inform these refinements should be, I'm not prepared to do that yet.

MR. KUHN: Also answering your question, Glenn, does this move us in the right positive direction, I think it does, so I would agree with that.

And I'm really pleased that we are looking at refinements only on the heels of this policy being implemented, which began last October. Historically, when a lot of folks review Medicare policy, it's four, five, six years after it's been implemented. So the fact that we're
almost going concurrently to begin raising these issues, I think, is helpful and useful to the program and those that provide services through the program, principally hospitals here.

I would just say that, as the conversation has gone before, that I think the SES issue is a critical issue and I like the recommendations that we have here. I do think that SES presents a significant explanatory power in terms of readmissions, and I think to have an unadjusted rate, I think sends all the wrong signals to those institutions that are serving a very difficult population that's out there.

And so I think what we have here is a good recommendation, but what I'd like us to see, maybe as we move forward with this paper, if we could add some ideas or thoughts based on some of the conversations we've had here and perhaps others that there might be some other SES-enriched models that we could look at into the future and maybe give a little bit of lean towards this is one way to do it, but there might be more refinements down the road, and see if we can continue that conversation or at least encourage others to continue that conversation down the
DR. COOMBS: Thank you very much for the work you've done. I appreciate the detail.

I think that this moves us in the right direction, and I have some reservations about just the amount of data that we have at our fingertips. And one of the things I would like to see is for us to actually investigate this whole notion of what happens when the patient leaves the hospital. I think it's really important. It may be that we discover that there's some really best practices that hospitals will probably be motivated to pursue in avoidance of any kind of penalty. And I think that's where we want to be, not just to implement penalties without some kind of change in the culture. And changing the culture means we have all the data at our fingertips to say, this is like a best practice.

I am concerned that, you know, you look at the data and many of the charts and there's not a consistent correlation with whether or not they're rural -- I mean, there seems to be some propensity for rural, for academics because of more of the SES penetration there, but it's not a consistent for-profit, nonprofit, pattern there. And I
would be interested if there's something that we're kind of missing that might lend itself to us changing the environment for the beneficiaries.

So the data that I would recommend is looking at the number of beds in general areas in terms of readmission. And I think it's really true, because what happens at the microscopic level in terms of in the emergency room does matter in terms of the threshold to fill beds in terms of occupancy, and those kind of things, I think, become very important, that you might not want to incentivize in certain areas. So there's another opportunity to make a difference in terms of cost and quality for patients.

DR. HOADLEY: Thank you. This is really a good chapter on some pretty complicated stuff, so thanks.

I do, as others have said, I think we are going in the right direction on this.

I think one thing that might -- you know, a lot of people here have been talking about what are the ways that hospitals are responding to this policy and maybe this is an area where a little more qualitative look at some of what hospitals, in fact, have been doing and interacting with some of the factors that we're putting up here. So would a
fixed known target be something that would encourage a response in a different way than the way it's currently structured, or the all condition measure versus the specific areas. You know, is a hospital more likely to do that kind of broad culture change that somebody mentioned versus, say, oh, we've got a problem here with our cardiac patients and we ought to go and do something specifically in that area, or maybe it's all of the above. It might be some discussion with some hospitals around the country in just terms of how they are responding, how they would respond to some of these alternatives.

And the only other thing I'd put up there, there was a little bit of concern on the all condition measure. Maybe it was Craig that mentioned it. If some of the larger teaching hospitals, more complicated hospitals, by picking up all the measures, there may be putting them at some disadvantage, and whether there's any kind of a role for a "most conditions" measure as opposed to an "all conditions" measure, where you would take sort of all of the different kinds of common things that kind of are broadly used across all hospitals and aggregate them, but not necessarily absolutely everything. So I don't really know what that
means, but I sort of throw it out there as something that
might be worth a little thinking.

DR. SAMITT: I think this is definitely going in
the right direction and I support all the recommendations,
actually.

My only concern is, while it's heading in the
right direction, I'm just not sure it's going far enough. I
have to admit, I'm underwhelmed by the progress to date in
reducing readmissions. It makes me wonder whether there are
reasons we're not seeing more progress. I'd echo some of
the questions raised earlier. You know, if the costs to
implement interventions that would reduce the readmissions
are greater than the reduction in the penalty, maybe
institutions won't do it as readily.

There was also some comment about if you start
with an ACO, then the physicians are already aligned around
the need to reduce readmissions and then now hospitals in
partnership because of this. I'd ask the other way around.
So if hospitals are now responsible for readmissions but
they're not in partnership with a physician group that's
aligned and there isn't an ACO, does that really hamstring
the hospital from really doing all the things they need to
do to reduce readmissions?

So I'm just worried about the lack of progress. And while this solves the inequities of the penalty, I'm just worried that it doesn't enhance the imperative to solve this big problem, and maybe we just need to wait longer to see if we see more progress over the course of the next few years because it's still young. But I'm a bit impatient and I'm thinking that we should probably do more.

DR. CHERNEW: So, first in response to that, I do think the ACO is automatically aligned in some sense, because they're responsible for the readmission even if it's not at all related to them. But I think the broader point is that in the spirit of what David said earlier, hospitals are doing a lot of things and we sometimes talk about this like this is the only activity that they should then focus on.

And I think while I'm supportive of encouraging reductions in readmissions, continued monitoring of its impact on overall quality, along with monitoring overall quality because of payment reform and a bunch of other reasons, becomes crucially important.

And as long as we can maintain the recognition
that this is a small part of quality of care that now has a separate system, but it's not the totality of care quality, then I'm basically supportive of this. And I do think some attention to the cohorts and the issues of the seam affects and exactly what we're doing will require some more discussion. But basically, I'm supportive.

MR. ARMSTRONG: Yeah, I too support the general direction we are heading in and the principles that we're using to evaluate the analysis that we're doing. I would just add, I share Craig's point of view that while I think it's very impressive right on the heels of implementing a policy change where evaluating the impact of it and asking, you know, how can we improve on that, we just have to remember, this is -- readmission rates are a symptom of a system that's not working very well.

And it's costing us and it's costing our patient or beneficiaries in pretty severe ways. This is one more example where the frustration of trying to deal with payment policy tweaks on one small component of a system feels very un-gratifying. That's our job and so we're going to do that, but to the degree we can, you know, keep pushing this forward of trying things and not over-analyze this and then
adjust, I think it's kind of an attitude I hope we try to
lean a little bit more toward, rather than worrying that we
need to get this perfect and do endless analysis until we
have exactly the right answer because we never will. We
just never will.

And then remember other payment reforms really, I
think, ultimately are going to be the better answer to
solving this problem.

MR. HACKBARTH: Scott, do you know your
readmission rate for Medicare patients?

MR. ARMSTRONG: I know my overall readmission
rate. And I know that I've taken it down by 30 percent over
the last three years.

MR. HACKBARTH: It might be -- you know, I think
there really are issues about focusing in on one particular
thing and trying to create the incentives versus the broader
approaches and I'm a fan of the broader approaches. We
embarked on this path as an opportunity to get started while
broader things developed and were put into place.

But there is this issue of how you make the
transitions. You don't want to apply all of your resources
into the narrow thing to the point they become a distraction
from the broader thing. That's an important strategic question.

MR. ARMSTRONG: Just one additional point. I know Mary's made this and others have as well. A very few of our interventions to reduce readmission rates had anything to do with the patient's care in the hospital. So, I mean, I think that's part of the issue that we're dealing with.

MR. BUTLER: Said a little differently about the importance, it's hard to believe June 2008 is when the chapter was created that put this in motion. I'm not sure it would have happened and PPACA without it. I mean, it certainly was a helpful thing and people shouldn't forget that some of these statements made at a certain time do have a big impact.

For that reason alone, I think it's our obligation to continue to try to get this right, because we've got to set it in motion, and what's laid out there in this chapter really does directionally help further refine. So I think as a principle and how we've processed things, this is one that we not only -- we have a responsibility, almost, to stay after it to try to get it right.

MR. HACKBARTH: I certainly feel that. I'm sure
the staff feel it even more intensely, that to some extent people see this as, Oh, this is a MedPAC idea. Don't you dare, just to say -- walk away, say oh, never mind. So I think that's a really important point.

On the other hand, we also have to keep in mind that this wasn't the end goal. It's not a goal of itself. It was part of a planned start the system moving and these transitions, when you go from one approach to another are really important ones.

My general feeling is that, you know, to use this as an example, I want to create pressure here. I think it is a problem. It's detrimental to beneficiaries. Let's use this easier focus mechanism to draw attention to it. But then let's start opening other doors that are broader payment options that create more flexibility for institutions.

You don't have to necessarily ever repeal this. People will volunteer to say, Oh, this alternative is a better approach than being accountable just for readmissions. I want to be accountable more broadly. Cori.

MS. UCCELLO: So I am supportive of the direction we're going in terms of the all-condition measure and
setting the target. I'm less comfortable with how we're dealing with SES. I could be convinced that this peer group way might be better, but I'm still concerned. I'm especially concerned about talk of including more SES-type measures into this process. Our goal here isn't to explain readmission rates. It's not to predict readmission rates. The goal of this is to improve patient care, and allowing hospitals who treat certain patients to have higher readmission rates I don't think gets at that goal.

You know, one of our implicit, maybe not explicit, goals here is to reduce disparities, and, you know, maybe in this peer group way that can, I mean, maybe potentially get at that if you're still applying pressure. But I'm wondering if a way to do that better is to rather than reducing penalties, is if these patients are more costly, need more resources to care for, that we need to be thinking more about how to address this from the up-front payment side, rather than the readmission side.

DR. MARK MILLER: Now I just got a clarification that I wasn't following earlier. So when we were having this exchange, I was thinking you were saying you were
agreeing that maybe we should consider putting it in the
formula with some of the -- the concept. I don't know. And
you're saying no, and so that's a clarification in my
thinking about where you were.

And one of the things I wanted to remind you of is
the Commission did make a recommendation a couple of years
back -- I've forgotten now -- about how to target the QIO
money and say it should be going to hospitals that are
struggling with -- it could be viewed as saying hospitals
like this, to give them the resources to try and turn their
situation around, enough, not enough. You know, for the
moment, I'll be agnostic, but there is some thought in the -
-

MS. UCCELLO: And I completely agree with that and
maybe we need to reiterate that, you know, in this
discussion. And yeah, my initial reaction to this peer
group may or may not be this kind of the same kind of
ultimate thought that Kate was having, but it's like, well,
this just seems like a different way to risk adjust to me.
I'm not comfortable with risk adjusting so I'm not
comfortable with this different way of doing it.

DR. HALL: I think our discussion and what you've
done has been very informative and I think we're all saying that we should look at readmission rates as a marker of something. It may be a marker of good care sometimes clinically, or may be a marker of bad care. It's like the speech that every first-year medical student gets when the professor gets up and says, 50 percent of what we teach you is going to be wrong, but we don't know which 50 percent. But we have to find markers to get to that 50 percent if we're going to reach this triple bottom line of quality care, safe care, and cost effective care. So I think we're doing the right stuff here. As long as we don't think that it's an end in and of itself. I guess four or five or six -- maybe we've all said that. Thank you.

DR. REDBERG: So, I wanted to say, overall I think the policy has clearly, you know, moved us in the right direction, in the right direction being better patient care, because I think that is our goal. In terms of the refinements, it does seem to me like an all-condition measure would be better.

I wasn't here in 2008, but, you know, there is -- it seems -- especially because the correlations with the reduction in readmission really correlated better with
potentially preventable readmission that might be a better measure than all, because readmission -- and I have to say that this penalty multiplier and the idea of adjusting, although I understood the reason for it, I'm not sure that that was overall a good thing, especially the penalty multiplier which really -- you know, because if you have a lower readmission rate, you get a huge multiplier and it doesn't seem like what you want to be rewarding.

I mean, you always have the absolute and the relative, which is why I don't think setting a target in advance would necessarily be good, because like the example you gave, if your readmissions were really high, you'd never have an incentive to go lower because you're just not going to get there.

And so, at some point, you know, we should probably also look at, you know, have there been an increase in observation stays at the hospitals at lower readmission or an increase in readmissions that started on day 31 and after.

But the other thing I have a comment on, on the socioeconomic, again I think it's very tough. I mean, I understand when I read the reason for not including the
adjuster was not to give hospitals a buy for not reducing readmissions in low SES patients and that makes sense. But I think the issue is, you know, kind of as Scott pointed out, in his hospital, they reduced readmissions. It really had nothing to do with what was happening in the hospital.

And I think a lot of, particularly in low SES areas, it's not even in the health care system what's causing readmissions. We're talking about huge social problems, housing, education. Those aren't things that is any -- no matter how great the health care system can try to be, they're not going to address those other issues and they're going to be penalized for it. So I think we need to consider that.

MR. HACKBARTH: Okay. Good discussion and thanks for the great work on this. And so, we will reconvene at -- sorry, sorry. I'm hungry. We'll have our public comment period in just a second. My goal here is, we're substantially behind, obviously, and so my goal here will be to be back and started again by 2:15. With that in mind, we will have a -- thank you, Mark. You're so sweet.

DR. MARK MILLER: Everyone says that.

MR. HACKBARTH: We will have a brief public
comment period, and help me get to real lunch, please, by being brief.

MR. LIND: Very brief. Keith Lind, AARP. I just wanted to address a comment that's sort of floating over the discussion but hasn't really been nailed. I think we don't really know where the lowest level of readmissions can go. I think the point over here about we don't know which 50 percent is not the right 50 percent.

As you push down readmissions, at some point you may see an increase in mortality. I think the Krumholz JAMA article was reassuring. There's almost no relationship between readmissions at this point. But as you drive it down, somebody needs to be monitoring mortality rates, not just quality. Quality absolutely, but mortality rates, too. That should be a big, visible measure.

Thank you.

MR. HACKBARTH: Thank you all for not standing between me and my lunch.

[Laughter.]

MR. HACKBARTH: So we will reconvene at 2:15.

[Whereupon, at 1:17 p.m., the meeting was recessed, to reconvene at 2:15 p.m., this same day.]
AFTERNOON SESSION [2:16 p.m.]

MR. HACKBARTH: Okay. It is time to begin our afternoon session and first up is competitively-determined plan contributions.

MS. LEE: Good afternoon. The Commission has been considering reforming the traditional Medicare benefit to complement our ongoing work to improve the payment system and the health care delivery system. Last fall, we presented an overview of the concept we call competitively-determined plan contributions and today we continue our discussion on CPCs.

So let's begin with a very brief review of the two previous presentations on the topic. In September, we defined what we mean by CPCs, which refer to Federal contributions toward the coverage of the Medicare benefit based on the cost of competing options for the coverage. Also in September, we discussed some of the key policy issues that the Commission would need to consider under a CPC approach, such as should the benefit package be standardized and how should the Federal contribution be calculated? We won't go over them in the presentation today, but they are included in your mailing materials.
In November, Jeff and Carlos discussed the relationship between provider prices and the cost of private Medicare plans relative to fee-for-service Medicare. Because a CPC approach first relies on competing options for the Medicare coverage from private plans, the factors affecting their costs are important.

Today's presentation is in two parts. First, we'll quickly go over the conceptual framework of a CPC model, and second, we'll present a preliminary analysis of private plan bids and availability using current MA bids as a starting point of the analysis. We want to emphasize that we made many simplifying assumptions that may be unrealistic if the design of a CPC model diverges from the current MA system. We'll discuss them in more detail later in the presentation.

Before we get to the analysis, let's briefly review what happens in a CPC model and the context in which we need to look at what these plans do.

There are three main actors in a CPC model. One, the Medicare program designs the model and makes the rules for determining the CPC contributions and plan payments. The program's goal is to design a system so that private
plans have the incentive to lower their cost and to bid
close to their true cost and the beneficiaries have the
incentive to make cost-conscious choices. Additionally,
Medicare will continue to manage and set fee-for-service
payment rates.

Now, given these rules, private plans make their
business decisions, such as whether to enter or exit a
market, and if they decide to enter, then how much to bid
and what benefit designs or products to offer.

And finally, given the options for the Medicare
benefit at the prices offered by the plans, beneficiary
choose how they will get their Medicare coverage. Because
their individual premiums depend on their choice under a CPC
model, they will have to trade off the benefit and cost of
what they wish to buy.

Our analysis today focuses on the second actor,
private plans, and tries to understand where private plans
might be available and what their bids might be. As a proxy
for plan bids and availability under a CPC model, we used
the data from MA plan bids for 2013 and we organized those
bids at the level of payment areas to best approximate the
insurance markets served by private plans.
The definition of payment areas are based on the Commission's recommendation from 2005. I will return to a more detailed discussion of payment areas in the next slide.

As we mentioned at the beginning of the presentation, we also made several simplifying assumptions in our analysis. First, we assumed the same plans would participate at their current bids. In other words, we haven't adjusted for potential new entry and exit and different bidding strategies if the CPC rules were different from the current MA rules. We also assumed that plans have the capacity to serve the payment area.

So let's go back to the definition of payment areas used in our analysis. Under current law, MA plans choose the counties that make up their service areas. In 2005, the Commission recommended combining counties into larger payment areas consisting of MSAs and Health Service Areas outside the MSAs. Health Service Areas are defined by where beneficiaries receive most of their short-term hospital care.

The goal of the recommendation was to define payment areas that reflect more accurately the insurance markets served by private plans. This definition of payment
areas means that, for our analysis, we need to convert
current MA bids, which are at the level of service areas,
to recalculated bids at the level of the payment areas.
This process involves quite a few steps, and now Scott will
describe exactly what they are.

DR. HARRISON: As Julie described, calculating
plan bids at the payment area presents complications and
requires that we make a few big assumptions. Remember that
plans currently submit bids for service areas made up of one
or more counties that each plan chooses for itself. Those
service areas can be smaller than one payment area or could
span many payment areas, so our task is to attribute the
bids for the service areas to the new payment areas that
Julie defined.

First, we assume that the bids the plans submit
are constant over their entire self-selected service area,
meaning that the plans are making the same bid for each of
the payment areas within their service area.

Then we eliminate some bids for some payment areas
because we assume that the bid doesn't really reflect the
plan's true cost for the average beneficiary in the area.
Generally, we excluded bids from plans that are not
available to all types of beneficiaries, such as employer-sponsored plans and special needs plans. These plans enroll only certain subgroups of beneficiaries and, therefore, would only reflect the cost of those subgroups. We also excluded bids from plans who did not demonstrate they could offer enough capacity in the payment area. Thus, we excluded bids from plans that did not project significant enrollment in the area, and also, we only accepted bids from plans for areas where the plan was available to the majority of the beneficiaries in the area. There is more detail on the methodology in the paper and I can give more details on question.

This slide summarizes the payment areas in the plan bids that result from our assumptions. We end up with 1,229 payment areas and fee-for-service spending averages $784 per month. Looking at the second column on the table, most payment areas have average fee-for-service spending between $690 and $825 per member per month. And looking at the lower right of the table, 61 percent of the beneficiaries live in payment areas that average more than $750 in monthly fee-for-service spending.

As for bids, our final sample included 1,550
independent bids. Most bids span more than one payment area, and after the exclusions, there is an average of four-and-a-half bids per payment area.

However, our data leaves us with 167 payment areas containing about two percent of all beneficiaries where there are no bids. This result is somewhat different from the current state of play, where less than half-a-percent of beneficiaries do not have a plan available.

Here, we have displayed the average bid, as well as the tenth and 90th percentile bids, for groups of payment areas that we described. We see that, as expected, the average bid rises as fee-for-service spending in the area increases. The lowest group of payment areas, those with average fee-for-service spending under $645, have average bids of $701 per month. And those areas with spending over $900 have bids that average $762. So while the bids do tend to rise, they do not rise as fast as fee-for-service spending.

Now, as I showed you on the last slide, bids rise as fee-for-service spending rises, but you can see clearer here that the ratio of the bid to fee-for-service declines as fee-for-service spending rises.
The three groups of payment areas shown on the left with fee-for-service spending under $750 have average bids that exceed local fee-for-service spending, illustrated by the average ratios over one that go from 1.14 down to 1.01, which are the yellow numbers. The three groups of areas over $750, as shown on the right, have average bids below fee-for-service, shown by average ratios below one and as low as 0.79 for the highest fee-for-service spending group. The main lesson from the chart is that plans often bid considerably less than fee-for-service in areas where fee-for-service is relatively high, but tend to bid higher than fee-for-service in low-spending areas.

So we took the bid data that I've just described and used it to determine the Federal contribution under a couple of illustrative scenarios. We also looked at the results from setting the contribution at 100 percent of fee-for-service spending in the local payment areas as a base of comparison. Local fee-for-service spending ranges from $543 to $1,335, averaging $784 per month. And, of course, fee-for-service always has a ratio of one with itself, so those next three numbers are all one. And our data have 86 percent of beneficiaries living in payment areas where at
least one private plan is bidding below fee-for-service, but availability will vary geographically.

I should note that, currently, virtually all beneficiaries have plans available, but in some areas, plans are bidding above fee-for-service and the program is subsidizing them by contributing more than fee-for-service, so that's why currently we have more than 86 percent of beneficiaries with plans available.

Under the next scenario, we consider local fee-for-service as a plan bid, calculate the average plan bid, including fee-for-service, and set the Federal contribution to that average. The average contribution under this scenario would be $763, which is about 98 percent of fee-for-service. Because plan bids can be above or below fee-for-service, the contribution set by combining the plan bids and fee-for-service can result in the Federal contribution being above or below one, as you can see from the ratios. Because the contribution can be above fee-for-service, we see an increase in the number of beneficiaries living in an area where at least one private plan is bidding at or below the Federal contribution.

Under the last scenario, the Federal contribution
would be set at the lesser of the average plan bid in the payment area or the average fee-for-service spending in the area. Here, fee-for-service is not included in the average bid. The average contribution would be $727, or about 93 percent of fee-for-service. Here, because under this scenario the contribution is not allowed to go above fee-for-service, the ratio to fee-for-service never goes above one. Even though the Federal contribution is seven percent less than the 100 percent fee-for-service scenario, the same percentage of beneficiaries, 86, live in an area where a private plan bids at or below the contribution.

Now, let's look at how these scenarios might affect the beneficiaries. As with the plan bids, we are showing static effects. We did not model any beneficiary behavioral responses to new premiums. It is very likely that beneficiaries would move to less expensive plans if they were available. The results here, however, assume that beneficiaries stay in fee-for-service or whatever plan that they are currently in. We also assume that any change in the Federal contribution would be fully offset by a change in the premiums paid by the beneficiary. We show the changes separately for beneficiaries in and remaining in
fee-for-service and for plan enrollees who are assumed to remain in their current plan.

Looking at the first line, enrollees in fee-for-service Medicare would not see any changes in premiums if the contribution were set at local fee-for-service spending. However, as plan bids are below fee-for-service, on average, many plan enrollees would get premium rebates, which would average $56 per month in the absence of any enrollment changes. Some plan enrollees would get much larger rebates, but enrollees in some plans would see premium increases.

Under the scenario where fee-for-service is considered a plan bid, fee-for-service beneficiaries would see an average premium increase of $10 per month, but beneficiaries in some areas would get rebates. Plan enrollees under this scenario would see an average rebate of $35, but some enrollees would have to pay additional premiums, assuming they did not switch plans.

The last scenario, which lowers the Federal contribution the most, would raise premiums the most, by $53 per month, on average, for fee-for-service beneficiaries. Ten percent of fee-for-service beneficiaries would see premium increases of $154 per month, assuming they remain in
fee-for-service. Now, looking at the plan enrollees, while some would receive premium rebates, the average premium for enrollees would rise by $17, and ten percent would see their premiums rise by at least 97 percent, assuming they did not switch plans.

DR. MARK MILLER: [Off microphone.]

DR. HARRISON: Ninety-seven dollars. Sorry.

MR. HACKBARTH: You said percent.

DR. HARRISON: Dollars. Sorry.

Well, that is our presentation for today.

[Laughter.]

DR. HARRISON: Next month, staff will present on issues related to low-income beneficiaries, and now we are happy to take your questions and comments on the methodology and simulation findings, and you may wish to discuss principles for determining the Federal contribution under CPC.

MR. HACKBARTH: Okay. Good job.

Before we turn to questions about CPC, let me just do a little housekeeping here.

In order to -- my goal is going to be to finish at
6 o'clock, so for anybody who needs to tell dinner parties their time of arrival, we're going to be finished at 6 o'clock. In order to do that, I'm going to do two things. One is pare down the time a little bit for each of the sessions on the schedule. And the second thing is that I'm going to propose to speed up the process, and instead of going around one by one for Round 1 clarifying questions, I'm just going to open the floor for a few minutes to the group at large, and raise your hand if you have a clarifying question about a particular slide. And then -- not yet, Cori. Boy, you're eager.

[Laughter.]

DR. CHERNEW: Cori has a question.

MR. HACKBARTH: So that's what we're going to do on the schedule, and I'm sure we'll finish by 6:00. Before we go to Cori, just one additional comment for the audience, for people who haven't been following MedPAC's discussions of this topic. We're using this phrase "competitively priced contributions," and for some of you in the audience, you may be saying to yourself, "Boy, this sounds a lot like premium support" or some other legislative proposal out there.
The reason that we're using this term, "competitively priced contributions," is to avoid terminology that already is closely associated with existing proposals. We are not in the process of evaluating any particular proposal but, rather, certain principles and concepts that may or may not be appropriate for the Medicare program. So we want to abstract ourselves from all of the sometimes heated discussion that has existed about premium support or vouchers or defined contribution and try to look at this strictly from an analytic perspective in the first instance. So that's where this name comes from.

Now we are ready to have clarifying questions, and Cori is going to lead off.

MS. UCCELLO: So Slide 11, all of this is going to take a little while to sink in for me, but the one question I have here is, on the first row, the last column on the right, that 86 percent, tell me again why that's not higher.

DR. HARRISON: Okay. What this says is that 86 percent of beneficiaries live in a payment area where at least one plan is bidding at or below the contribution, one private plan, so fee-for-service doesn't count.

MS. UCCELLO: Okay. That was --
DR. HARRISON: But, you know, there are -- that number is currently higher, but a lot of the reason it's higher is because there are areas where plans are bidding above fee-for-service, but the current payment rates are above fee-for-service.

MS. UCCELLO: So this last column is reflecting private plans.

DR. HARRISON: Yes.

MS. UCCELLO: Okay. Thank you.

MR. HACKBARTH: I am too a little uncertain about this. So this last row, Medicare fee-for-service isn't counted in the calculation? I had thought that it was.

DR. HARRISON: Instead, it's the lower of the average bid without fee for -- the row above we include fee-for-service in the bid calculation.

MR. HACKBARTH: And in the last row it's fee --

DR. HARRISON: In the last row, it's the lower of fee-for-service or the bids -- the bids without -- right?

MR. HACKBARTH: So the average is not calculated with the private bids.

DR. HARRISON: It's the average of the private bids and fee-for-service -- not the average. The lesser of.
MR. HACKBARTH: Yeah. You know, you could do it the other way where fee-for-service is always calculated in the average, but there's a cap. We never pay more than the fee-for-service level. That's what I had thought initially the last row was. But it sounds like you -- you've taken the fee-for-service out of the calculation at the average.

DR. HARRISON: And just used it -- right.

MR. HACKBARTH: And just used it as an upper limit.

DR. HARRISON: Yeah.

MR. HACKBARTH: Okay. Other clarifying questions?

DR. SAMITT: So I'm on page 12, and I'm trying to understand how the percentiles compare from the current fee-for-service beneficiary box to the current plan enrollee box. And so if the presumption is that I as a beneficiary can choose fee-for-service or choose a plan, can I -- is it fair to say that I'm comparing percentiles against each other? So as I look at this and I analyze these boxes, I would say for the most part, assuming the percentiles align in each of those boxes, if I have a choice, I'm going to choose a plan, not fee-for-service, in every scenario other than if I'm in the 90th percentile in the fee-for-service
area today, so 100 percent local fee-for-service and average bid. So I think I'm having a hard time understanding that as a beneficiary, knowing that I have a choice, how would I use this information to make decisions?

DR. HARRISON: This doesn't set up choices for -- this assumes that everybody stays where they are.

DR. SAMITT: Okay.

DR. HARRISON: And so living in different areas, you're going to have different possibilities.

DR. SAMITT: Okay.

DR. HARRISON: In all areas --

DR. MARK MILLER: It's also true that the 90th and the 10th percentile are not particularly comparable because the people who make those up in each of the two different boxes --

DR. SAMITT: Are different.

DR. MARK MILLER: -- maybe living in different places.

DR. HARRISON: Right. Now --

DR. SAMITT: And that's what I was getting at.

They're not comparable.

DR. HARRISON: Right. Now, one thing to think of
is in all these scenarios, everybody in the country would be able to get something, either fee-for-service or a plan, for no additional premium. It just depends where you live what it is you would be able to get.

DR. SAMITT: I see.

DR. HOADLEY: When you're calculating the plan bid amounts, I assume you're not counting the drug expenses, Part D?

DR. HARRISON: Correct. Yeah, just A-B.

DR. HOADLEY: And for the plan bid, are you making any kind of adjustment for extra benefits added by the plan?

DR. HARRISON: No.

DR. HOADLEY: So everything's included.

DR. HARRISON: No, because when they submit a bid, there's a piece of it that says this is for A-B.

DR. HOADLEY: Okay. So it's only the A-B part of it.

DR. HARRISON: Right.

DR. HOADLEY: Okay. And then when you're making the comparisons on, say, Slide 12, the fact that some beneficiaries may have a rebated Part B premium, how is that figured in?
DR. HARRISON: Yeah, that's not figured in. This is really just a difference in premiums.

DR. HOADLEY: So they would just kind of --

DR. HARRISON: Whatever they had before, they would sort of carry through.

DR. HOADLEY: It wouldn't be a negative premium to pick up the fact that they also are getting some of their Part B --

DR. HARRISON: Right, that's not figured in.

DR. HOADLEY: Okay.

MR. ARMSTRONG: This is a little bit off the specific topic but related. Over the course of time, this spread between the high-cost fee-for-service markets and the low-cost fee-for-service markets, has that spread been relatively constant? Or is it getting wider or is it getting narrower?

DR. HARRISON: I think when -- the first time we saw this in the late 1990s, I kind of thought there was like a 3:1 or 4:1 spread between the high and the low county. So maybe it's gotten a little bit better.

Go to the slide before. So now we're at -- no, the other one, the 543, the min and the max. Well, it was
543 to 13 something. So I guess that's slightly better than it used to be.

MR. ARMSTRONG: I mean, I'm just asking -- and correct me if the way I'm thinking about this is wrong. We're basing policy and pricing for these prospective products on the basis of average fee-for-service cost in different markets. And it just kind of presumes that -- it is what it is. I know that. But it kind of ignores the fact that that's a pretty spectacular range, and it in and of itself implies there's something wrong. But I don't know if maybe it's getting better or worse over time. Anyway, like I said, it may not be relevant to this particular topic, except for the fact that it is a basis upon which we're thinking about how we might structure the benefit.

MR. HACKBARTH: Just to be clear, put up one of the tables that you had up with the different approaches for calculating the contribution. If you use the calculation in the first row, then basically you're sort of locking in this wide distribution. As you move to the second row, then you would be starting to compress the government contributions. So you're putting your finger on something which is one of the central policy choices here. It's a big issue.
MR. ARMSTRONG: Yeah, and I think I'm tipping my hand to my bias around this, obviously, but --

MR. HACKBARTH: Let me guess.

[Laughter.]

MR. ARMSTRONG: Yeah, but I guess it's a completely different issue. You know, what are we doing to confront the fact that there is this huge variation in the average fee-for-service cost in different markets?

MR. HACKBARTH: Yeah, and, you know, a little digression here I think is useful. So the huge variation has been a topic for a long time, and one of the things that the Congress tried to do with Medicare Advantage by creating the system of benchmarks was to have less variation in the payments to Medicare Advantage plans than existed in fee-for-service. And as a result, in some areas of the country, including, I think, Seattle, we were paying Medicare Advantage plans significantly more than the underlying Medicare fee-for-service costs. And so they tried to use Medicare Advantage as a redistributive mechanism to address perceived inequities in Medicare fee-for-service payments.

The problem is that doesn't work. What you end up is you pay really high amounts under Medicare Advantage in
some markets of the country, including Bend, Oregon, and private plans get paid a lot of money and Medicare beneficiaries get a lot of benefits for doing nothing, for — you know, even private fee-for-service plans.

So trying to redress the imbalance in regional payments through Medicare Advantage alone while Medicare itself is on the side doesn't work. It creates a whole different set of problems.

These pricing schemes, like the second row, would say, well, if you really want to redress regional imbalances in Medicare, you have to include Medicare fee-for-service in the bidding. And then you have a structure where you can start to say, oh, this huge range is going to be reduced. And there are a lot of different ways that you can do it. You could use blends of local and national average bids and gradually move towards equalization or a lot of different variations. But it is one of the central policy questions here. Are we going to try to use this as a mechanism to redress regional differences in payments?

DR. HOADLEY: A quick follow-up on that point [off microphone]. If you did the second — so the first or the second row on the mins and maxes goes to just the point
you're talking about. So fee-for-service today ranges from 1543 to 1335. But the second row is the average of bids plus fee-for-service, so I assume there's a fair amount of fee-for-service, those are weighted averages. Do you know what the second row would look like if it was only the average of bids or approximately what it would look like? Because that would sort of go to how much range of variation is there just on the MA side?

DR. MARK MILLER: [off microphone].

DR. HOADLEY: Is that -- okay.

DR. HARRISON: That shows you the range of bids.

DR. HOADLEY: Okay. So from six something at the min end -- or that's actually the 10th percentile, but --

DR. HARRISON: Yeah.

DR. HOADLEY: So it's not quite, but -- okay.

Thank you.

DR. MARK MILLER: But as a matter of just to bring a line of sight, we can tell you the variation on the bids and the variation on fee-for-service, put it in a table, and put it in the paper. Okay? So that's certainly one takeaway from this.

MR. HACKBARTH: Okay. Other clarifying questions?
[No response.]

MR. HACKBARTH: Okay. Hearing none, we'll move now to Round 2, and, Rita, do you want to lead off?

DR. REDBERG: Sure, and just thank you for all of this. I'm still trying to digest it. But what would be helpful, besides looking at the difference in bids, is if we had any data on outcomes and how the private plans do compared to fee-for-service, so that we kind of can get some feeling for the value for the spend. What kind of outcomes?

DR. HARRISON: Got any suggestions on how to measure that?

DR. REDBERG: Well, I mean --

DR. HARRISON: In our quality discussions, we've tried.

DR. REDBERG: -- you could either do mortality or condition specific, you know, I think --

DR. HARRISON: But you're thinking quality kind of measures?

DR. REDBERG: Yes. Well, like, how are patients doing. Yeah, so quality outcome kind of measures, not process, like not how many tests they're getting but how -- you know, are they having less hospitalizations, less
readmissions, dying less, less MI, less stroke, things like
that.

DR. HARRISON: Craig usually starts with this
question, but the encounter data from -- we don't have any
encounter data from plans yet, so we don't know what goes on
inside. We expect that we may get some in a few months.

DR. REDBERG: Right.

DR. HARRISON: They started collecting it at the
beginning of 2012, so hopefully we will have something in
the not too distant future that we can look at.

DR. REDBERG: Great.

DR. HARRISON: But it is unlikely before --

DR. REDBERG: The next meeting?

DR. HARRISON: The next meeting, yeah.

DR. REDBERG: Thanks.

MS. UCCELLO: I'm still processing this myself,
but in future steps, is there a thought that that's going to
move beyond the static analysis and incorporate any kinds of
switching? Or is this really just to show, all right, this
is what people would face if they just stayed where they
were?

DR. MARK MILLER: All right. The way to see
what's going on right now in the short term is we're building a chapter for June, so we have all the stuff from the fall and we did this analysis and that analysis, and this would be another step in that. And for the purposes of June, the answer would be no.

Also, even going forward, it's very complicated and very open to -- and I know you know this -- interpretation as to how you make those assumptions. We can take it under advisement, and Glenn is probably going to say something in a minute. But this gets a lot harder when you start making those kinds of --

MS. UCCELLO: Or is there another way to maybe display the choices that people face other than if you stay -- I mean, these are just averages of, well, if people stay, the range in saving this or spending more of that, is there another way to kind of look at the range of choices incorporating both sides of this.

DR. BAICKER: Sorry to jump in, but to follow up on that, I had wondered whether you might be able to display in the static framework something like the distribution of savings available to people were they to switch. Without saying how many people were going to switch, you could say
here's how many people could have their payments lower,
here's how many people could save $100 or here's how many
people could save $200 without making a judgment about
whether they would. And then a complement to that would be
to add to that a row to the table that said what if instead
of pricing at -- you know, the contribution being at the
average of the bids, what if it was at the 25th percentile
or some other amount, which would be another way of showing
the range of savings to people available without making a
judgment?

MR. HACKBARTH: Let me pick up on Kate's point. I
think making a prediction about how people will respond will
be very difficult. But I like the idea of saying are there
ways that we can more clearly array what the choices would
be to people. So if we could pursue that, that would be
helpful.

One of the concerns that I have had about a static
analysis like this is that sometimes it produces commentary
that says, well, you know, people are going to have to pay
this amount for this option. And at one level that's true.
I'm not saying that's inaccurate or dishonest.

But, on the other hand, to some extent that's the
point of the policy, is that you create options, give people choices with different financial implications. If they choose higher-cost options, then they ought to pay for that. That's the design. That's not an unintended consequence. That's the design.

Now, people can and will debate whether that's a good principle to apply to the Medicare population. But I think any way that we can enhance sort of understanding here are the choices that people will have, here are the opportunities they may have, enriches the debate without making predictions on exactly how they'll respond.

MS. UCCELLO: Right. And I think when this is written up, if it kind of highlights that caveat of the -- you know, here's where they stayed, but they don't have to do that. So it lessens the ability to take some of these results out of context.

MR. ARMSTRONG: I just want to affirm that, you know, the way in which we pay for this kind of a plan is -- I don't know what the right answer is, but the way the analysis is being organized, I think you're asking all the right questions. So I think the directions are great.

DR. CHERNEW: So I think three things are
important. The first one relates to this issue that was raised about how behavior is going to change. But I don't want to let it go by without noting that it's not just the question of how consumers would change in response to the incentives, but it's also how plans would change in response to the bids, and that matters a lot.

The second point is this isn't happening in a vacuum, and thinking about how this would work and how it would be synchronized with ACOs becomes very important. And the ACOs are paid a particular way, and the plans are paid a particular way, and it's not exactly congruent. For example, the plans here are paid based on the service area, which you discussed, where the ACOs are paid based on sort of their own organization's historic spending, if I follow correctly. And, in fact, there's some organizations that could choose between being an ACO or a plan, depending on their size, and so there's a lot of synchronization that I think is important to think about when you think about how this payment is going forward.

The third thing that I think is important is we've built an elaborate policy relating to the rebates that happen so these are all A-B with no supplemental coverage,
and we've built an elaborate set of rules for what happens when the plans bid below the benchmark and it goes back to beneficiaries and there's a series of things that happen, which is important.

Right now we're kind of silent on what we say would happen to those rules, which might be fine, but I do think it's worth thinking about, at least a little bit, in this context -- if the plans would be forced to give the whole difference back, if they'd be able to give it back with a tax, if you will, you know, some portion of it back based on their star rating, what happens if they bid above. And so there are some nuances about that which I think in the broad scheme of the policy are important.

All of that said, I think this is exceptionally illustrative of where we are right now, and I think that's really important for people to understand because doing all these behavioral things is going to be very, very difficult. And any sense of what the status quo would look like if there weren't big changes I think is helpful to let people see this wide range of possible outcomes.

DR. SAMITT: I think I'm where Michael is on this. It's hard for me to get my head around the scenario in a
static circumstance, because it's not static. So in many respects, I think to understand it, we need to see a simulation of sorts to say, you know, if these various alternatives were put in place, what would the beneficiaries do and what would the plans do in response, and how does that begin to change and shift the scenarios? Because if we play that out several times, it may highlight much more clearly the best alternatives. So I don't know if I articulated that well, but it's hard to understand it just from a purely static perspective.

MR. HACKBARTH: Any follow-up? Scott or Julie, do you understand what Craig is seeking?

DR. MARK MILLER: I mean, the way I--

DR. SAMITT: I may not be understanding what I'm seeking.

DR. MARK MILLER: No, no, no. I think I understand what you're saying, but it doesn't remove the inherent tension here. I think what you're saying is your mind, and, you know, any person's mind, might be able to absorb better if this is the starting point, assuming behavioral changes, this is -- you know, ten plans would participate, or nine, and, you know, seven beneficiaries
would pay more and three would pay less. And you would say, okay, now I understand how this works.

This definitely goes back to this very difficult problem of what do you assume in a world that nobody has observed yet and you're working with data from a world that doesn't operate that way. And the secondary follow-up on that, when you say, well, I made a guess and here it is, and people jump all over you for your guess. First point.

But to Kate's point and some of what I think was happening around the table here with Glenn is maybe some of that can be gotten across by showing the distributions and saying more clearly if a portion of these people -- we might be able to get to some motion in this data to serve your question.

MR. HACKBARTH: You know, trying to figure out how you might do this in a quantifiable way is way beyond my skills. But it occurs to me that a scenario sort of approach, a qualitative approach may have some value, and let me focus on one particular scenario.

Let's assume a market where traditional Medicare is one of the more expensive options or the most expensive option, and we're in a contribution scheme where
beneficiaries who wish to stay in traditional Medicare have to pay significant sums out of pocket to do that. And assume as a result of that there's significant disenrollment from traditional Medicare over time, people shift to private plans. What are the implications of that happening?

You'll recall that -- I think it was in November when we talked about this -- we talked about the effect of Medicare fee-for-service rates on the dynamics in health care markets, and there are some indications that having Medicare there with its market power and its rates actually has a disciplining effect on what happens in the negotiations between private plans and providers. So in a scenario when traditional Medicare withers and maybe can't command those same low rates anymore, how does that then affect the dynamics in the private marketplace, including the negotiations between private plans and providers? So even if we can't sort of have a predictive model, here's how people are going to react, there may be some particular scenarios that we want to think through in a conceptual way to see if it leads to important policy implications.

DR. SAMITT: I think that would work. I mean, it would give us a clearer sense of how this could play out.
DR. HOADLEY: I had one sort of smaller question that I want to come back to on this topic of static and sort of how you deal with it. The smaller question, I guess, came up with Slide 8 in terms of the number of areas, and, you know, I know that there was the previous recommendation that sort of going from the current system that, you know, counties was too small. But is it clear that the right way to envision this is something that would have 1,229 areas across the country as opposed to, you know, the exchanges, which there will be one per state, or even the regional PPO or Part D market, which were designed to be even less than one per state? And it seems like that makes the world look a lot different in terms of how -- so I don't know if that has been thought about, or it just seems like something we ought to think about at some point.

MR. HACKBARTH: So the design of these areas is something that we have thought about.

DR. HOADLEY: Right.

MR. HACKBARTH: And this approach to defining the areas was something that MedPAC recommended. How long ago, Scott? Five years? Something like that.

MR. HACKBARTH: 2005. And, you know, we didn't like the counties because of, you know, the cliffs and all sorts of specific issues. So we tried to come up with an alternative configuration that would make sense for Medicare Advantage where you would have reasonably homogeneous areas, minimize the cliff, have stable numbers, you know, sort of optimizing among multiple considerations, and came up --

DR. HARRISON: And small enough so an HMO could cover the whole thing without --

MR. HACKBARTH: Yeah. Now, that was all done within the confines of Medicare Advantage without looking at, you know, all these other areas that are now in other parts of Medicare and ACA. And so, you know, it may make sense to reconsider. But that's where this particular set came from.

DR. HOADLEY: And I don't necessarily think the other is better. I mean, the idea of HMOs that have limited ability to have a service area certainly has got to be thought about in that. But, you know, we should just be careful about locking this in as we move forward in this.

I guess as we think about all these issues of how to get beyond a static model, I think a couple of
considerations I would throw out. One is we really do have
to make sure we're thinking about dynamic decisions both at
the beneficiary level and at the plan level, and it's the
kind of things that Mike was talking about, but it's also
just, you know, a plan that's planning to go in an existing
Medicare Advantage market and put these bids up, is thinking
about the dynamic that exists in that market where they are
playing -- potentially looking for a small market share,
doing certain things, in or out of the market depending on
the current Medicare Advantage rules. And so I think we
need to be careful about assuming the kinds of bids that
exist in that world, you know, could be radically different
from bids that might exist in another world. I don't know
how you deal with that, but I think it's just worth --

DR. MARK MILLER: Would you tell Craig that? He's
the one that wants --

[Laughter.]

DR. HOADLEY: And then I think on the beneficiary
side, you know, I agree with sort of the solution in the
short term is, you know, thinking about some scenarios and
trying to picture just what we have, but as we go further
down on this, I mean, there just seems -- I can just start
to list the complications in terms of thinking about how 
beneficiaries respond to this. Some of it goes back to some 
of the design issues that we didn't talk about today, like 
how much standardization you do, what are the rules around 
supplemental coverage, is supplemental coverage -- you know, 
do you have, as in Part D where there has to be a standard 
option and can be an enhanced option, or might enhanced 
versions be the only thing? You know, then the basic issue 
of the stickiness of beneficiaries in wanting to -- being 
reluctant often to change choices. You know, would this be 
rolled out as a sort of one-shot new thing where this is 
kind of like, okay, this is a new system, you're making a 
sort of first-time choice? Or is it more blended in where 
people's default is sort of to stay where they are? And so 
the ability to think about people switching and, therefore, 
the plan response, the premium response is to those 
assumptions matters a lot.

So, I mean, obviously that's not stuff we can do 
in any kind of a short run, but I just wanted to talk about 
those a little bit.

MR. HACKBARTH: You're mentioning benefits and, 
you know, what are the rules of the game around benefits.
It just reminds me to say that, you know, what we're trying to do is explore this really complicated topic in sort of bite-sized pieces. And so there are lots of issues like are the benefits standardized, how much variation is permitted, that are really important policy questions, and the fact that they haven't been mentioned to this point doesn't mean that, oh, we're oblivious to that or that we won't talk about them later. We're just trying to do it, you know, sort of a step at a time in a way that can fit into an hour and a half or an hour and 15 minutes.

DR. COOMBS: Thank you. I think the algorithm or some kind of flow or scenario that actually puts beneficiaries in the system and walks us through this whole process might be helpful, as you mentioned.

I was just thinking about some of the things that are kind of similar with exchanges in terms of some of the issues because it's kind of comparable in terms of, you know, that there's this paternalistic impact that you might have on helping patients and beneficiaries navigate the system. So I think it's important in that respect.

MR. GRADISON: I continue to try to figure out the relationship of what we're talking about to the experience
that individuals would have who acquire their insurance through the exchanges. And so this question for another day is related to that. Do we have or can you find for us any data that relates to the income of beneficiaries to the choices that they make among MA plans?

DR. HARRISON: Meaning which types of designs they go into within MA?

MR. GRADISON: Yes, or whether they choose MA as against traditional Medicare.

DR. HARRISON: We might have some ways of getting at that, like MCBS may have some data on that.

MR. GRADISON: If you don't mind, take a look. That's all I'm asking now.

DR. HARRISON: Yeah, the income stuff is hard to find.

MR. GRADISON: I understand that. Thank you.

DR. MARK MILLER: Scott, and, Carlos, if I need you, would you please be read? We have looked at some of this in the past. Have we not?

DR. HARRISON: I think we've reviewed other documents. Dan may have done something.

DR. MARK MILLER: All right. Fine. Bill, I'll
140

get t his.

DR. ZABINSKI: [off microphone].

DR. MARK MILLER: All right. We'll sort this out.

I do think we have some of this.

MR. ZARABOZO: Next month we'll have it [off microphone].

MR. HACKBARTH: Bill, this has, in fact, been an issue in the Medicare Advantage debate, and AHIP and others as well have said that their analysis suggests that lower-income beneficiaries are more likely to enroll in Medicare Advantage. And so there has been a fair amount of conversation about that and about the analysis that they did, and then I'll let Mark and the staff handle the rest of that.

But it also reminds me of another issue, in the spirit of what I said to Jack. You know, a whole other question here is if Medicare were to go to a CPC type system, what would you do for low-income beneficiaries? You could within the system build in, you know, special protections and what-not for low-income people in a very targeted way, you know, protections on premiums and stuff like that.
DR. NERENZ: Do you think the examples that you have to work with, the current plan bids, are based largely or even perhaps exclusively on fee-for-service payment from plan to provider? Would that be fair? The vast majority of them?

DR. HARRISON: That's not something we -- we haven't looked at how the providers are paid.

DR. NERENZ: Okay. Well, I'm not suggesting that that change a whole lot here, but I'm just observing -- this is actually, I think, prompted by a comment Scott made a while ago -- that there are clearly some plans, particularly those in organizations like he and Craig have, where the payment from plan to provider could be structured differently, the nature of the benefits, the packaging and things could be done differently, and, therefore, the bid price might be different. And I don't think you're in a position where you can simulate that whole range now, but just as a tangential thing around the edge of this, you might just acknowledge that those possibilities are out there so that there could be plans that would bid differently because of the way they would be able to pay providers differently.
DR. MARK MILLER: The only thing I want to pick up in that is -- and, again, I don't see Jeff, but I do see Carlos.

[Laughter.]

MR. HACKBARTH: He's trying to hide.

DR. MARK MILLER: Yeah. I mean, I thought some of our analysis from the fall suggested that, by and large, the prices are closer to fee-for-service among the managed care plans -- not plan by plan --

DR. HOADLEY: Provider [off microphone]?

DR. MARK MILLER: Yeah, that's what I'm -- I'm sorry. I'm not being clear. That, you know, the provider payment rate are closer to fee-for-service in the MA plans. Right?

DR. LEE: So the overall relationship, yes, they tend to follow the level of benchmark, which comes from fee-for-service. Now, as to what is happening between plans and providers and what kind of arrangements they have to get the negotiated rates, we do not know. We only looked at overall area level averages.

DR. MARK MILLER: And I was going to say obviously I'm sure it varies and you can find plans all over the
place. But the thing I wanted to loop back with Scott's comment, just in case there was enough time -- and I'm sure there isn't -- is while there is vast variation in fee-for-service -- and that's a very disturbing and unhappy situation that we have to face -- keep in mind also that when you look at private sector pricing payments among providers, there is extreme variation across the country. And so that also you have to keep in mind.

Do I want to introduce this variation in fee-for-service that's making me crazy? But if you bring in the variation in private sector prices, you have huge variation out there as well. So you have a couple of difficult pulls to navigate between.

DR. SAMITT: So can I add a supplemental request to my usual request, which is that I would love to see a correlation between the manner by which private plans incent and pay providers versus the quality of outcomes in those institutions once we get MA information. That correlation will be very important for us to see, I think.

MR. HACKBARTH: Although the MA information, even when we get it, will be encounter data and will not characterize the method of payment used by the MA plan to
providers. They'll just say this many visits, this many 
hospital days. I don't know what the level of granularity 
is. But it doesn't relate to the contractual relationship 
between --

DR. HOADLEY: Or quantity, not price [off microphone].

MR. HACKBARTH: Yes. I think that's right.

Correct me if I'm wrong, Scott.

DR. HARRISON: I don't know, but it's possible

that the encounter data will have some sort of pricing on

it.

MR. HACKBARTH: Price level --

DR. HARRISON: Yeah, but --

MR. HACKBARTH: -- as opposed to --

DR. MARK MILLER: I'll take any money on that.

[Laughter.]

MR. HACKBARTH: If we ask for that, that will be,

let's see, 2024 that it arrives.

DR. BAICKER: It will be any day now [off microphone].

MR. HACKBARTH: Right, right.

[Laughter.]
DR. HOADLEY: And tomorrow never comes

MR. GEORGE MILLER: Yeah, just briefly. In the reading it mentioned that 64 percent of the beneficiaries live in an area below the bid, and then correspondingly, 35 percent live above. Do we map that out? Do we know where that is — it was in the reading material, Mark, not on the slides.

DR. MARK MILLER: Well, there's some of it right there on that slide.

MR. GEORGE MILLER: No, where they lived in the country.

MR. HACKBARTH: Yeah, so George is looking for —

MR. GEORGE MILLER: Geographically.

MR. HACKBARTH: -- a geographical distribution.

MR. GEORGE MILLER: Geographically where they live in the country. Yeah, I agree with the slide, but I'm just curious if there is something unique about the area of the country that's below the bid amount. Is there something to learn from that? I'm just wondering if there's anything to learn, and those that are above, like those above, is that in Miami-Dade County?

DR. MARK MILLER: Bids below fee-for-service, just
to use your example, in Miami-Dade bids are well below fee-for-service on average because fee-for-service is very high in Miami, bids here.

MR. GEORGE MILLER: Got it.

DR. MARK MILLER: Then you go out to some low fee-for-service area, bids are higher. We could give you some sense of the -- you know, when you go across the --

MR. GEORGE MILLER: I don't know if there's anything to learn from it. I'm just curious.

DR. MARK MILLER: But we're happy to give you some sense as you look across that, you know, who might be in one group versus another, just to give you a sense.

MR. HACKBARTH: Yeah, so you've seen the Dartmouth Atlas with the variation.

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: It would be sort of the --

MR. GEORGE MILLER: So are we consistent with --

MR. HACKBARTH: Yeah. You know, generally speaking, that's the pattern. Where Medicare fee-for-service is very high, the private plans are able to bid lower. Where Medicare fee-for-service is really low, like in Oregon, private plans tend to bid higher. So it's sort
of -- that's the pattern.

MR. GEORGE MILLER: Okay. Thank you.

MR. HACKBARTH: Would you put up Slide 11 for just a second, Scott? So the rows here represent three different ways of calculating the bids. Another way that has been discussed is to, you know, calculate an average Medicare cost per beneficiary in year one and then index that number by some inflator. And so that's another approach that isn't modeled here. That would not really fit under the heading of competitively priced contributions. That would be, you know, sort of more a defined contribution sort of model. But I just wanted to point out that there is another approach.

The other thing I want to emphasize about this is, you know, none of these approaches is sort of right versus wrong. They each have different characteristics. And for me, one of the most important questions in working down this path is what is your objective here. If your primary objective is to produce scorable CBO savings, then what you may want to do is use the approach I just described. Let's calculate the average Medicare expenditure in year one and then index it by a low number that's likely to be lower than
the increase in Medicare fee-for-service costs and you'll start to get CBO pictures that show a growing wedge and a big budget savings for the program.

For me at least, that would not be the principal objective or the desirable way to go. I'm not saying it doesn't have merits, but for me, the worry would be that we're creating another SGR sort of mechanism where we have a government formula that may be increasingly disconnected from the real-world health care delivery and insurance marketplace.

For me, the principal objective here is not to produce a CBO score, but it would be, if Medicare were to go down this path, to change the dynamics in the health care marketplace. And so that's the test for me. Can this be done in a way that would enhance our efforts to encourage, stimulate reform of the health care delivery system, change how health care is delivered in the country? That would be the objective.

Now, I think it's still, in my mind at least, very much an open question whether, in fact, it would be a useful tool for that. But that's the target that my eye is on, not can we ring up a big CBO score.
The reason that I think that, despite all the complications and difficulty of this that it's at least worth thinking through, is that, you know, as I look at the health care system, one of the things that continues to strike me is the very large variation in performance among health care providers, even within the same market. And when you have that sort of variation, applying the tools that we now have in our Medicare arsenal, you know, sort of across-the-board hospital payment systems, physician payments systems, those are really weak tools for dealing with this variation in performance. What you need are tools that discriminate more among individual providers and their performance and move volume of patients to the high performers and, conversely, volume away from the low performers. And I think that's really sort of difficult to do with traditional Medicare.

And so for me, the question is: Would this be a tool that would create that sort of dynamic forcing improvement at the level of health care delivery? And as I say, I don't know the answer to that in my own mind yet, let alone for the whole Commission. But that's why I think this is worth trudging through some pretty complicated issues to
try to sort it out. So on that note, we will end -- thank you, Julie and Scott -- and move on to our next session. We're almost on -- actually a little bit ahead of my revised schedule here. So the next one is on effects of adherents to Part D-covered drugs on Parts A and B spending.

[Pause.]

MS. SUZUKI: Good afternoon. Medication adherence is viewed as an important component in the treatment of many medical conditions. In this session, we'll report on preliminary findings for analysis of the Medicare data to see how the use of Part D drugs affects spending on medical services covered under Parts A and B of Medicare. We're pursuing this research because we'd like to understand the relationship between medication adherence and health care spending for the Medicare population. That will help us better understand how the Part D benefits affect Parts A and B spending. It could also help us inform our thinking on the LIS cost-sharing policy that we recommended last year.

Finally, this research may help us understand the relationship between medication adherence and inappropriate
use, including overuse and underuse, in the Medicare population. There are many studies that looks at the impact of medication adherence on medical service use and costs. Because these studies generally focus on younger populations with less complex medical conditions compared to the Medicare population, findings from past studies may have limited applicability to Medicare beneficiaries.

Our study asks two questions: First, what is the relationship between medication adherence and medical service use for the Medicare population? Second, does that relationship between medication adherence and medical service use vary by condition and/or medication regimen?

We selected three conditions for this study. We chose CHF and COPD because these are high-cost conditions that are likely to benefit the most from appropriate medication therapy that prevents or reduce the incidence of costly complications.

We subdivided the CHF cohort into non-severe and severe cohort because effects may be different depending on the degree of severity. An individual was classified as having severe CHF based on clinical markers such as having a pacemaker implanted. For COPD, we looked at people with
severe COPD, defined as having diagnosis for COPD and requiring the use of supplemental oxygen.

Finally, we chose depression as the third condition because there is no clear literature regarding the effects of medication adherence on medical spending for antidepressants. For CHF and COPD, we further divided the condition cohort by the specific drug regimens shown on this slide. In total, we examined 10 condition-drug regimen cohorts.

Our analysis consisted of three time periods. In the first period, the selection period that span roughly 18 months, from January 2008 to June 2009, we identified study cohorts based on diagnostic codes on Parts A and B claims and the use of designated drug therapies based on Part D claims.

In the second period, the observation period which spanned six months, from July 2009 to December 2009, we identified the level of adherence to the study medications based on Part D claims data. In the third period, the outcome period, which is the entire 12 months in 2010, we measured our outcomes of interest, which is annual Medicare spending for Parts A and B services.
Beneficiaries in each condition-drug cohort were classified into four groups based on the level of adherence to study medications measured during the observation period. Medication adherence was measured using the proportion of days covered metric, which is defined as the number of days covered by a prescription for a given drug divided by the total number of days in a measurement period. Beneficiaries with PDC at or below .3 was classified as the least adherent, and beneficiaries with PDC above .8 was classified as the most adherent. Although PDC metric is an imperfect measure of medication adherence, we have no other data sources to measure adherence and we expect a fairly high correlation between the fills observed in Part D claims and the level of actual adherence.

We used regression analysis to estimate the effects of improved adherence on medical spending for each condition-drug cohort, with separate models for LIS and non-LIS beneficiaries. Our outcome variables were Medicare Parts A and B spending in 2010, and Medicare spending in 2010 by service category, such as inpatient hospital, outpatient hospital, and home health.

Effects of the improved adherence is the
difference between the predicted spending at the highest level of adherence and the predicted spending at a lower level of adherence, such as those in the category with PDC less than .3. That is, we are measuring what the potential change in spending would be if people who were not adherent became adherent. We make two pretty big assumptions. One, that it’s possible to change people’s behavior to take their medications as directed. Two, that when people become more adherent, the health outcomes and spending will look more like those who are currently adherent.

In reality, making people more adherent may be difficult. Even if better health outcomes and lower spending were achievable through improved adherence, those effects may take time before they are fully realized. The net effect of an improved adherence is the sum of the effects on Parts A and B spending and the increase in drug costs from becoming adherent.

The increase in drug costs of improved adherence was estimated by taking the difference in average gross spending for beneficiaries with the highest level of adherence and gross spending for beneficiaries with a lower
level of adherence.

The costs of becoming adherent, in this analysis, do not reflect other potential costs of increasing adherence to medications, such as lowering copays.

In the next few slides, I'll go through some of the preliminary findings from our analysis. The first few will present our findings on the level of medication adherence across cohorts and over time. The next few will show selected estimates of the effects of improved adherence on Medicare spending. And finally, I’ll have a few slides to show the relationship between medication adherence and Medicare spending we observed for our study cohorts.

This table shows the number of beneficiaries in each condition cohort, shares of beneficiaries who received Part D’s low-income subsidy in 2010, and the level of adherence to study medications, as measured by the PDC metric. As you can see, the share of beneficiaries receiving the low-income subsidy ranged from 41 percent among beneficiaries in the severe CHF cohort to 66 percent among those in the depression cohort.

Comparing the first two columns, you’ll see that the distribution across the four PDC categories are nearly
identical for beneficiaries in the severe and non-severe CHF cohort, with slightly less than three-quarters of the beneficiaries in the category with PDC above .8. Adherence was much lower for severe COPD cohort, shown in the third column. And the last column shows that 78 percent of beneficiaries in the depression cohort were in the category with PDC greater than .8, which was the highest among the four conditions.

Adherence rates were higher among LIS beneficiaries for those in COPD and depression cohorts, but not for those in the two CHF cohorts. Although not shown on the slide, among the CHF and COPD cohorts, those on combination regimen had lower mean PDC compared to those on single regimen.

This chart shows how the rate of adherence to study medications declined for all condition-drug cohorts over time. The decrease between 2009 and the end of 2010 ranged from about 7 percentage points for the depression cohort to about 14 percentage points for beneficiaries in one of the severe COPD cohort.

For many cohorts, the rate of decline were similar for both LIS and non-LIS beneficiaries like the trends for
the CHF cohort shown in orange and yellow lines at the top. For COPD cohorts, divergence between LIS and non-LIS tended to be large, as you can see in the blue lines at the bottom. In 2010, most non-LIS beneficiaries faced 100 percent of the cost of the drugs filled in the coverage gap. And even during the initial benefit phase, cost sharing tends to be higher for higher cost medications.

LIS beneficiaries, on the other hand, has no cost sharing or a nominal cost sharing because the subsidy picks up most of their cost sharing. This difference in cost sharing may have contributed to the divergence in the drop in adherence rates between LIS and non-LIS.

This table shows the estimated change in Medicare spending from improved adherence to study medications from the lowest adherence category to the highest adherence category for selected cohorts. The column on the right shows the effects of improved adherence on Parts A and B spending.

As expected, we found reductions in Parts A and B spending for many of the CHF and COPD cohorts. There were some exceptions. For example, improved adherence resulted in higher A/B spending among LIS beneficiaries with severe
CHF treated with beta-blockers. For the depression cohort, the reduction was very small or positive, indicating a higher expected spending with better adherence.

The second column shows the drug costs to Medicare of improved adherence, and the last column shows the overall effects on Medicare spending after accounting for the increase in Part D spending. As you can see, the net effects on spending varied across cohorts and by LIS status. As I noted earlier, the medications used to treat COPD are high compared to other treatment regimens that we examined, so that even though we found reductions in A/B spending for many COPD cohort, the effects on overall Medicare spending tended to be small and not statistically significant or a net increase for many of the COPD cohorts.

For a subset of cohorts with severe CHF, we found that over 60 percent of the effects resulting from improved adherence were attributable to CHF-related conditions. But one of the surprising findings was that in other cohorts, the effects on condition-specific costs accounted for relatively small portions of those effects.

For example, we found that CHF-specific costs accounted for less than a quarter of the effects on Parts A
and B spending for many non-severe CHF cohort. And among the COPD cohorts where we found significant reductions in Parts A and B spending, COPD-specific costs accounted for less than a third of the effects on medical spending.

The effects of improved adherence on spending differed across health care settings. As expected, we found that for most cohorts where better adherence resulted in a significant reduction in A/B spending, the largest effects were typically for inpatient hospital spending.

Better adherence often resulted in lower spending for physician services and services provided in emergency room settings, but magnitudes were much smaller and not as consistent. And we found mixed results for other health care settings.

For drug therapies that do tend to improve health outcomes and reduce the use of other medical services, we had expected that there would be a larger reduction in spending from individuals who were the least adherent compared with those who were more adherent. And I’ll explain this using a hypothetical example shown on this chart.

The vertical axis shows the effects of improved
adherence on medical spending. The left bar represents beneficiaries with the lowest adherence, the next one in the middle representing those with moderately low adherence, and the bar on the right represents those who are nearly adherent.

Our expectation was that the effects of improved adherence on spending would be largest for those with the lowest adherence, and smallest for those who were nearly adherent, and that’s what this chart is showing. Largest reduction on the left, and the smaller reduction as you move to the right.

This chart shows our findings on the effects of improved adherence on Parts A and B spending for beneficiaries in the severe CHF cohort. The chart on the top shows the effects on spending for non-LIS beneficiaries. Again, the lightest green represents those with the lowest PDC and the darkest green representing those who are nearly adherent. The chart on the bottom shows the effects for LIS beneficiaries.

As you can see, it looks very different from the previous chart. In general, the effects were not proportional to the magnitude of the improvement in
adherence as we had expected. This may be because there are unobserved characteristics that differ between the adherent and less adherent beneficiaries that are not captured by our model that rely on observational data.

So to summarize, we found that adherence to study medications varied across conditions and drug regimen. Adherence declined over time for all cohorts. Effects of improved adherence on Medicare spending varied by condition, medication regimen, and by LIS status.

Reduction in spending were typically largest for inpatient hospital, but we found mixed results for other services. Effects on condition-specific cost varied across conditions, and a greater improvement in adherence did not always result in larger reduction in spending.

I'd like to point out some of the limitations of our study as you consider the future direction for this research. The analysis was limited to specific conditions and drug regimens. The variability in their findings across conditions and within conditions, depending on the medication regimen, raises some questions, but it does confirm that a relationship found for a given condition or drug regimen are not generalizable to other conditions and
Our estimates of the net effects of improved adherence likely overstates the effects on spending, first because we assumed that you can move people into the highest adherence category. In reality, particularly for some regimen, that may not be possible. And the fact that adherence fell over time for all cohorts raises questions about sustainability of high adherence, even if it were achieved.

Second, we ignored the costs of making people more adherent. As I mentioned earlier, we cannot measure people’s adherence directly with administrative data. The PDC metric is an imperfect measure, and there may be cases where the PDC metric is not a good proxy.

Finally, the study period was not long enough to observe the longer-term effects of greater adherence. Given that adherence decline over time for all conditions, we may want to examine longer time periods to determine whether the effects on spending are sustained beyond the 12-month period.

In the next phase of this study, we intend to analyze other conditions and observe longer time periods to
see effects during the first -- effects to see if the
effects are sustained beyond the first year.

That concludes my presentation.

MR. HACKBARTH: Okay, thank you, Shinobu.

So let me ask for clarifying questions. Kate?

Ooh, they woke up.

[Laughter.]

DR. CHERNEW: No one on this side.

MR. HACKBARTH: Kate first, and we'll just go down

this row and then over here.

DR. BAICKER: So just limiting to strictly
clarifying questions, the definition of PDC, I wasn't clear
whether being on a drug to begin with was sort of a
requisite index event or just having the diagnosis. In
other words, could you -- do you measure it among people who
are diagnosed with, you know, CHF and thus should be on a
drug, and if they have zero, that's a zero, or are they only
in if they first have a drug?

MS. SUZUKI: So we had three periods, and in the
observation period, we looked at people's adherence, and we
actually require that people had the drug at the beginning
of the observation period.
DR. BAICKER: So that's an "and" not an "or."

MS. SUZUKI: Mm-hmm.

DR. BAICKER: So then that seems to me to build in that mechanical reason that you would see declines over time, because to be in the cohort where you are looking at adherence you have to first be in the possession of the drug. There's some necessary mean reversion built in where I would think you'd almost have to see some decline over time, because people can't get more adherent than they were in the starting period where you're measuring them as being in full possession. An alternative way would be to look at people who ought to have a drug based on their diagnosis and have that be the index event, regardless of whether they have an initial prescription, and then they could -- then I wouldn't expect that mechanical thing. But I just wanted to make sure I understood that it was an "and," not an "or," and how that builds that in.

MS. SUZUKI: So maybe I'm -- I'll just clarify how we measure this. The six-month period, observation period, we measured -- we require that people had the drug. We measure the adherence for that six-month period. And then we were looking at 2010 quarterly to see what their PDC was.
And I understand that since we required the possession, that would necessarily be the case.

MR. BUTLER: Line 12. The chapter was a little clearer than the slide to me. So I'm not -- this is the estimated impact on spending, but the title says -- are these people that have moved from low compliance to high compliance? Tell me again what --

MS. SUZUKI: So this is assuming -- right. So we're looking at what happens when people's adherence changed from the lowest category to the highest category.

MR. BUTLER: So these people were at the bottom end and now they're at the top end, and that's the impact on Medicare spending for --

DR. MARK MILLER: Just to put this a little bit differently, you measure their adherence.

MR. BUTLER: Yeah.

DR. MARK MILLER: You measure you're a and B and then you say, knowing how A and B behave for people who are highly adherent, if the low adherents moved to that, how much A would be. So it's an imputation as opposed to --

MR. BUTLER: Oh. It didn't say that's what would happen. That's what would happen if they moved to high
adherence.

DR. CHERNEW: Can I -- there aren't people that are moving from low to high. You look at low people, high people --

MR. BUTLER: No, I've got it. I've got it.

MS. SUZUKI: Right.

MS. UCCELLO: So, to clarify, the outcomes are looking at Medicare spending, A and B. Is that gross Medicare spending or does it net out the out-of-pocket?

MS. SUZUKI: On the A and B is the Medicare payments, so program spending. So not the out-of-pocket --

MS. UCCELLO: Would including that make any difference, I mean, because we care about out-of-pocket spending, too, on this stuff. I mean, maybe the results would be the same, but --

And this is probably obvious, but the people who -- the reduction in adherence over time, presumably, that's more because people are just dropping out of adherence as opposed to kind of moving down gradually?

MS. SUZUKI: We don't know the answer to that question, but we can definitely look into this.

MS. UCCELLO: And for one of these or more, you
looked at when the cost changed, what costs were the
condition-specific versus those that were not. Did you do
this for the depression? I know there really wasn't
savings, but I'm just wondering how their spending differed
by depression-related versus non.

MS. SUZUKI: So identifying condition-specific
costs are sort of an imperfect science, and for CHF and
COPD, we were able to figure out the diagnoses that are
associated with the condition and fairly reliably identify
those that look like they were related.

For depression, we were not sure if depression
ever even became the primary reason for, say, admission or
visits, so we couldn't reliably identify related conditions
for depression.

DR. HALL: Shinobu, I was interested in Table 1 in
the reading material. The depression population seems quite
a bit different. They're much younger. Almost half are not
age 65 yet. Just note that. I'm not sure that means
anything.

But my question was, would it be possible to make
any breakdown looking at the older age cohorts there? The
numbers may get very small, but within the Medicare age
range, I would predict that the older population might have very different drug effects on concomitant chronic disease than the younger --

MS. SUZUKI: I think that would be interesting to look at.

MR. HACKBARTH: [Off microphone.] Rita, did you have anything?

DR. REDBERG: Yes. Just to clarify, when you were doing this analysis, there was no intervention to make people more adherent, because, you know, when it says improvement in adherence, it makes it sound like you're doing something to help them improve adherence. And the reason I ask is because it's very different. You know, we know that people that take their medicines are very different than people that don't take their medicines, and their health status is kind of independent in some cases of their medicines. It's like people that show up for their doctors' appointments are, in general, a healthier group. People that sign up for randomized trials are a healthier group.

And so this wasn't an intervention study. So I think we have to be careful not to say "improvements,"
because this is really different groups of people that take their medicines and don't. And, in general for medicines, people do stop taking them over time. So it's hard to look at.

I mean, I think -- this is not a clarifying question, so I could save it. I just had a comment.

MR. HACKBARTH: [Off microphone.]

DR. MARK MILLER: She already, like, violated the rule, so --

[Laughter.]

DR. MARK MILLER: -- so I'm not going to violate the rule is what I was going to say.

MR. HACKBARTH: Right.

DR. REDBERG: You are exemplary, Mark --

[Laughter.]

DR. MARK MILLER: No, the thing I want to follow up on that is, first of all -- and I'm sorry to interrupt -- but first of all, on the vocabulary, you're right, and we will -- you know, it's a draft and we will work to get this right in the chapter. And it is difficult, because the line of questioning here is you sort of impute a change. So we will try and get that straight.
But your point, I also think is one that's really important to track on. You can statistically say, if this person moved from here to here, here is what you might expect. But a real question is, what do you have to do to get that person to move? And so the notion of as adherence changes, you get these savings, or you don't, whichever way the case may be, but there may be also a cost involved in getting the person to move, and I think that's what's got to also be kind of understood in this. And I think that's your most underlying point, if I followed it. No, it's not?

DR. REDBERG: I thank you.

DR. SOKOLOVSKY: I think that one thing Shinobu said that we're very interested in is exactly what I thought you were saying, that maybe these people are different in ways we can't measure, and if you have some idea about how we could measure it, that would be great.

DR. REDBERG: Well, just in some of the things I said, because I think people that take their medicines more they are different, I mean, and the different -- their taking their medicines is just one way that they are different. I mean, in general, like I said, people that show behaviors where they're actively taking an interest in their
health have a lot of different behaviors. They tend to have a lot more healthier habits. Those are the ones who show up for their doctors’ appointments. Those are the ones who watch their diet more. They tend to smoke less, you know, eat healthier diets. So they have a lot of different characteristics besides taking their medicines.

DR. CHERNEW: [Off microphone.]

DR. REDBERG: Then just on a technical point, but now we maybe could discuss offline, because I think it's hard to define severe heart failure and non-severe heart failure, but I'm not sure just using an ICD pacemaker definition would be the -- you know, we could talk about that.

DR. CHERNEW: There is literature that uses a different approach that looks at interventions when people -- particularly around Part D -- when people were taking their meds more because they were getting better coverage. What happened to the offsets, and the Congressional Budget Office has a bit of a literature review on this in their memo that they put out when they changed their assumption which is useful, I think, to think about, because they're all intended to try and figure out how to solve this case
mix difference that Rita is raising, which I think is a really important one.

DR. REDBERG: And again, it depends -- last clarifying comment -- it's kind of that healthy user hypothesis. I mean, there are medicines and there are medicines, so it depends what you are taking. But, you know, like the healthy user is probably why a lot of the estrogen studies, the famous example, but the vitamin supplement studies. I mean, people that tend to take those, they tend to be healthier anyway, so it really depends on what we're looking at. Are they taking a life-saving medicine? Are they taking a medicine that doesn't really matter if they take it or not? Or are they taking a medicine that actually might be harmful for them, and that's very nuanced.

MR. HACKBARTH: [Off microphone.] Other clarifying questions?

DR. SAMITT: I guess the purpose of my clarifying question is to really -- I would imagine we're looking at this to determine what's actionable to improve adherence and reduce medical costs. So my clarifying question is, does the study enable us to look at other potential correlates
with adherence?

So, for example, I'm interested in knowing whether we can determine whether there's polypharmacy going on with these patients and that polypharmacy is driving non-adherence, or whether there's a way to get at patient satisfaction levels with their providers as a correlate with adherence, because there are other studies that would suggest that, you know, what we want to do -- if we presume that adherence drives a reduction in medical costs, then what we really want to know is what do we do to improve adherence that is under our control, as opposed to what's not under our control, which is the patients are just different.

So I don't know whether the analysis enables us to do those correlates. With the assumption that there is a correlation between adherence and reduction in cost, we then want to know -- we want to go sort of further upstream to know what we can do about adherence.

DR. HOADLEY: I will stick to my purely technical question. When you're measuring -- you have it on Slide 6, but when you're measuring adherence, you're just doing a straight measure within that, I think it's six-month period,
of how many fills, how many units they filled in that period --

MS. SUZUKI: They supply --

DR. HOADLEY: -- divided by days?

MS. SUZUKI: Mm-hmm.

DR. HOADLEY: And have you done any looking at sort of the boundary issues of if people are doing a 90-day supply in December or right before the period starts, any of that kind of stuff?

MS. SUZUKI: We have not -- well, we haven't, but we can check with our analysts and --

DR. HOADLEY: I think especially given that this is just a six-month period to test, we should take a good look at the literature and see if there's any other suggestions for refining that.

MS. SUZUKI: Okay.

MR. KUHN: Unlike Craig, I am interested in the other potential correlates, but I think it's fascinating that we're having this conversation, where we started the day talking about readmissions, which hopefully will help lead to compliance, and we'll finish tomorrow with shared decision making, which will help. So I think it's nice that
this is sandwiched in between those two conversations. But I'll define mine as technical. But I'm just curious, on Slide 11, the one on COPD --

DR. HOADLEY: [Off microphone.]

MR. KUHN: Yeah. I'm on Rita's list, too. We're both on the watch list.

I'm just fascinated. Maybe some of the clinicians can answer this question, as well, in the room, but the COPD, I'm just fascinated that the adherence drops so steeply for so many others, but this one in particular just fascinates me with the potential breathing problems these patients would have and you would see compliance drop dramatically here. Does anybody, I mean, any kind of speculation why this one -- we would see this, particularly with the one that says severe COPD? I was just fascinated by that.

DR. COOMBS: I was going to comment on round two about COPD specifically because the six-month trial for adherence for COPD is really short, and there's so many other mitigating factors, and you look at the Part A and B, which is considerably increased. And so the COPDs have less under control when you compare them to CHF in the sense that
an infection throws them off, and smoking, and those are two of the compounding things that you have no control over.

So, in a sense, the COPD is a very hard disease to get your arms around in terms of looking at the impact of subsidy or no subsidy and the impact of adherence versus non-adherence because you have exacerbation of COPD and increasing costs.

And then the other piece of it is that a lot of the drugs that are used in COPD are not on formulary, and then so there's maybe some other issues in terms of copays and things of that nature, especially for some of the long-acting beta agonists, whereas CHF has a lot of drugs that are pretty much -- they've become benchmark drugs in terms of where you follow the algorithm. So I think COPD lends itself clinically to a lot more variation in the type of drugs that you use, and hence the generic name under COPD as long-acting. They didn't specifically do ARBs versus ACE inhibitors.

So I think that's part of the piece of the puzzle, because you're not really comparing two diseases that are comparable, and the time frame for COPD, I don't think, is a realistic measure of being able to say that adherence is
going to make a big difference in their money spent, either, because of the other factors that enter in.

DR. REDBERG: I also wondered about that when I saw this slide, because you have to think, if the medicine was making you feel better, you wouldn't stop taking it. So it does make you wonder. People don't -- it's a lot harder to get people to keep taking medicines when they don't feel the effects of it, but COPD is something you would have expected to -- actually, it's treating symptoms, so it does make you wonder about the efficacy of the treatment.

DR. HALL: Just very briefly, COPD is notoriously [indiscernible] by the season of the year in which you study it. So it really depends when flu is around. This year, that was 2009, flu was around December, January, February, which confirm to my bias. On the other hand, if flu came in the fall, I wouldn't expect that to happen, but it's a very iffy thing to follow seasonally.

MR. GEORGE MILLER: Yeah, I think most of this has been covered by Herb and Rita, but just for a clarifying question of the -- in this context, what do we define as adherence, and if the other socio-economic factors are a part of that equation as we look at this going forward.
Particularly, I'm wondering if the effects of disparity have any impact on adherence, as well, and how do we handle that going forward and what recommendations we made. But most of mine track what already Rita has said.

MR. HACKBARTH: Okay. So we have already sort of gone partially into round two, but we will now officially go into round two. Rita, we'll start with you.

DR. REDBERG: Really, I was -- I kind of alluded to it in the last comments --

MR. HACKBARTH: Yes.

DR. REDBERG: -- it's just that there are different kinds of medications, and if we really -- and I'm sure you tried to pick the ones that are in the life-saving categories, but, I mean, as Craig alluded to, it does depend a lot on how many medicines you're on and also what kind there are, because, I mean, as we saw in the Garfinkle study that you mentioned last time, not all medicines are necessary or even beneficial and so it's important that we kind of try to make that distinction: The ones that are life-saving or certainly beneficial in outcomes, the ones that maybe don't make a difference one way or another, and the ones that you probably would be better off not taking,
and looking at the adherence.

Presumably, CHF and COPD, most of them were in the beneficial on outcomes category. But, the problem is they might have been on other drugs, too, and then we know the more drugs people are on, the less likely they are to take them, in general, because they get a lot more side effects, particularly in the Medicare age group. You know, the interactions just are synergistic with number of medications, particularly once they're up to three to five, and so many beneficiaries are over that number at this time.

MR. BUTLER: So a little bit along those lines, this is, first, really -- I think it's really good, but it would -- I suspect there's many problems. If you look at all the elderly that had more than X number of drugs, you'd see more damage done by that than the opportunity that there is by adhering to ones that can make an impact. So it would be another way to look at the lens of what's going on.

DR. BAICKER: Yeah. I'm really supportive of this kind of analysis because I think if we don't look at costs across silos, we'll never be able to think about aligning payment. So I'm really a big fan of the question.

And the part that makes me most concerned is the
attribution of the causality, and I think this is part of what Rita was getting at and what I was gesturing at Mark about, is that to me, the issue of how much it costs to get somebody from low adherence to high adherence is second order relative to would we really expect to see somebody who looks non-adherent now to look like somebody who looks adherent now if we just made them adherent or are there fundamental differences in these patients that are coming from lots of other things. When I take my meds, I also diet or I also do other things that my doctor is recommending to control my diabetes and it's not just taking the meds per se. It's a constellation of behaviors, whereas if you could change the med taking behavior, you still might not realize the better outcomes of the more adherent patient.

And so the fact you're looking at this highly relevant population is a big advantage over some previous literature, but some previous literature has some advantages in identification strategies in using other mechanisms to try to get at really causal effects of changing adherence. and until we feel as though -- I think documenting the variation in adherence is a really important first step, but until we're able to really pin down a causal story more
persuasively, using words like "results" and "effect" make me a little nervous. I don't think that we're there yet and I want to see, though, that set of accumulated facts documented nonetheless. Even if we can't get at the causal story, I still think there's a lot of value here, but we need to be really careful with that causal language.

DR. CHERNEW: So, first, my main point is I agree with Kate, and my follow-up points are --

DR. BAICKER: [Off microphone.]

[Laughter.]

DR. CHERNEW: Well, no, I was just going to say it again.

DR. MARK MILLER: [Off microphone.] Do you want to change your --

DR. CHERNEW: Most importantly, I think it's a huge step forward just generally to recognize the connection between Part D and Part A-B. It moves us away from silos, and anything in that direction, I think, is really important.

I'll say that it's important to recognize -- and this didn't come up -- that you're measuring adherence, which is what you set out to measure, which I think is fine,
but that's different than measuring use. So there's people that weren't using at all that may start using and they are basically not included in here. So you're not measuring that thing.

More broadly, there's clinical questions and there's policy questions, and in some ways, this is designed to answer a clinical question, "If you take your drugs, what will happen," of which there is work on. But it's important to recognize that when we do that, we have to be aware that that's not the same as actually the policy question, "What would happen if we were to make changes in the Part D coverage gap" or anything of that nature. And so that disconnect becomes important in what we infer from this work. But, nevertheless, I think understanding this stuff is really important.

The last thing that I'll say, which, again, follows, I think, on where Rita was, and she was exactly right, that there's a lot of heterogeneity. There's good things that we want to spend a lot of time encouraging, whether it saves money or not, but we care about the quality. And then there's all kinds of other issues, unintended consequences of polypharmacy and situations where
there's not a lot of value for taking the drugs, or when you're purchasing them, inefficiency, a whole lot of things you might not want to do.

And so understanding the connection between the policies that we're thinking about and how detailed they are at addressing the specific clinical things matter, because some policies we look at quality measurement is sometimes relatively clinically specific. We are thinking about this type of adherence as a quality measure for various types of plans. Other times, changing copays and the Part D coverage gap, tend not to be particularly nuanced. They tend to be a very broad stroke, where you're lowering copays on good, wonderful, high-value drugs and maybe some that aren't so much.

So the more we can recognize the analysis and how it's going to be used in the context of policy, I think, the more we can add to what I believe is still a very useful exercise of recognizing the connection between Part D and the rest of the Medicare program.

DR. SAMITT: So, I'm admittedly struggling with this. I think that it's valuable to look at adherence, but I think that there are so many organizations like our own
and pharmaceutical companies and others that really struggle with changing behavior and enhancing adherence, and I would want us to spend our time on the things that we can truly control and influence.

So I hate to sound like a broken record, but in high-performing organizations, so Pioneers or ACOs or Medicare Advantage-type plans, I'd be interesting in knowing, you know, let's step away from adherence, knowing which organizations have very effectively been able to control the costs of severe CHF or non-severe CHF or COPD, and what are the specific interventions that they've put in place to influence quality and cost, and maybe adherence is not where they spend their time and effort because it's not something that they can do a whole lot about. You know, maybe, as we think about policy, the levers we should pull are different ones.

So I think what I struggle with is the degree to which adherence is a lever that we concentrate on, because at the end of the day, how much would we really be able to move that versus other potential interventions.

DR. HOADLEY: So, I'm really glad to see this analysis, and I think part of what we've been talking about,
but some of also what you've talked about for future
directions, is what'll help make this more valuable. So
trying to think about what are the measures that influence
adherence is certainly a part of what needs to go into this,
and in the Commission's recommendation of last year on
changing the copay policy for the LIS population, part of
that was to increase generic use, and there are studies that
suggest increased generic use is associated with increased
adherence. So there are some policy levers we can think
about how these pieces start to go together, and I think
that's part of it.

We've also -- you've also done a lot of work on
the medication therapy management, and we don't know a lot
about what plans are doing. Maybe we will soon. But that's
obviously aimed at doing various things, part of which would
be increasing adherence. And so thinking about the
correlates of adherence, as Craig was talking about, would
be part of getting into that.

I think as you think about a longer time period
over this, there may be some of the measurement issues that
we're struggling with that might straighten out a bit with
more time period.
A few other things that I want to just mention. I mean, there's definitely a literature out there about declining adherence over time. So some of it may be the statistical property of starting with the adherers and that assumption. But there's also literature that suggests that people get tired of taking their drugs and these sorts of things, regardless of where they start. So, I mean, you clearly want to take a look at that, if you haven't already, and think about where that fits in and whether that -- even things about things that you want to do as adjustments to looking at some of the modeling of this.

And I wonder if it's possible to look at -- I mean, you have, with a period of time, the clarification. You said you were doing a modeling process to look at what would low adherers look like if they became high adherers, but you all do have some in the population who do move from one adherence category to another, and maybe separately to look at that group, see if there are some things associated with that that might give us some further clues and get us a tiny bit closer towards that causality, cause and effect kind of thing. It won't get us there, but it might help.

I'm generally not surprised by the kind of
condition-specific variation, but it's also something, and we've already had some discussion around this, that we'd want to keep challenging. You know, what are the clinical expectations for these different conditions? Where are ones where we might think you'd get a result? Where are ones -- you picked depression because there wasn't an obvious argument whether we should see a difference, and that's a useful starting point. You didn't see a difference, so maybe that's as expected.

Others, and as you begin to look at more conditions, having a good preexisting sense of where clinical expectations are, both for what you'd expect in impact on spending, but also whether that impact is purely on the spending for that condition. In some cases, if people are healthier, it's not always going to show up in the spending related to that condition. It could show up in a broader set of spending, because, obviously, health conditions are interrelated. But I think it can be a good sense of expectations going into the different conditions we look at, would be helpful, both before going into it but also as you try to explain it.

And the last comment, I'll link back to something
Mike said about the CBO memo of last fall where they do have some literature, and obviously you know about that, but there are some subtle differences there because they were looking specifically at volume of drug use as opposed to adherence, and as we talk about this, trying to tease out, you know, where there's just more drug use in their case as associated with lower overall A and B spending, and if at some point we can understand the difference between volume effects and adherence effects, that would obviously be useful going forward.

So I can elaborate on these at another time, if that's helpful, but I wanted to throw a bunch of things out.

DR. COOMBS: So there's lots of studies out there on adherence, and I think Ira Wilson has done a great job looking at some models of adherence.

I think your questions are spot on, first of all, and I think where you're going with this is important. And I'd like to remind everyone that we're actually looking at a movie and we're just looking at a position in time. Where we're talking about medical homes, we're talking about going to ACOs and the like, it's possible, and I'm sure there are some best practices out there, to get to adherence that
looks much better than this. We're not there yet, so I think it behooves us to really kind of pay attention to this corridor right now and what we're dealing with in terms of moving to the next meter of making sure that adherence is important.

I do believe that the adherence is a key factor in terms of hospitalizations for some diseases. I'm not sure that's avoidable in many of the cases of COPD, as Bill and I have mentioned already in terms of what moves COPD into hospitals and exacerbation of illness.

So I think you're spot on. I think it's going to be a lot more than six months that's necessary to get some real, true information. Thank you.

MR. GRADISON: You mentioned that you might take a look at other conditions, and with apologies to the clinicians, I'm going to suggest one, which is atrial fibrillation and the use of anticoagulants. I had occasion to spend quite a bit of time focusing on this recently in preparation for a couple of days with a think tank. And here, we're talking in the conditions that you have already listed of potentially serious effects, like stroke, in this instance.
But one of the special features here is that there's some novel agents that have come along as options to coumadin. Coumadin has to be monitored very closely. It can have some pretty bad reactions to it in some instances. and it is a periodic -- staying on it isn't easy because of the periodic testing, which is, as I understand it, not as required -- the frequency is not as required, or it's not as often as for these new agents.

So I think you might get some interesting, a different window looking at this, because as I think about this, and I know this is very subjective, but watching the decline, I do -- a couple of questions come to my mind, but one of them is the question of side effects, which I appreciate that's a very difficult thing to quantify. But perhaps as you're looking at different conditions and particularly different drugs that just by their history have significantly higher levels of potentially serious or uncomfortable side effects, that might be an interesting window into this, as well. Thank you.

DR. NAYLOR: So I'm really delighted you're pursuing this. I think this is such a central system issue for which policy responses might be important, and there are
three paths that you're already focused on, but I would
courage if we can continue to look at it.

One already mentioned is the whole notion of
polypharmacy, and your data already suggests that fewer
prescribers and medications lead, and there is a pretty good
body of literature suggesting for older adults, polypharmacy
is a major factor that inhibits adherence.

The second is one which might test some hypotheses
with which I think people have a sense that we know the
causal path, and that's the group of people who have high
rates of hospitalizations and heart failure. And there's
always the sense that they're not adherent. Therefore,
they're going into the ED and using acute care resources and
coming back again. And I'm wondering -- I don't know
whether or not there's an opportunity here to look at what
might be the path here. Is it because they have these acute
episodes of illness that make them feel really awful that
contribute to poor adherence, et cetera? I don't know
whether or not.

And the third thing is interesting here in
diabetes. Diabetes has been a focal point of patient-
centered medical homes and huge investments in diabetes
educators and so on. And here you have for a -- in the LIS
group -- a very, much higher rate of diabetes as comorbid.
So wondering whether or not that presents an opportunity to
avenue for you to look at is that kind of investment
beginning to pay off in focused education for that problem.

   DR. NERENZ: Yeah. I'm just trying to think ahead
to some of the Medicare payment implications of this whole
body of analysis, and I'm going to observe that even if a
causal relationship between shifting patients from low to
high adherence produces the effect on savings that Kate was
concerned about, let's just imagine that that can happen,
it's real, illustrated, for example, on Slide 12.

   My next observation, though, is that the entities
incurring the costs of producing that improvement in
adherence will not be the entities realizing the savings
unless you're in Medicare Advantage, and only in a partial
sense if you're in an ACO.

   So even as this line of thought keeps going
forward, I think we have to say, if these relationships are
real, and if they are causal, and if we can improve it here,
and we can generate savings, how are we going to move the
money to actually make those actions occur?
DR. HOADLEY: No, I think Dave raises a really important point, and it's almost worse because a Part D plan's costs go up if adherence goes up, because they're on the hook for those costs. And thinking about how to do that, even if we don't think about ways to move money around, thinking about how to create incentives to the Part D plans to take measures to encourage adherence is something that's not obvious and not simple, and I think that as we think about the policy side of this, we really do want to think about that, those points.

MR. HACKBARTH: Agreed. Good points.

Thank you, Shinobu and Joan. Nice work.

And we're on to our final session for today, and this is addressing differences in Medicare payment rates across settings.

[Pause.]

MR. WINTER: Ready? Okay. In this session, we'll be continuing our exploration of payment differences across settings for ambulatory services, and I want to begin by thanking Jeff Stensland, Kevin Hayes, Julie Somers, and Zack Gaumer for their help with this work.

First, we'll explain the importance of addressing
payment differences across settings. We will then review
the Commission's principles for how Medicare should pay for
similar services provided in multiple sites of care. Next,
we'll consider different types of services for which it may
be appropriate to align payment rates across settings, based
on our principles. And for each of these groups of
services, we have modeled the impact of alignment payment
rates on Medicare spending, beneficiary cost sharing, and
different categories of hospitals. And we will also
describe ways to mitigate the impact of these changes on
hospitals that serve many low-income patients.

So, let's start by talking about why it's
important to address this issue. There has been rapid
growth in hospital employment of physicians, which has
contributed to the migration of ambulatory services from
free-standing offices to outpatient departments. According
to the AHA's Annual Hospital Survey, the number of
physicians employed by hospitals increased by 55 percent
from 2003 to 2011. And according to a survey by the
American College of Cardiology, the share of cardiologists
employed by hospitals grew from 11 percent to 35 percent
from 2007 to 2012.
As more physicians become employed by hospitals, the billing of services in Medicare is shifting from freestanding offices to OPDs. As shown on this slide, the number of evaluation and management visits per beneficiary grew by eight percent in OPDs from 2010 to 2011 compared with a small decline in offices. The number of echocardiograms increased rapidly in OPDs while declining in offices. And the trend is similar for nuclear cardiology studies.

Because payment rates for most services are higher in OPDs than in offices, the result of services shifting to OPDs is higher program spending and beneficiary cost sharing. Meanwhile, there may be no significant changes in patient care.

We projected how much more Medicare would spend per year if the migration of E&M visits and cardiac tests to outpatient departments were to continue at the same rate over the next ten years. We estimate that by 2021, Medicare spending on E&M visits would be over $1 billion higher annually due to the shift to OPDs, and beneficiary cost sharing would be about $300 million higher. Medicare spending and cost sharing for echocardiograms and nuclear
cardiology studies would also be higher by similar amounts.

The Commission has developed key principles to guide Medicare in paying for similar services in multiple settings. First, patients should have access to settings that provide the appropriate level of care. But if the same service can be safely provided in different sectors, it may be undesirable for a prudent purchaser to pay more for that service in one setting than another. Therefore, Medicare should base its payment rates on the resources needed to treat patients in the lowest-cost clinically appropriate setting.

But there are reasons why it may make sense for Medicare to pay more for certain services in a hospital outpatient department than in other settings. First, hospitals incur costs to maintain stand-by capacity for handling emergencies and to comply with additional regulatory requirements. Second, patients treated in OPDs may be more medically complex than patients treated in offices and it might be more costly to treat sicker patients. And, third, the hospital Outpatient Prospective Payment System is more likely than the Physician Fee Schedule to combine the cost of a primary service with
ancillary services into a single payment, a concept known as packaging.

In our March 2012 report, the Commission made a recommendation to equalize payment rates for non-emergency E&M visits across settings, and the rationale for this recommendation is described on the slide. We also recommended that this change be phased in over three years and that there should be a stop-loss policy for hospitals with a high share of low-income patients. This recommendation would result in lower payment rates for E&M visits in OPDs, producing annual total savings of $820 million and cost sharing savings for beneficiaries of $190 million.

Since we made our recommendation on E&M visits, we have been exploring other services that meet the Commission's principles for aligning payment rates across settings. For the purpose of this analysis, we combined services into Ambulatory Payment Classification Groups, or APCs, which is the unit of payment in the Outpatient PPS. And based on a careful analysis of how our different services stack up with our criteria, we identify three groups of APCs.
Groups one and two include 66 APCs for which payment rates could either be equalized between OPDs and offices or the differences could be narrowed, and we discussed these two groups at the October and November meetings. We also focused -- since then, we have focused on three cardiac imaging APCs that appear in groups one and two. And, finally, we have identified 12 APCs that are commonly done in ambulatory surgical centers and for which payment rates could be equalized between OPDs and ASCs.

So this slide talks about groups one and two. Group one includes APCs for which payment rates could be equal across settings, and group two includes APCs for which the OPD rate could be higher than the office rate, but the differences in the payments could be reduced or narrowed from the current level.

At the November meeting, we described the selection criteria for each group. The key difference between the criteria for groups one and two is the extent of packaging. Services in group two have a significantly higher level of packaging in the OPD, and we factor in these costs when we calculate the revised OPD payment rates. As a result, the OPD payment rates are still higher than the
office rate, but the gap is narrower.

Since the November meeting, we have had a lot of
discussion with hospital industry groups about the criteria
that we used to identify these services. As a result of
their comments, we changed how we measure the frequency with
which an APC is provided with an emergency department visit,
which is the third criteria shown on the slide, in both
boxes. As a result of this change, we ended up dropping
five APCs from groups one and two. So it went from 71
altogether to 66 APCs in both groups. And I'd be happy to
take questions about this during the discussion period.

Next, Dan will explain the impact of changing
payment rates for APCs in groups one and two.

DR. ZABINSKI: So we evaluated the national level
financial effects of the payments adjustments for groups one
and two that Ariel just covered and we find that combined
program spending and beneficiary cost sharing would decline
by about $900 million per year.

In your meeting paper, we mention the amounts by
which beneficiary cost sharing would decline depends on the
method used to determine the copayments for each OPC, and
the specifics are in your paper, but the cost sharing would
decline from in a range of $140 million to $380 million per year. Also, the more beneficiaries save in cost sharing, the lower the program savings are by the same amount.

And we also estimated that these payment adjustments in groups one and two would reduce hospitals' overall Medicare revenue by 0.6 percent and their Medicare OPD revenue by 2.7 percent.

We also evaluated the effect on hospital categories, including urban and rural; nonprofit, for profit, and government-owned; and major teaching, other teaching, and non-teaching. And the effect of these payment adjustments for groups one and two is similar to the overall average of 0.6 percent for each of these hospital categories, except for rural, which would have their Medicare revenue decline by 0.9 percent.

Finally, we evaluated the effects of combining the payment adjustments for groups one and two with equal payments across OPDs and freestanding offices for E&M visits the Commission recommended in the March 2012 report. We found that this combined policy would reduce hospitals' overall Medicare revenue by 1.2 percent and Medicare OPD revenue by 5.4 percent. And this combined policy would have
a disproportionately large impact on rural, major teaching, and government-owned hospitals.

A concern that many have expressed about aligning payments between OPDs and freestanding offices is that access to ambulatory services among low-income patients may be adversely affected. In response, we have considered methods to mitigate the impact on hospitals serving low-income patients. Ideally, we would like to target hospitals that serve a lot of low-income Medicare patients in their OPDs, but currently, no measure represents that. In response, we have decided to use hospitals' disproportionate share, or DSH, percentages as a proxy. And the DSH is based on the number of inpatient days for low-income Medicare and Medicaid patients. But a better measure would be focused strictly on care provided to low-income Medicare patients in OPDs.

Another issue to consider is whether the policy should be a stop-loss protection or a set pool of dollars. A stop-loss has the advantage of providing assistance to all hospitals that meet a certain set of criteria for being deserving of assistance. But the amount of revenue returned to hospitals would not be known ahead of time and may exceed
the amount anticipated.  

A pre-set pool has the advantage that the amount returned to hospitals is known ahead of time, but it has the disadvantage in that it may result in some hospitals that may be deserving of assistance not getting as much as they need to remain viable.  

For the purpose of this presentation, we use the following illustrative example of a stop-loss, where losses would be limited to two percent of hospitals' overall Medicare revenue if their disproportionate share percentage is above the median of 25.6 percent. The Commission recommended the same policy in the March 2012 report, along with equal payments across settings for E&M visits.  

And we have collected the hospitals in our analysis into the categories listed on the left margin of this table. The first column of numbers in the table represents the effects of the payment adjustments for groups one and two on each of the hospital categories. Column one indicates these payment adjustments have quite similar effects across the hospital categories, except that rural hospitals are disproportionately affected, which we mentioned earlier.
The second column of numbers represents the effects of the payment adjustments for groups one and two plus the stop-loss that we just defined. We find that the stop-loss would return about $10 million, and this results in virtually no difference between the first and second columns, which indicates the stop-loss has a nearly trivial effect in this situation.

The third column represents the effects of combining the payment adjustments for groups one and two along with payment adjustments for the E&M policy that the Commission recommended in the March 2012 report, and we simply refer to this as the combined policy. And you can see that some categories lose much more than others under these combined categories, with rural, major teaching, and government-owned hospitals losing more than the average.

And the fourth column is the effects of the combined policy coupled with the stop-loss. In this case, the stop-loss would return $210 million to the qualifying hospitals and narrow some of the differences among the hospitals, and particularly reduces the losses for government-owned and major teaching hospitals.

So that completes our analysis of the 66 APCs in
Based on Commissioner comments at the meeting last October, we also did a similar analysis that focuses on three cardiac imaging APCs in groups one and two. These APCs have shown unusually rapid migration from office to OPDs, which reflects the increase in hospital employment of cardiologists. Also, payment rates are substantially higher in OPDs than in freestanding offices for these services, and they comprise over half of the savings from groups one and two. Following the same payment adjustments for these APCs that we did for them in our analysis of groups one and two would reduce combined program spending and beneficiary cost sharing by about $500 million per year, with beneficiaries' cost sharing going down by about $100 million.

And this slide has the same structure as the one presented two slides ago, but we've replaced the payment adjustments for groups one and two with the payment adjustments for the three cardiac imaging APCs. Column one indicates these payment adjustments have a similar effect in all hospital categories, except that rural loses a bit more than the other categories. Column two indicates that adding the stop-loss to
hospitals that serve low-income patients has little effect
on the payment adjustments for the three cardiac imaging
APCs.

And column three, we combine the payment
adjustments for the cardiac imaging APCs with the E&M policy
from the March 2012 report. And as you can see, some
hospital categories are affected more than others, with
rural, major teaching, and government losing more than
average.

And column four, the stop-loss returns $140
million to qualifying hospitals under this combined policy.
It narrows the differences between the hospital categories
and provides the most assistance to government-owned and
major teaching hospitals.

And we also identified 100 hospitals that would be
most affected by the payment adjustments for the three
cardiac imaging APCs without any stop-loss or the effects of
equal payments across settings for E&M visits. Compared to
all other hospitals, these 100 most affected hospitals are
more likely to be rural or nonprofit, less likely to be
major teaching or for-profit, have about one-third the
number of beds, on average, and they have a similar DSH
percentage, and only six of them are specialty hospitals. So far, we've focused on payment rate differences between OPDs and freestanding physician offices. At a previous meeting, Commissioners suggested that we also investigate aligning payment rates between OPDs and ambulatory surgical centers, or ASCs. For all services, payment rates are higher in OPDs than in ASCs, with most services being 78 percent higher in OPDs.

We have identified three criteria that should be met for a service to have equal payment rates in ASCs and OPDs. They should be performed more than 50 percent of the time at ASCs, infrequently provided with an ED visit when done in an OPD, and patient severity should be no greater in OPDs than ASCs.

And we identified 12 APCs that meet these three criteria. Reducing OPD rates to the level for ASCs in these 12 APCs would reduce combined program spending and beneficiary cost sharing by about $590 million per year, with beneficiary cost sharing declining between $40 million and $220 million per year, depending on how copayments are determined.

And this is the third time you've seen the version
of this slide. In the first column, you can see that the
equal payment rates between OPDs and ASCs for the 12 APCs
reduces revenue in most hospital categories by close to the
0.4 percent for all hospitals. Rural hospitals are an
exception and lose 0.7 percent.

In the second column, we add the stop-loss that we
discussed earlier, and it would return $10 million to the
qualifying hospitals, and its effect is largely minimal in
terms of the differences between the first and second
column.

The third column shows the effect of combining the
equal payments across settings for the 12 APCs with equal
payment rates in OPDs and freestanding offices for E&M
visits. This combined policy would vary across hospital
categories, with rural, government-owned, and major teaching
hospitals being disproportionately affected.

And the fourth column shows the effects of adding
the stop-loss we defined earlier to the third column. In
this situation, the stop-loss would return $160 million to
the qualifying hospitals and has important effects for
reducing the impacts on government-owned and major teaching
hospitals.
And once again, we identify the 100 hospitals that would be most affected by the equal payment rates across OPDs and ASCs for these 12 APCs. This excludes the effects of the stop-loss and equal payments across settings for E&M visits. Compared to all other hospitals, the 100 most affected hospitals are more likely to be rural or for profit. They have one-sixth the number of beds of all other hospitals, on average. They are less likely to be nonprofit or major teaching. They tend to have a lower DSH percentage. And 61 of them are specialty hospitals.

So the summary of our discussion today starts with identifying 66 APCs where differences in payment rates between OPDs and freestanding offices could be narrowed or eliminated, and we define these as groups one and two. And we evaluated the effects of these payment adjustments on program spending and beneficiary cost sharing. We also evaluated the spending and cost sharing effects of focusing on three cardiac imaging APCs that are in groups one and two. And, finally, we evaluated the spending and cost sharing effects of equal payments in OPDs and ASCs for 12 APCs that are commonly done in ASCs.

On this table, the first column is a summary of
the effect on combined program spending and beneficiary cost sharing of the policies that we discussed today.

Then adding the Commission's recommendation of equal payment rates in OPDs and freestanding offices for E&M visits would increase the effect of each policy by 0.6 percent, which is the second column on the table.

The third column shows that the three policies we discussed today would substantially reduce annual Medicare spending and beneficiary cost sharing.

And the fourth column indicates that the reduction in beneficiary cost sharing would vary, with the level of reduction depending on how beneficiaries' copayments are determined in each APC.

Please note that there is overlap between the APCs in groups one and two and the other two categories on the slide. And because of that, the total impact on spending and cost sharing from doing the changes in all three categories would be much smaller than the amounts determined by simply summing the columns on the table.

So to close, areas of discussion that would be helpful for us today as we move forward on this issue include questions about the analysis we presented,
discussions and additional services that meet the principles of aligning payments across settings, and discussions of ways to mitigate the impact on hospitals that serve low-income patients or reduce beneficiary cost sharing, and we turn things over to the Commission for discussion.

MR. HACKBARTH: Thank you.

So let me just say for the audience a little bit more about the context of this discussion. This is a topic that we've been talking about for a while now, and it's become almost a regular feature of our meetings.

Much of the material in today's presentation is addressing questions raised at our last discussion, whenever that was, I guess in January or maybe it was in December that we last discussed it.

DR. MARK MILLER: More like November, wasn't it?

MR. HACKBARTH: Okay, whenever. So we are trying to respond to issues and ideas raised by Commissioners in previous sessions. We have made a formal recommendation on E&M services. We have no draft recommendation under consideration right now, and plan no recommendation for our June report. Based on the conversation today, we'll decide what our future path is on this topic for the fall when we
reconvene again.

So with that, let's start Round 1, except I'm amending the ground rules here. To be a qualifying Round 1 item, it has to be phrased as, "Please put up Slide blank," and then followed by, "What does blank mean?" Okay? In order to qualify for Round 1, this is sort of like Jeopardy where your answer has to be in the form of a question.

Round 1 has to fit --

DR. BAICKER: It has to be in the form of a question.

MR. HACKBARTH: Yeah. This question, one of these two questions. Okay? So Bill, you're going to be the --

MR. GRADISON: There are a lot of slides to have the word rural on them. It's just a specific, very specific question. When you use the category rural, does it include critical access hospitals and solo community hospitals?

What's in rural?

DR. ZABINSKI: It excludes CAHs, the critical access hospitals, and it includes solo community hospitals.

MR. GRADISON: Thank you.

DR. ZABINSKI: Basically it's all rural hospitals that are under the inpatient prospective payment system.
MR. GRADISON: Thank you.

MR. KUHN: On Slide 23 -- excuse me -- please, on Slide 23, I'm curious about the last column, beneficiary savings, and you have ranges for the first two, but the middle one is an absolute, you know, as close as you can get. Because of the ranges, is that because of the formula-driven overpayment, if that's what's driving that? What's creating those ranges?

DR. ZABINSKI: What's going on with that one -- how to say -- I think you probably know about the way that co-payments are determined once -- in the outpatient PPS, once they reach the 20 percent level, they go up or down with the payment rate. And in this case, all three of them are at the 20 percent -- well, it's not all three of them -- two of them. But most of the money in there is at the 20 percent.

So we have three different methods for, you know, estimating the effects on cost sharing, and since all three of them are at that 20 percent level, then the three different methods that we have produces essentially the same $100 million impact.

MR. KUHN: And so, that's why those are. And then
the others, because of the variation, some are above the 20
percent and that's why we've got that way. Thank you.

DR. COOMBS: Yes. Slide 13, please. So the third
bullet, in the writing you talked about -- in the paper you
talked about Medicaid, and I was wondering if that last
bullet was -- you were intending to put Medicaid, a Medicaid
benchmark there?

MR. WINTER: One of the questions is, it's more
about the second bullet, the second sub-bullet using DSH as
a proxy, because DSH includes share of inpatient days that
are for Medicaid patients as well as share of inpatient days
that are for Medicare patients on SSI. So the question is,
do you want to use a Medicaid measure as part of the measure
for determining hospitals that serve a large share of low-
income patients.

DR. COOMBS: Right. Right.

DR. ZABINSKI: Ideally -- I mean, I guess ideally,
we would like some measure.

DR. COOMBS: It was mentioned in the paper.

That's why I'm just bringing it up and I didn't see it up
there.

DR. ZABINSKI: Okay.
DR. MARK MILLER: Just to expand -- please, stay on this Slide 13. Just to stay on this for just a second, I think the conversation, if we end up talking about mitigation policies, we'll engage in questions like, should the measure be Medicare, say SSI/Medicare patients, should it be Medicare plus Medicaid. But then another question has come up is, what about inpatient versus outpatient?

I think what we're trying to do in a summary fashion and in somewhat more detail in the paper, is put all those questions in front of you. If you accept the Medicaid point, and this conversation has occurred before, you are kind of implicitly saying, Well, then we're going to include a different payer in the measurement. And then there's the inpatient and outpatient back and forth that we've had here in other ones. Thank you.

DR. COOMBS: This is not a to-fro, but I do want to say that I'm persuaded by the presence of Medicaid as well. That's the only reason I asked the question.

DR. SAMITT: Slide 23, please. And this may be more about -- less about this topic, but more of an educational opportunity for me about Medigap. So in the last column, the beneficiary savings, do these savings truly
accrue to the beneficiary or do they accrue to Medigap
plans, and do they then translate ultimately to the
beneficiary and reduce premiums?

MR. HACKBARTH: Let me try, Dan, and see if I've
got it right. I assume it's calculated just based on the
cost-sharing structure in Medicare. And so, to the extent
that a beneficiary is covered by a supplemental plan, it
would not flow directly into the beneficiary's pocket. If
the markets are at all competitive, it may ultimately flow
through to the premiums, but there's some reason to question
whether -- how competitive the supplemental markets are.

MR. ARMSTRONG: Could you please go back to Slide
13? And I just want -- the question I have is just to
remind me of why this is an issue. The concern about, you
know, applying our principles where we've applied them
everywhere else to those hospitals that have a higher
percentage of low-income patients, is our concern that those
hospitals rely on the cross-subsidization of Medicare
payments to pay for other payments -- patients? I just want
to be reminded why this is an issue for us.

MR. HACKBARTH: So our initial concern, the reason
why we put this in the recommendation we made on E&M
services was that in at least some communities, hospital outpatient departments are really important providers of these services. There aren't as many private physician practices where people could go to receive the services. So to the extent that we would compromise the ability of those institutions to provide the services, it could mean an access problem for Medicare beneficiaries. And so, we wanted to err on the side of caution, take special -- make special precautions not to hurt those institutions unduly.

DR. MARK MILLER: And this is again with respect to Alice's comment and still staying on this slide, is that's the question. If it's about access for Medicare beneficiaries in a particular community, your measure might be different. And that's why we're trying to raise the questions around the measurement.

MR. HACKBARTH: The other part of our recommendation, as you probably recall, Scott, was to recommend that the Secretary look further at this issue. If the issue is protecting institutions that are important for serving a particular community's low-income people, perhaps the best way to do that is not through a subsidy run through
the Medicare program, but through another, a better targeted
approach. So this was sort of a stop-gap to create some
time for another approach to be examined.

MR. ARMSTRONG: It seems to me we've actually been
explicit about that principle in other conversations; that
that is not our responsibility. We're responsible to make
sure there's access for our Medicare beneficiaries, but for
cross subsidizing other programs that don't cover the costs,
that's not a criteria we should be applying.

MR. HACKBARTH: Clarifying questions.

MR. BUTLER: If it wouldn't be too much trouble,
please put up Slide 23. All right. So I'm curious on the
three cardiac imaging. You know, it's a whopping amount of
the total, as we've pointed out at earlier meetings. And I
think I asked you this privately before. Of all of the --
what do these three represent, though, of the totality of
the heart APCs? These happen to be the three that are the
big focus.

Is this, you know, like 90 percent of it, do you
think? I just don't know enough about the APCs to know if
there are a lot of other ones down the line beyond that that
are part of what would be addressed.
DR. ZABINSKI: I don't know how many, if you want to call them, define them as cardiac APCs there are. You know, just because these -- these three APCs have a lot of volume in them and that's why there's such a big -- there's such a big effect when you change the payment rates for them.

So I would guess that they are a good chunk of the total volume among all the current cardiac APCs that are in the outpatient PPS, but I don't know that for certain. But as far as how much, I, you know, I don't know.

DR. MARK MILLER: We could know that.

DR. ZABINSKI: Definitely could know that, yes.

DR. HALL: Please, 23. The assumption is that there will be no net change in the number of procedures done. Is that correct?

DR. ZABINSKI: That's correct, yeah.

DR. HALL: Okay. And we're sure of that?

DR. ZABINSKI: Well, basically the idea here is get a sense of, you know, if you just paid hospitals at a rate that aligns with another sector, how much would the, you know, program spending and beneficiary cost-sharing be affected. That's the idea here.
MR. WINTER: This is not meant to be -- this is a basic model. We're not doing a very sophisticated analysis, but we're considering behavioral responses such as CBO might consider if they were doing an official score.

DR. HALL: Sure. We're in Round 2 already. I'm sorry. I just wanted to clarify that one point.

MR. HACKBARTH: Round 1. Any further Round 1 clarifications? Rita.

DR. REDBERG: Please, we could stay on this slide for -- I actually was looking at Slide 4 where you had the - so my question on Slide 4, and perhaps I missed this, but you have the increase in growth in OPD, the decrease in free-standing. But overall in that time period, was there an increase or a decrease in overall imaging for these services, the echo and the nuclear cardiology?

DR. ZABINSKI: I believe there was a small increase overall. It was largely an offset, I believe, you know. The decrease in the physician office and the increase in the OPD largely offset each other.

DR. REDBERG: And then on Slide 23, please, did I understand correctly that your assumption was that there would be a decrease in Medicare spending because the volume
would stay the same despite the difference in reimbursement?

DR. ZABINSKI: Right.

DR. REDBERG: Just because, I mean, our experience in SGR and other things, that hasn't been true.

DR. ZABINSKI: True. I'm not sure how much to assume as far as a behavioral effect in this situation. One can think that, okay, if they're not done, you know, you could drop the rate in the OPD, you know. You could get them done in a free-standing office, perhaps with no affect on the volume. You know, it's hard to say what exactly the behavioral impact would be.

DR. CHERNEW: We don't even know which direction the behavioral impact might be.

DR. MARK MILLER: Like the CPC discussion that we had earlier today, I mean, in a sense we're trying to go through this in a static way to answer your questions that you asked earlier and get to your sense of zeroing in on things and then pick up from there and go further. But I think Mike does make a good point. Which way you would assume here if we got to that point, would be an interesting question.

MR. HACKBARTH: No further Round 1 clarifying
questions? Okay. Let me kick off Round 2. Could you put up Slide 14, please? So on various slides here for different combinations, we have a column that says, you know, here's the total revenue effect of combining these policies. I just want to make a connection for people that otherwise may be missed.

So certainly if you look at the far right column — and these are combined revenue loss numbers, right? And so, these are revenue losses. All other things being equal, what that would mean is that the overall Medicare margins would decline by these numbers. And, of course, the other place that we think about the overall level of Medicare payments to institutions is during the update process.

So to the extent that the magnitude of the numbers in that column, or any one of the columns in subsequent slides, is an issue. Another opportunity to address revenue loss is through the update process as opposed to the path of thinking, Well, we ought not do this because it results in the net revenue loss and the net decline in margins. There are other payment variables at work here. And so, I just wanted to highlight that for people, to get people to think about that.
DR. MARK MILLER: And the only thing I would say to that is, just a different way to think about that is, and we do this all of the time when you think about when we go through the payments systems. There's the level and then there's the underlying equity of the -- and work ability of the payment system. You can think of this as what's the underlying workability of the payment system. And then if there's more revenue to add, then the update part. I'm just trying to state it a little bit different.

MR. HACKBARTH: So Dave, do you want to start on Round 2?

DR. NERENZ: The first one would follow on some of these other observations about behavioral change. I realize it's hard to model that, but one of the questions, on some of these examples, we've showed a fairly heavy effect on rural hospitals, for example. It would be interesting to know what alternatives to HOPD placement exists in those places specifically. For example, would there be an ambulatory/surgical site available as an alternative site, even if you wanted to pay at that rate?

All those questions, I think, bear on the speculation of what the behavioral changes really would be.
The one behavioral change actually that would probably leave you with the same numbers would be if the procedures were done overall at the same rate, but they just shifted in the opposite direction, like from HOPD elsewhere. That wouldn't change your projected payments. But enough change in procedure volume would. So just observation.

The other thing -- you'll just cut me off if this doesn't work. I noticed the figure that you have in the chapter doesn't appear in the slides. And I did have a question on that. I'm looking for the page where that is. I'm sorry. This is the one, the scatter plot -- yeah, that one. What page is it on?


DR. NERENZ: Page 26, sorry. I just, to repeat an observation I think I made in November, that the -- what seemed to me interesting in this when you first showed it, and I make the point again, is the absence of relationship here may actually be meaningful in that the way the thing is arrayed, the points up near the top of this diagram are the ones that have a lot of extra HOPD payment, if we call it that way.

That effect, all else equal, would tend to push
those dots to the right, I think. The fact they are not
shifted to the right suggests that there's some sort of
corresponding efficiency effect. Now, it may be very small.
I understand that, you know, the contribution of these CNM
payments to this 30-day measure, this may not be so small.

But I guess the context here is that the absence
of relationship means there's nothing going on. My point
might be the absence of a relationship means that there
probably is something going on. It might be small, but it
might be something. I guess just to put a fine point on it,
you know, you talked about largely random r-squared .05. Is
there actually a statistically significant relationship in
here?

MR. WINTER: Yes, there is.

DR. NERENZ: But it's small.

MR. WINTER: Yeah. I mean, the .05, it's a
negative correlation and it's just not significant, but the
question is, is it a meaningful difference? So the
correlation is so small, you know, it doesn't seem to be
like a really meaningful correlation between how much from
revenue hospitals are getting from these services and their
scores on Medicare spending per beneficiary.
DR. NERENZ: But again, my starting point.

MR. WINTER: Right.

DR. NERENZ: The absence of a relationship may be meaningful.

MR. WINTER: And so, the point I would make there, as you alluded to, looking at 30-day -- spending for a 30-day episode around admission, so most of the spending there is going to be on the outpatient side and supposed to give care. Much of it -- a very small portion is going to be related to outpatient services like E&M clinic visits. So yeah. And we did have the slide up at the November meeting, so we didn't have enough time to put it back up again, but thanks for raising the question.

MR. HACKBARTH: Just to go back to the November discussion again, so even if you stipulate that there is this small negative relationship, you're not finished with your analysis. Then the next question is, is this the best way to encourage effective management that reduces episode costs or is this a not very well targeted approach?

DR. NERENZ: Agree 100 percent on that. I have no problem with that at all. It's just exactly, how was this presented in the written material.
DR. NAYLOR: Just with each iteration of this work, I've become more and more convinced that this is the right direction. And it's so aligned with the principles as you described on Slide 6 and reiterated. The only issue, and I guess I'm channeling Tom, is the impact on rural hospitals.

But that said, I think all of the proposed directions in terms of getting people who are clinically the same, our program paying for the services, Medicare's program paying for the services in the most efficient and effective way is absolutely an important principle to pursue.

MR. GRADISON: Maybe more on the same point. It would seem to me that there may be some benefit in combining our comments with regard to paying hospitals or other entities the same for identical tests and other kinds of services regardless of the site of service with the same point that we've made about post-acute care. It's precisely the same point.

And I realize we've had separate projects going on, but it would seem to me they really ought to be combined because it seems to me exactly the same issue, which is
paying equal pay for equal work, to go back to the old ERA argument or something.

MR. KUHN: Dan and Ariel, thank you both for all the work here and listening to the conversation from the last meeting and including all the details you have here. Like others, just point out the impact statements and tables you've put up here. In particular the impacts on the rural hospitals are a concern.

But the other issue, I just want to see if there was a chance as we kind of carry forward this work into the future, is really kind of thinking a little bit, after the conversation this morning, about the readmission policy, and the fact that there are things people are doing now in the post-discharge environment, that would this interrupt that feedback loop.

So are there some things now going on as a result of the deal with readmissions that they are aligning differently with the outpatient department, that these two either might synch up or they might not. And does that kind of create some issues there?

The other thing I would be real curious about, as the care coordination efforts continue to get more robust
out there, particularly with the ACOs and maybe even the
Pioneer ACOs, does this -- would a policy like this
interrupt or would it support those kind of programs on a
go-forward basis? And so, as we continue to think about
that, I'd like to know how -- if there was a way that those
interactions could be looked at further.

DR. COOMBS: So as I looked and read the paper,
which was excellent -- I really appreciate the job that you
guys have done -- Table 3 and Table 4 actually deal with
what kind of adjustments would happen if we would make those
changes that we proposed. And one of the things that I was
very concerned with is, even the adjustment that's made is
still quite robust for different sites, same procedure,
different sites. And, you know, there's opportunity for
even greater savings there.

I don't know if we've actually, you know, thought
along those lines, because, you know, I'm looking at the OPD
for the Level III echo in terms of what goes to the hospital
and what goes to the physician who does it. And it's more
than you would account for in an office, considerably more.
And so, I think we've talked about stand-by capacity for
hospitals and how we cover them.
But I'm not sure that we've gotten to a place that's actually even better in terms of our ability to kind of justify what those charges are for and how we pay the hospitals. Still, I think it's probably a little on the heavier side compared to the same thing that actually happens in the office for both the Level II and the Level III.

And then I agree with what Glenn has said in terms of that marker for what is a threatened access in the community. We have a lot of hospitals that might fit into that niche of being a safety net in terms of right being at the border for the percentage of Medicare patients treated, and the Medicaid penetration is probably a better proxy for that hospital being under duress or stress in terms of just the availability of resources in a given area.

So I think that's a real important thing to keep in mind, not just as, Scott, you alluded to that we're -- Medicaid patients are not our charge, but many times that is probably a more reflective marker of what kind of needs exist in a community.

DR. HOADLEY: Yeah, thank you. As this has been -- this issue has been articulated over the series of
meetings, and like Mary said, it seems to me it builds an increasingly convincing case that this is a sensible route to go. I think, you know, the refinements of it and the sort of details, and obviously there's a few choices we can make in terms of actually how to shape the details of a recommendation at whatever point we do that, but I find this very convincing, and especially in the context of so much of this serve as shifting sectors already.

We're just saying, Okay, so if there's something that's helping to move it from one place to the other, let's try to level that playing field, in particular in this situation.

DR. SAMITT: This is a great job. It keeps getting better. I'm comfortable, absolutely comfortable with where this is going. I think in the world of the ACO, the ACOs themselves are seeking out these opportunities. So in the world of bundled payment, we want to know all the things, that actually we can achieve the same quality of care or better in a lower acuity, lower cost setting.

And so, all of these things make total sense to me. I'm equally concerned about the rural hospital problem. You know, I think we've talked about things like this in
sort of similar settings, but is there a methodology that we can use that says, you know, if a setting is available, so if there is an ASC that is available in a rural area, then the rate is paid at the lower rate. But if an ASC is not available, for example, it's paid at a higher rate.

The concern about that is you want to incent the creation of lower cost settings if that makes sense. But maybe there's a methodology like that that can help float rural.

And the last thing that I would say that I think I've brought up before is, you know, thinking of the next generation of these opportunities, I think the threshold of looking at 50 percent being done in outpatient is too high. I would imagine that there are some innovators where the ratio is actually lower. So I'd be curious.

Even in some APCs that have a 25 percent outpatient rate, who's doing those and is the quality in an outpatient setting equal to an inpatient setting? It's the innovators or those who are ACOs or what have you that are exploring those. It may highlight the next generation of APCs that we should be looking at next.

MR. HACKBARTH: Let me raise a question and invite
the rest of the commenters to react to it and then we can also get people on this side a chance at the end as well.

So part of what we tried to accomplish with this presentation is lay out different possible paths to do the groups 1 and 2 with the criteria defined, focus on the cardiac, add in the ASCs, and nobody has really addressed the thoughts of which of those paths makes sense to them. So that would be helpful. If you have thoughts about where you might start, which of those paths makes sense, please address that and then we'll go around here and give these folks a chance.

DR. SAMITT: Do you want us to pick one?

MR. HACKBARTH: No. I'd just like to know what people are thinking about that, because it will help give us some guidance on how to shape the future.

DR. MARK MILLER: And the only other thing that's unspoken and is, you know, transition, that type of thing. You can either pick paths to say, I want to focus on these things first, but you could also roll into a much broader set more slowly. Those are also ideas.

DR. CHERNEW: To answer your question, I prefer the broader sets of services to apply this to, but I want to
emphasize that in the spirit of what you said to start with, my motivation is not at all to save money or to take money away from sort of facilities. In fact, as again you alluded to, I think in the end, we actually won't be saving as much money as shows up on the slides because we're going to come back in our update recommendations and have to deal with updates in ways that reflect this.

So the concern that I have with the broader approach, which I tend to recommend, is that there are distributional consequences. So it's not true that if you take a certain amount of money out and then put it back in, that everyone is exactly the same. It's that you've taken it out disproportionately from some versus others.

And so, I'm very supportive of the entire set of analyses you've done about how to mitigate that, and I think we have to keep thinking about that. But I think that becomes important.

More broadly, what I'd like to at least get to say on the record is that prices are not simply a mechanism for funneling money to different provider types. They inherently create incentives. And so, as we think through the payment system here and wherever, an analysis which
simply tries to equate different amounts of money going to
different types of organizations is not the right way that I
would think about how to manage the system.

I would prefer to think about trying to get the
prices right -- relative prices right and then try and
adjust through some of the other tools that we have. And I
think this is a step in the right direction. So to the
extent that people think that you should not do something
because it's taking too much money out of a particular type
of organization, I would ask, well, let's worry about
getting the prices right.

And if we're causing some other problem with the
amount of money going one way or another, let's think of an
efficient way to get there. That principle, I think,
transcends just this discussion, but I think it's important
as we move forward.

MR. HACKBARTH: Could I just sort of amplify on
that, Scott? So if the relative prices are skewed and
sending distorting signals, we are influencing behavior and
we're seeing that real-time right now. The longer we stay
in this structure where we're paying dramatically rates for
the same service based on the location -- we've done that
test. We know people will respond to it. And so, getting
the relatives right is really important. This isn't an
academic exercise.

MR. ARMSTRONG: Well, I would start just by saying
I share that point of view that you just expressed, too,
Glenn. I think these payment principles are sound. We've
debated them for, it seems, at least a couple of years now.
I would take the broadest application of this, as defined by
the choices here.

I wouldn't apply the stop-loss kind of adjustments
that you've been talking about for some of the reason I've
mentioned before. Frankly, I would have extended the
application of these principles to these 61 or 66 APCs and
then the equalization of payments between the
ambulatory/surgery centers and the outpatient departments
back in March when we first made the payment policy changes
to the E&M codes. So if anything, I think we are too slow
and I would go much more quickly than we're talking about.

I think the last point I would make is that not
only is this a pricing structure that creates behavior
that's costing the Medicare program in ways that doesn't
create any value for the beneficiaries, the cost to health
care is far more than just the Medicare program. There are a lot of payment structures in private plans that are organized around the Medicare structure. I think that there's tremendous waste as a result of this payment structure. The sooner we change it, the better.

DR. BAICKER: I agree wholeheartedly with the concept that the prices have to be right, and that involves paying roughly the same amount for the same service delivered to the same patient, and you want patients in the right venues.

I have less of a problem with a stop-loss if it's focused as you've outlined as one of the options on preventing big sudden changes for vulnerable entities that don't have as much of a smoothing capacity. So that implies that it should be the two-part test of the -- a big drop and only for targeted entities but, importantly, that it be temporary, that this is just we don't want to pull the rug out from under you.

The prices are wrong; we need the prices to be right, but because we didn't announce it far enough ahead we want to give you a little bit of time to adjust would be the principle, I would think.
And I don't know how difficult it is to really make something truly temporary instead of having it built in forever.

And if the cost of having temporary smoothing is that it's permanent smoothing, then I'd reconsider my stance on that and look for alternative mechanisms. But if we really had faith that it would be temporary, then I think it's okay to have that transition smoothed out.

MR. BUTLER: So why am I not quite as enthusiastic as the rest?

Getting the pricing is absolutely right, especially if right now it's creating behaviors that increase costs or increase movement from one to -- setting to another because of price.

So I'm absolutely -- and Mike, I think, articulated that well. And I think there is still some movement going on because of that problem.

Of course, then there's a danger of cherry-picking, and it's easy to say, well, this price is wrong, and that price, but then you don't look at underpricing elsewhere. So you just pick off the ones that are -- look obvious.
But I'll now get to some other comments.

On the ASC, I'm less convinced. I agree with the principle, but the -- you know, we're a little earlier on in terms of suggesting which ones.

And unlike this -- unlike the E&M codes, there still, I think, is movement from outpatient surgical -- outpatient surgery is still moving into the ASCs, not the reverse. So it appears that the pricing isn't -- there's anecdotally in the chapter, say, physician-owned surgery centers that are closing up shop and moving into hospital outpatient departments, but I think our data suggested that there's actually more movement going the other way in the aggregate.

So it's a little less obvious that, at least, we're moving into more expensive settings because of the prices.

So I wouldn't take it off the table. I'm just a little less convinced by the data.

Now, Mark you also said what I do like. You've told me publically and privately that I suggested heart was a focus from the very beginning almost two years ago, and I think it is. I think that's where I see this employment and
salaries being propped up by this mechanism. And I don't
know that it was necessarily the reason for employment, but
it certainly made it easier.

And so I really do appreciate kind of advancing
the heart ones especially and because I said, boy, if you
can figure it out for those three and then maybe a few
others, you know, you've got like half of the money almost,
something like that.

Or, said another way, if you can't do it for
heart, you know, you're going to have a hard time doing it
in a diverse set of the other APCs, I would think.

So that's my comment on the heart.

It still -- this is technically still not so
simple, I think as you know. How you actually set the
professional component and the facility component the way we
proposed, I'm not actually sure that that works well, but
we're not here to vote on a recommendation today. But I
would say that there's still more analytical or at least
thinking through how that might work.

I do get nervous about the fact that this is going
to be a chapter when we're not really done with kind of
firming up the specific recommendation. I understand the
need to advance it, but I do think that even though you have
the fiscal cliff hit on things like the coding and then the
2 percent this will just be viewed as, okay, here's another
one.

They can -- anybody can self-select what they want
from this menu and say, well, MedPAC has got it in their
report. Let's go forward with it. And it could be cherry-
picked along with some other things.

But I'm not saying we shouldn't publish the
chapter. I think we just have to be careful about the
messaging in the chapter itself as we put it out.

Now finally, go back to slide -- please -- 14. A
little bit on this impact issue -- and you know -- and Mark
knows what I'm going to say about inpatient versus
outpatient, but I have to say it because the chapter does
highlight the differences in the inpatient versus the
outpatient impact.

But if you look at these -- and Glenn rightfully
says we look at the aggregate Medicare margin when we look
at these things, not try to silo it.

But I do need to point out on the outpatient side,
for example, overall, it's 5.4 percent where it's 1 -- I'm
sorry.

Move to the third column over. So if you take the Groups 1 and 2 in the E&--I just looked in the chapter -- it's 5.4 percent reduction on outpatient but 1.2 percent overall.

And we express -- for the teaching -- major teaching hospitals, it is 8.9 percent on the outpatient and 1.6 percent overall. The spread is a lot larger simply because teaching hospitals have a smaller part of their business in inpatient care.

And, for example, the rural hospital which looks like it's identical to the major teaching hospital only is 6.2 percent reduction on the outpatient.

So, if you separate out, it's a very different -- this looks like everybody is kind of not too far from each other.

And, Glenn, back to your point about you've got to look at the overall, well, a major teaching hospital would say we just got hit by a minimum of a 6 percent hit on NIH, which is part of our overall economic enterprise. So, if you really want to take the total impact as you have here on the hospital side, you'd want to add in the rest of the
federal funding that is being impacted in academic medical
centers.

So I still have a little problem with that,
particularly because when I think people get to this
outpatient side -- and, Scott, this is a little to your
point. I understand the subsidy issue in looking at
Medicare alone, and Glenn articulated Medicare access in
certain communities may be dependent on these OPDs.

I look at it as a number of the OPDs as being the
only place for Medicaid and dual eligibles. These are the
open doors in some communities. And, believe me, there's
never been more of a frenzy for everybody chasing after the
insured dollars and beginning to say how can I avoid those
that can't pay. It's just, frankly, part of the equation.

So I think that those, as open doors, are going to
potentially close or be harder to get into. And yes, it's
not Medicare except dual eligibles do fit into that
category.

So these disruptions that don't look too bad when
you look at it at this level get to be double digit for some
institutions -- 251 major teaching hospitals that are
averaging the 8.9 percent decrease, so that the really major
ones are up in the double digit area. So I've had a -- I felt I needed to say those things even though the principle of getting the pricing right, particularly for the heart, is -- you can't ignore that. You really can't ignore something like that that I think is something we need to address.

MR. HACKBARTH: Just two quick things. On the messaging point that you made, Peter, about people will see a chapter, you know, I do -- I agree we need to take care when we write the chapter to frame it properly and make it clear that we are not at the point of recommending any of these.

I do think it's useful to publish a chapter because that's a way that people have something to react to. You know. They see the analysis, and then they can say: You know, don't do this path; that path is better. Or, here are the implications.

And so it's part of our transparency and eliciting feedback.

MR. BUTLER: In fact, for that very reason I'm very supportive of publishing it because I think there has been concern so far, as Mark well knows, about, well, what
are these 66 APCs?

What are -- give us more so we can see what we're actually looking at, and I think that the chapter will help do that.

MR. HACKBARTH: Yeah. And then one other quick observation on cardiac, which does stand out. You know, I think it illustrates, you know, the web of different policy and pricing decisions because I think one of the things that caused the dramatic shift in cardiac was that on the physician fee schedule side fees were significantly reduced as we changed the relative values, not just on work but on practice expense.

And so the cardiac area was one that went down significantly in that redistribution, and that made cardiologists more receptive to the hospital offer -- come here and oh, by the way, we'll get these higher rates under the OPD schedule.

So these things are amazingly interconnected with one another.

DR. MARK MILLER: I would just reinforce that when we publish the chapter all the stuff that you cited will be in the chapter and that that was put in front of you.
As you can see those tables, they start to get heavy when you do both ways, both with stop-gap and both with combined, and it just becomes a sea of numbers. But they will be published in the reports -- the statistics that you went through.

MR. WINTER: Something quickly about what Peter said about the migration between ASCs and OPDs of the surgical procedures. It's true that between '06 and 2010 we were seeing a migration from OPDs to ASCs of these outpatient surgical procedures. But between 2010 and 2011 that appears to have stalled, and actually, we're seeing faster growth in OPDs than in ASCs for these covered surgical procedures, which suggests the migration that was occurring has stalled or, if not, stopped.

MR. BUTLER: It's not much though yet, right?

MR. WINTER: One year. It's one year.

MR. BUTLER: No, but I remember we looked at it when we looked at updates.

MR. WINTER: Yeah.

MR. BUTLER: So it wasn't much of -- anyway, there's nothing like --

MR. WINTER: There was a slight difference --
MR. BUTLER: There's nothing as compelling as what's here, but it's something to watch for sure.

MS. UCCELLO: So I agree with the direction of this. I agree with the people who say, you know, we need to get the prices right and to look at this as broadly as possible -- seems to be the right way to go about it.

This is maybe more of a question than a comment, but as I was -- with respect to the stop-loss issue. When I'm reading the chapter, it made it seem like, well, these DSH -- high DSH hospitals don't seem to be disproportionately hit by these procedures perhaps as much as they were for the E&M, and that seemed to imply that maybe stop-loss wasn't needed for these.

But now kind of what I'm hearing more is that, well, it's not necessarily that they're disproportionately hit. It's that the hits that they're taking might matter more to the people that they serve.

Is that --

DR. MARK MILLER: I would say two things. One was the reason that we kept the stop-loss, you know, front and center and presented the data, for example, this way and why we had all of the permutations is you're absolutely right
that when you look at the new policies in isolation, at
least at the average, they don't do all that much. But when
they're combined with the E&M, which was also something that
you requested, we wanted to make sure it's like, okay, you
put E&M together and then the stop-loss comes back to
mattering again even at the averages.

And then, remember even if it doesn't move that
average around a lot there are some hospitals out of the
distribution where it could matter even in the new policies
although it doesn't have a big impact there.

You are correct in your interpretation of the
analysis.

MS. UCCELLO: So when we're thinking about this
now, we're not -- are we thinking of it more globally as
opposed to we're not -- if we do -- if this is taken up,
there wouldn't be a stop-loss just on the E&M, but it's a
stop-loss over whatever procedures are included in this
approach.

DR. MARK MILLER: [Off microphone.] Whatever
condition [inaudible].

DR. HALL: I think the more we've gotten into this
the more impressed I am with the granularity here. We know
a lot more about this than when we started, and I'm very much in favor of the direction that we're going.

I guess one thing that I've been trying to do since I became educated on this is to just in my local environment ask a number of what-if questions, and it largely has to do with who are these Medicare eligibles who are coming to hospital OPD departments where in lieu -- they used to come to offices.

And it's not all because of marketing. I mean, a lot of them really, truly are there because they represent this -- the real tsunami population. The population in the United States reaching 65 has leveled off now. The next tsunami, which has started, is the 75 to 85-year-old population.

And many times bundling in a very concrete way, not in the figurative way we use it in other ways -- it makes sense for them to have the advantages of all the ancillary services that are present at particularly a teaching hospital and an OPD clinic.

So I think we've got to make sure that we're not disenfranchising that population. They may not show up in a disproportionate share. It's really saying a frailer, older
population who may need services that are much more suitable in an institutional setting than in a private office in a shopping mall.

DR. REDBERG: I certainly echo -- I think it was a great chapter and that the payment principles that are outlined I endorse and for applying them to broader sets of services.

I would just add when we talk about getting the payment right I think what we really want to be going for is really value, not so much what we're paying, because the other part of that is what are we getting for it. And some of these services -- just like some of the drugs -- are very valuable, and some of them are not. In fact, some of them are leading to probably harm, and our beneficiaries would be better off without them. And right now the payment rates don't reflect any of that.

And so, you know, for example, looking at table 5, page 20, although there certainly are a lot of cardiology things, I notice that IMRT has a very large increase. Well, IMRT has not been shown to be -- to lead any better outcomes than much less expensive, you know, treatments for prostate cancer, but we're paying a lot of money for it. So I would
say that's a very low value, you know, proposition unless you can show that we're -- you know, that there's a reason that it's priced so high when the outcomes have not been shown to be better or even equal.

And the same with some of the imaging services -- again, you know, there's the whole choosing wisely and professional society. Well, some of the imaging services on this list have been nominated by the professional societies as things we shouldn't be doing or should be doing a lot less of.

So none of our payment structure currently acknowledges any of that, and so certainly as we go forward I think we really want to think about value more than just cost and charges.

MR. HACKBARTH: I wanted to give people on this side an opportunity to react to different paths that we might take -- Groups 1 and 2, cardiac only, include ASCs, not include ASCs. Any thoughts people want to offer?

DR. NAYLOR: I had written it down -- broadest possible.

DR. HOADLEY: I agree on the broadest possible, and I think the point that's been made that would get some
of the other options in the chapter means that we also show
people what other things would do, what lesser options would
do. So that's useful too.

MR. HACKBARTH: Okay. Thank you. Good job.

DR. COOMBS: Glenn, I just wanted to say I agree
with the stop-loss in order to ensure access.

And then I was thinking along the line of a phase
kind of approach more so because you can actually titrate or
study the impact of what you do, but I think that we're
going in the right direction.

MR. HACKBARTH: And when we did the E&M piece of
this, we had a three-year transition. So that's another
policy variable.

Oh, Craig.

DR. SAMITT: The only other thing I would add is
I'd echo Peter's observation that if we kind of need to pick
a path -- cardiology because it's the one that seems as if
it's been the most reaction following a prior action that
suggests that this is being propped up. And if we need a
pilot phase or what have you to really understand how this
transition will work, that may be the best place to start.

MR. HACKBARTH: Okay. Thank you, Ariel and Dan.
Great job.

We'll now have our public comment period, and let me reiterate the ground rules. Please begin by introducing yourself and your organization. And, as I always do, I'll remind people this isn't your only, or even your best, opportunity to provide input on MedPAC's work. When the light comes back on, that signifies the end of your two-minute period.

MS. CONROY: Thank you. I'm Joanne Conroy from the AAMC, and we serve our nation's teaching hospitals and medical schools.

We continue to be concerned about access issues. We have undergone an analysis of those patients that actually have been cared for in the HOPD versus physician outpatient setting, and there are differences in the patient population -- far greater number of dual eligible, complex patients and certainly disabled patients. So, as you continue deliberations, we certainly encourage you to consider what this might do to access for these patients for these services.

We will provide our research to you on an online option.
Thank you.

MS. KIM: Hi. I'm Joanna Kim with the American Hospital Association.

Perhaps, unsurprisingly, we're also very concerned about the discussion that was undertaken here today.

The Commission has already recommended cuts to a number of services of about a billion dollars as far as the cut to the hospitals, and today we discussed another $1.5 billion in cuts. That, as you said, would reduce outpatient revenue by about 5.4 percent, and that's to a system that already has a negative margin of 11 percent. And, as you noted, the cuts continue to hammer the same types of hospitals over and over -- teaching hospitals, safety net hospitals, the public hospitals and rural hospitals.

And we're having a hard time seeing how those discussions fit with the 1 percent update recommendations that are going to made in the March report.

The inpatient net update for fiscal year 2014 is, right now, projected to be negative 0.6 percent and the outpatient, about 1.8 percent. But that doesn't include the sequester. It doesn't include the redistribution of DSH payments. It doesn't include the increasing readmission
penalties, the HACs or meaningful use.

In addition, we have serious concerns about the analysis that led to the list of APCs that was discussed today. Last year, we worked with the MedPAC staff to understand their analysis, and they were very generous in their time, walking us through it and explaining all the major points. But despite being on the same page as far as all the major points of the analysis, when we did our own analysis we were only able to replicate 33 of the then 71 APCs as meeting the criteria.

I think that speaks to the complexity of all the payment systems that are being analyzed, but I think it also speaks to the fact that small technical decisions in the analysis are leading to really big results -- result differences.

So that leads to questions in our mind of how that policy is going to stand up over time. Are there going to be APCs that float in and out of meeting the criteria year after year, and how will those be considered?

In fact, one of the APCs that we could not replicate as meeting the criteria was the cardiac one that accounts for over a third of the savings. I believe it's
number 269. We didn't find that that met the ED criteria. So, given the obvious complexity here and the disproportionate impact that some very small technical decisions are having on the results, we'd like to see an increased level of transparency as far as the methodology that was used before it's committed to a public chapter because we absolutely think it will be used to support going ahead with the cuts that you've discussed in the chapter., and we look forward to working with you on that.

Thank you.

MR. HACKBARTH: Okay, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:37 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, March 8, 2013.]
PUBLIC MEETING

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

Friday, March 8, 2013
8:31 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP
AGENDA

Medicare’s health professionals shortage areas (HPSA) payment adjustment
- Kate Bloniarz, Kevin Hayes, Katelyn Smalley 3

An update on shared decision-making
- Joan Sokolovsky, Katelyn Smalley 64

Public Comment 136
MR. HACKBARTH: Okay. It's time for us to get started, and we have two topics for today: the payment adjustment for health profession shortage areas is up first, and then shared decisionmaking second.

So who is leading? Kevin? Go ahead.

DR. HAYES: Good morning. This session is about Medicare's health professional shortage areas payment adjustment.

Recall that during work on the mandated report about the physician fee schedule's geographic practice cost index for work -- the work GPCI -- the Commission adopted a framework for evaluating policy options that address issues of spending, access, quality, and advancing payment reform.

At the end of that process, there was discussion of targeting payments toward beneficiary access problems and using approaches other than the broad brush of, say, establishing a floor for the work GPCI. The commitment then was to come back for further discussion of payment adjustments that are targeted.

The purpose of this session is to see if the HPSA payment adjustment is an example of targeting payments
toward access problems. We anticipate that this session will be the first in a series of conversations on this. In this presentation, we will begin with the rationale for reviewing the HPSA payment adjustment. From there, we will describe the adjustment itself: the criteria for designating HPSAs; who is eligible to receive the adjustment; total adjustment dollars and how they are distributed by physician specialty and type of service; and how beneficiary use of services varies when HPSAs are compared to other areas.

Next, we will list policy issues you might wish to consider. And, lastly, we will outline possible next steps for further work on this topic.

Just to recap a few points on the mandated report on the work GPCI:

The Congress asked the Commission to consider whether there should be a work GPCI. To address this question and conduct its work on two other mandated reports -- on outpatient therapy and ambulance services -- you adopted an evaluation framework structured according to issues of spending, access, quality, and advancing payment reform.
Specific to the issue of access, the finding was that the GPCI's impact is unclear.

While the supply of physicians and other health professionals varies between high- and low-GPCI areas, we do not see differences in service use across high- and low-GPCI areas.

More broadly, you concluded that if access problems are found, it's not advisable to implement broad-scale policies through the GPCIs, such as the floor. Instead, the policies needed are ones that focus on identifiable problems of beneficiary access and to do so in a way that is targeted.

All of which brings us to the question of whether Medicare's HPSA payment adjustment is an example of a targeted approach.

The HPSA payment adjustment is paid for services furnished in HPSAs. HPSAs are designated by the Health Resources and Services Administration within the Department of Health and Human Services.

HRSA's criteria for designating HPSAs focus on supply. For example, in the case of a HPSA designated as a primary care HPSA, an area must have a general population-
to-primary care physician ratio that is greater than or equal to 3,500:1.

However, there are exceptions. For example, the minimum is 3,000:1 if an area meets criteria of unusually high need as measured by: births per 1,000 women, the infant mortality rate, or the area's level of poverty. And there are other ways an area can qualify, too, but the focus remains on supply.

The HPSA designation is used to direct resources under about 30 federal programs in addition to Medicare's HPSA payment adjustment, programs such as the National Health Service Corps.

Kate will have more to say about the HPSA designations in a few minutes. But the point for now is that the criteria for designating HPSAs focus on supply, and the criteria are not specific to the Medicare population.

As to Medicare's payment adjustment, it is a 10 percent bonus for physician services furnished in a HPSA. It's paid for physicians' professional services. It does not apply to the technical component of imaging services. It's paid for psychiatrists' services, whether provided in a HPSA designated as a primary care HPSA or one
designated as a mental health HPSA based on the supply of mental health professionals. And the payment adjustment is paid for major surgical procedures performed in HPSAs by general surgeons. The adjustment is available to physicians only and not to nurse practitioners, physician assistants, or clinical nurse specialists who bill Medicare independently. When billing for outpatient services, critical access hospitals have the option of billing both facility services and professional services if the physician or other health professional reassigns his or her billing rights to the hospital. When billing under this option, the CAH is paid for the professional services at 115 percent of the amount otherwise paid under the physician fee schedule. In addition, if the services are furnished in a HPSA, there's the 10 percent adjustment on top of the 15 percent increase. That's an overview of the HPSA payment adjustment. Katelyn will continue with a graphic on HPSA locations across the U.S.

MS. SMALLEY: In 2013, there were 1,329 geographic
primary care HPSA areas covering 29 million people. After an area has been designated as a HPSA, the Medicare payment adjustment in these areas is made automatically based on the zip code on the claim.

HPSA bonus payments have nearly tripled in the last 10 years, from about $97 million in 2001 to $274 million in 2011.

The large increases in payment that you see in 2004 and 2011 may be attributable in part to the inclusion of mental health HPSAs in 2004 and the surgical bonuses instituted in 2011.

We will now discuss how these payments are allocated.

HPSAs are designated based on the ratio of primary care physicians to the population, but Medicare's payment adjustment is made to all physicians in the HPSA, regardless of specialty. Based on 2011 claims, 31 percent of all HPSA payments went to primary care physicians, including internal medicine, family medicine, and geriatrics. About one-fifth went to surgical specialties, including general surgery, orthopedics, and ophthalmology. Cardiology accounted for 7 percent of payments, and 5 percent went to diagnostic
radiology.

Broken down by type of service, again, about one-third of HPSA payments were made to primary care, and other evaluation and management visits accounted for about one-quarter of HPSA payments; 22 percent went to procedures, and 9 percent of HPSA payments were for imaging services.

Now Kate will talk about service use in HPSAs compared to other areas.

MS. BLONIARZ: So we also looked at ambulatory care service use across areas designated as HPSAs and those that are not, and we did a similar analysis for the work GPCI.

We see that the level of service use is quit comparable across HPSA and non-HPSA areas -- 10.3 visits per beneficiary on average in HPSA areas, and 10.0 visits per beneficiary in non-HPSA areas.

While there is pronounced variation across the country, the level and range of service use is similar. And this is the same finding we showed in the work GPCI where we did not see differences across high and low work GPCI areas in terms of ambulatory care.

So to turn to some issues that we would raise for
your consideration, with respect to the HPSA designation itself, first is the issue of the administrative process of regions being designated and de-designated as HPSAs. Regions become designated as HPSAs only if an entity affirmatively applies. There is no uniform national process to designate all areas meeting the HPSA standard. And areas that get designated can sometimes retain their designation years after they have been proposed for withdrawal.

Second, the HPSA measurement of population to providers excludes some providers, notably, physician assistants and advanced practice nurses. And the exclusion of these providers could significantly affect the number of regions designated as HPSAs and the depth of the shortage.

Turning to some issues with Medicare’s use of the HPSA designation to target a payment adjustment:

The HPSA was not designed for the Medicare program. It was created to allocate slots for the National Health Service Corps and is used in about 30 other federal programs, mostly in the public health and workforce area. The measurement, as Kevin mentioned, does not include measures specific to Medicare beneficiaries.

And the payment adjustment does not apply to all
practitioners. In particular, it is not paid to advanced practice nurses and physician assistants.

And finally are issues related more broadly to the use of the HPSA payment adjustment as a potential mechanism to improve access for Medicare beneficiaries.

The threshold for HPSA designation is set at a fixed provider-to-population ratio established in the 1970s and hasn't been updated since then. Using a fixed ratio does not account for differences or changes in practice style, productivity, or demand for health care.

And, finally, there is no or limited evidence to support a relationship between the supply of ambulatory care providers and access to quality care for Medicare beneficiaries. This has been shown through surveys of beneficiary access, quality measures, and ultimate outcomes across high- and low- supply areas.

With there, there are a couple of potential next steps for this work to take.

First is to do more work reviewing and assessing the current HPSA payment adjustment.

The second option is to consider how a Medicare-specific policy to improve access might be designed. How
should access to ambulatory care be measured, for example, service use, beneficiary satisfaction, or quality? And how would one target a potential policy?

Third, the Commission could also focus on pursuing other payment mechanisms, such as an incentive payment for primary care, or payments for patient-centered medical homes or health centers that meet a set of criteria for improving access to quality care.

So that concludes, and we're happy to take questions and look forward to your discussion.

MR. HACKBARTH: Okay. Thank you. Good job.

What I suggest is that we use the modified Round 1 process from yesterday and just continue to experiment. So Round 1 clarifying questions will be about, "What does that slide mean?" "Row 3, Box 2." Please. So let me see hands of people with clarifying questions. Mary, did you have your hand up?

DR. NAYLOR: I have to find the slide first [off microphone].

MR. HACKBARTH: Oh, okay. So we'll start with Dave and just work down the row here.

DR. NERENZ: Thank you. Slide 5, the top bullet,
which is just basically the statement of the 10 percent bonus, I wonder if you can tell us any more about exactly what the mechanism is linking that bonus to access? For example, is it designed to incent more professionals to come into that area? Or is it designed to reward the providers who are there for doing additional work, like being on call more or having late-night hours more? Is it one or the other or something different entirely? What is it supposed to do?

DR. HAYES: I can tell you what the considerations were when it was adopted back in the late '80s. The original provision I believe was in the Budget Reconciliation Act of 1987, and then there was a modification in 1989. But in both instances, there was a concern about supply, about availability of physicians in areas, and disparities in just numbers.

So inferring from that, it would be more an incentive to have a number of practitioners -- a desire to have physicians in low-supply areas.

DR. NERENZ: Would it follow then that if this program is successful, the HPSA designation should be time limited? Because if this incentive brings people in, then
there's no longer a shortage. Would that follow?

DR. HAYES: It would follow, yes.

DR. NAYLOR: Slide 11, please. So HPSA does not include certain providers that are recognized, and I'm wondering, were you able to look at the HPSA service areas and determine how many PAs or advanced practice nurses might be available and how that would change?

MS. BLONIARZ: So what I can tell you is GAO did a study almost more than a decade ago, and they looked at this question. Specifically, if you included just advanced practice nurses in the counts, you would change the level of providers available in those areas by 22 percent. And so many areas would probably lose designation if you did that, and then the depth of the shortage would be quite different. And that's over a decade ago. It is probably even higher, significantly higher now.

DR. NAYLOR: And especially if you also add PAs to that.

MS. BLONIARZ: That's right.

DR. NAYLOR: So on Slide 11, the general -- you're talking about knowledge of problems a decade ago, and you outlined in the report the barriers to act on those. But
I'm wondering if you could make that a little bit -- I mean, the timelessness and the absence of a national process for designation and when you get it, it never goes away. So can you comment on what's getting in the way of changing a methodology with the known flaws for such a period of time?

MS. BLONIARZ: So the two times that HRSA has tried to do comprehensive rulemaking to change both the HPSA -- or the HPSA and then also the medically underserved area designation, you're talking about -- they were, you know, considering processes that would really redistribute funds across areas, and areas that would lose federal funding or lose, you know, priority for federal funding, you know, you're just talking about reallocating money across the country, and a lot of groups and people were very upset about that.

DR. NAYLOR: 700 or something?

MS. BLONIARZ: Yeah, exactly. Exactly. Both times, you know, HRSA put out subsequent rules and said, look, we've got so many comments on this, there are so many concerns about the methodology, we just need to go back to the drawing board. I think the provision in PPACA that was established to create a consensus rulemaking process was
another attempt to try to say, okay, well, what if we get a
group of people together who represent different interests
and try to develop a new mechanism. That also failed. I
mean, I think it's just testament to how hard it is to
change formulas that are driving such a large share of
Federal dollars.

DR. NAYLOR: Thank you.

DR. MARK MILLER: And I think this was engaged in
there, but you have the geographic of moving money around,
but then -- and I know this will come as a surprise to you,
Mary. You also have, you know, the professionals sort of
deciding who gets counted and who doesn't get counted, and I
know that's a big surprise to you.

DR. NAYLOR: [off microphone].

MR. KUHN: Can I get Slide 10, please? I just
want to make sure I understand what we're looking at here.
So basically the service use is quite similar to HPSA and
non-HPSA areas. That's where we are.

So I was curious. Has there been any kind of
longitudinal data on the impact of these enhanced payments?
In particular, I'm thinking about the surgical incentive
payment that has just gone into place where you've got now a
20 percent bonus for those. Is there any evidence that that has improved access yet? Or is it too soon to tell in terms of where we are on that one?

MS. BLONIARZ: We haven't looked at it yet, I think just because it has only been in place since 2011. I think anytime you're thinking about doing a longitudinal analysis, there are just so many other things affecting access and service use over this -- you know, any time period that we would be considering. Kevin and I were also just talking. It's hard -- sometimes it's difficult to get a list of areas that have been designated and then that have either gained and lost designation longitudinally. So that's another kind of wrinkle there.

MR. KUHN: So basically the best indicator we have is kind of service use. It is going to be hard to do longitudinal work in this to really kind of understand the true impact of what these enhanced payments have done for access.

MS. BLONIARZ: Yeah, that's right.

MR. KUHN: Okay. Thank you.

MR. HACKBARTH: Let me just follow up on Herb's question. So you look at these numbers, and I can think of
at least two possible interpretations. One interpretation is, "Oh, it works." The other interpretation is, "Oh, this money's very poorly targeted." And we have no ability to discriminate between those two possible interpretations.

PARTICIPANT: Okay.

[Laughter.]

MR. HACKBARTH: That's what I was afraid was the answer.

DR. CHERNEW: That was clarifying, though.

DR. COOMBS: So I have two questions. One is there is -- has there been anything that actually looks at wait times? And the reason I'm asking that is because of the skew of the population. Whereas, you might have an average visit in an area, it may be some high utilizers who skew that number off the scale, and I was wondering if there was any kind of data that -- we talked about this, I think, with the GPCI issue as well.

MS. BLONIARZ: So one study that we cited in the paper is a study a couple years ago of Medicare beneficiaries' perception of access across areas that have high supply of ambulatory care providers and areas with low supply. And they didn't find a difference in -- when
beneficiaries were asked, you know, do you have trouble seeing a provider, do you have to wait a long time, are you able to see one if you have, you know, a routine issue or an illness or injury, and there just wasn't much difference across low- and high-supply areas. There was variation, but it wasn't correlated with how many providers there were in the community.

DR. COOMBS: And have there been any studies that look at pilots in terms of the pool mechanism within the HPSAs, looking at pooling of the patients, the differentials that might happen from geographic variations?

DR. MARK MILLER: What was [off microphone] --

DR. COOMBS: So if you look at aliquots of patients, you might find a trend in high-risk patients in given areas, and if there's some variables that kind of correlate with that, so it would help you to predict, you know, the utilization in some of the areas.

MS. BLONIARZ: I think this gets to just what the Medicare -- like what a national program, you know, how well it can identify access problems at very small geographic areas or for certain populations. I think that's just a problem that, you know, we're never going to be able to
identify at very granular levels, you know, based on surveys. You're just not going to be able to get down to that level of granularity that you might want. And I think -- I'm not sure we would be able to do that.

DR. HOADLEY: On Slide 7, you show us the total number of dollars represented by HPSA payments. Can you indicate what's the share of Medicare's overall fee schedule dollars both nationally and, if it's possible, within the HPSA regions? In other words, how big a pot are we working with?

DR. HAYES: Right, right, right. If you take the $274 million, I think we had a figure of -- it represented about 0.4 percent of total fee schedule spending.

DR. HOADLEY: Nationally.

DR. HAYES: Yeah.

DR. HOADLEY: But obviously within these regions, it would be a somewhat higher percentage.

DR. HAYES: Yes, that's true. Right.

DR. HOADLEY: That would be a useful number to have as a context for its influence within those regions as well as obviously the pot's pretty small overall.

DR. SAMITT: I have three hopefully quick
questions. If you could go to Slide 5, please. So what was
the motivation behind the introduction of the general
surgeon incentive program? So what motivated that change?

DR. HAYES: It was in the PPACA, and I'm not aware
of any research that was done ahead of time to show that
there was, you know, a difference in, say, the supply of
general surgeons, HPSAs versus non-HPSAs. It just kind of
appeared there.

MR. HACKBARTH: My recollection is the same as
Kevin's. I don't remember there being any research cited,
but it was a time when there were a lot of anecdotes about
problems with access to general surgery in rural areas in
certain parts of the country.

DR. SAMITT: No evidence of any kind?

MR. HACKBARTH: Not that I'm aware of.

DR. SAMITT: Okay.

DR. COOMBS: Glenn, I just want to say one thing.
I guess the surgical specialty had some issues around
training, and around that time they came out with a report
of about 1,000-plus residents being turned out, of which
300-some-odd residents were focused on general surgery. So
there was a perceived shortage long range of general
surgeons in the country.

DR. SAMITT: Okay. My second question is on Slide 7. When I first glanced at the recent dramatic increase, I thought it was purely because of the surgical incentive program, but that started in 2011. So do we know the makeup of this change and what has increased and where from essentially 2008 to 2011?

DR. HAYES: No. What we could do, if we -- we don't know the answer to that question. I think one way to start would be to look at distributional issues such as what you see here represented on the pie charts to see where the dollars are going.

DR. SAMITT: So we don't know if it's specialty based or geographic based.

DR. HAYES: That's correct.

DR. SAMITT: But we potentially could do that analysis.

DR. HAYES: Correct.

MR. HACKBARTH: Has there been a change, a material change in the number of HPSAs?

DR. HAYES: We're not aware -- as Kate said -- we don't know. As Kate said, we struggle with this question of
getting good data on how many HPSAs there are.

MR. HACKBARTH: Okay.

DR. HAYES: But we could try if there -- to decompose this.

DR. SAMITT: Great. Thank you. And then, lastly, on Slide 11, please. The one thing that wasn't clear to me in the report -- and I thought this was where Mary was going -- is there have been some HPSAs that have been de-designated, and yet they haven't been de-designated. So what's the obstacle, once it's been decided to de-designate, to actually make it happen?

MS. BLONIARZ: So the way the process works is HRSA requests updated information on HPSAs that it hasn't reviewed in three years from the states. If the states provide information that either shows that it no longer meets the criteria or that they don't provide any information, it goes into kind of this bucket of proposed for withdrawal. And at that point, the area -- you know, outside groups could come in and say, okay, I have additional information, I'd like to provide that. But it doesn't become final until HRSA releases a list in the Federal Register showing that it has been fully withdrawn.
I think we said in the paper it took about 10 years for that to happen. I don't know exactly why.

DR. CHERNEW: I have a question about Slide 6. I think this is similar to Jack's basic notion. When I look at this, I can't figure out, how close are the HPSAs to what we saw is rural?

MS. BLONIARZ: So what I can tell you is of all the primary care HPSAs, and this, again, there's geographic ones, there's population-based ones, there's facility-based HPSAs, but of all of those, about 60 percent are in non-metropolitan areas and about 40 percent are in metropolitan areas.

DR. CHERNEW: Of non-metropolitan areas, what portion of that is in HPSA?

MS. BLONIARZ: I don't know, but we could find out.

MR. BUTLER: On this slide, so two questions. One is, so the total number of physicians that are participating in HPSA is what, do you know? So you don't get -- is it, like, ten percent, or -- you just don't know. We just know it's $275 million or something like that --

MS. BLONIARZ: It's knowable, but we just don't
have it right now.

MR. BUTLER: And then this is one of the few that if Tom were here, he would say, hey, I've finally got some dots in my State.

[Laughter.]

MR. BUTLER: At the same time, there's some suspicious looking dots in part of the country where we also find some heavy utilization. Do you have any sense of this being representative of what you would expect versus skewed in some disproportionate way towards various --

DR. MARK MILLER: One of the reasons that it's hard to answer that question is, is we're all looking at this and saying, what would we expect for Medicare? And so, for example -- I think this is correct from our conversations -- until very recently, McAllen, Texas, was classified as a HPSA area.

MS. BLONIARZ: That's right.

DR. MARK MILLER: And so for utilization in Medicare, around this table, you would go, McAllen? But remember, just to try and get some balance, this stuff is created for lots of other purposes. So when you say, does this represent what you would expect, it's, I think,
whatever is up here, they're created for lots of different reasons. So think about infant mortality driving some classification of an area versus some other criteria, because it kind of varies from area to area. It would be kind of hard to answer -- for me to answer that question. From a Medicare point of view, not so much.

MR. BUTLER: So just to make sure I understand the process, every one of these dots is self -- I mean, it's voluntary. You've got to come forward and ask for it. There's no top-down, you know, have you thought about doing one over here, right?

MS. SMALLEY: Right. That's another point that we were going to make, is that it's an application process. So you need to affirmatively say that my area should be covered under this policy, and if a city or town doesn't have the resources to do that or the State legislature doesn't -- isn't as actively affirming HPSAs, you may not get one.

MR. HACKBARTH: I just wanted to pick up on Mark's point about McAllen. You know, that could be an illustration of the difficulties in designation and removing designation. But if you look at this map, you see swaths of the country where we know Medicare utilization of services
is very high relative to the average and a lot of HPSA designation. So at least there is not a very tight relationship between designation as a shortage area and use of services. Now, that's evident in your Slide 10, as well. But in a way, this makes that even more graphic, that this designation really isn't connected to utilization and access in that sense.

MR. BUTLER: Yeah. I'm just trying to get a sense of the elephant here, kind of. How many doctors, 274 million sprinkled across here? It sounds like it's really not many dollars for most of the dots when all is said and done, right?

MR. HACKBARTH: Yeah.

MR. BUTLER: At this point. But it's been increasing rapidly.

MR. HACKBARTH: Yeah.

MR. BUTLER: Okay.

DR. MARK MILLER: I'm sorry. And that's a really good thought to keep in mind, because there is always a lot of concern about anybody messing, you know, out in the general world, messing with these designations. But think about the work that we did with ambulance where there were
add-ons being put out there on a very broad basis. And what
the Commission ended up suggesting is, if you had a tighter
designation, you could actually provide greater support in
the areas that meet that designation. This may be really
obvious given the statements that you just made, but I also
just want to make sure that the audience gets how you could
rethink that sprinkling of dollars.

MR. HACKBARTH: Cori.

MS. UCCELLO: So you didn't discuss this in your
presentation, but in the mailing materials, on page 20 -- so
I get a page number in there -- you talk about the Primary
Care Incentive Payment Program, and this was something that
is temporary. So I'm wondering more about why that's
temporary. Is it just a stop-gap until we get a better
balance between primary and specialty, or was it thought
that it just would be fixed, or is it a money issue, or --

DR. HAYES: That's one that could be interpreted
in a lot of different ways. When we think about the cost of
PPACA, maybe there was some consideration of just budgetary
impact and they wanted to be careful there. The other is
that, to your point, that there were other provisions in the
law about things like addressing the issue of misvalued
codes, and so maybe that was going to play itself out in time and then there wouldn't be so much of a need for it, or whatever it was. I just can't say. But there's a lot of different ways, I would say, just to interpret what the motivations were. But to answer your question directly, we just don't know exactly what the thinking was.

DR. REDBERG: Please, on Slide 4, and also on page seven in the mailing materials, I'm just trying to understand who actually applies for the HPSA designation.

MS. BLONIARZ: So, technically, anyone can, any individual or group or government, State, local, Federal -- or not Federal, but -- but in practice, it's generally the States that are applying. The State Primary Care Office would apply, but technically, anyone could apply to have an area defined as a HPSA.

DR. REDBERG: And is it usually a county? When you say an area --

MS. BLONIARZ: Yeah --

DR. REDBERG: -- how is the area defined?

MS. BLONIARZ: There are a lot of full-county HPSAs, but then it can even be zip codes or census blocks. One thing is that the applicant -- the application defines
the area to be considered as a HPSA. So, you know, someone
is kind of affirmatively saying, this is -- I'm asserting
that my area has a health professional shortage and I'm
drawing the boundary of what that is.

HRSA does say that areas outside can't have a
supply of providers that would be available to residents of
the HPSA. So it's not like you could draw the boundary so
tight that if they just traveled ten, 15 minutes, they could
have access to another set of providers. But it is kind of
created by whoever is applying for the designation.

DR. REDBERG: So I'm just still trying to
understand this better. How do they know who the doctors
are? What data sources are they using, and how do they --
and it's supposed to be primary care practitioners in
particular, right, so --

MS. BLONIARZ: I think, in practice, a lot of
applicants will use the AMA Master File. What I don't know
as well is what HRSA uses to kind of validate that. But,
yeah, that's all I'll say.

DR. REDBERG: And continuing, and maybe, I think,
you had that information on another slide, but once somebody
-- once the area, whatever it is, is designated as HPSA,
it's not just the primary care practitioners that are
getting the HPSA increases, then. It's all doctors in that
area, even if they weren't particularly in a shortage.

MS. BLONIARZ: Under the Medicare payment
adjustment, it's all physicians billing under the fee
schedule.

DR. REDBERG: And I'll make this the last
question. But is it Medicare money and is this all new
money, so however many doctors there are, everyone's just
going to get this increase, so there's no upper limit?

MS. BLONIARZ: Right. It's not subject to budget
neutrality or anything like that. It's new money.

DR. REDBERG: And then it's -- it's all services -

MS. BLONIARZ: And it's all services.

DR. REDBERG: -- not just underutilized or --

MS. BLONIARZ: That's right.

DR. REDBERG: Okay. Thank you.

MR. HACKBARTH: Could you put up 10 again for a
second. So the annual visits to physician office or
outpatient facility is included in this count, just M.D.
visits, or does this include other health professionals?

DR. HAYES: This would include the other health
professionals, also. So these are services -- for the
annual visits to physician offices, those would be office
visits billable under the fee schedule.

MR. HACKBARTH: Okay.

DR. HAYES: And then we've included also the
outpatient facility visits, as well.

MR. HACKBARTH: Okay. Well, for me, maybe --
there are a lot of interesting, important questions here,
but for me, this is sort of like the most basic one. Do
these numbers reflect that the program works or do they
reflect that it's just poorly targeted and we need to start
anew?


DR. NERENZ: Well, you just said my main thought
on this. I think that is the fundamental question. I also
repeat my question about clarifying the intent of this.
Exactly through what mechanism should this address access?
But whatever path ultimately gets us to here, and then, as
you said, we can't really tell from these numbers whether
it's either working or unnecessary, and I don't know how to
move past that.

DR. NAYLOR: So, a great report, and I think that
it leans -- I am leaning toward thinking about how we would move from lessons learned from this to targeted policies that really promote optimal access of Medicare beneficiaries to primary care to the availability of all workforce members -- APNs, PAs, and physicians -- to access to all of the system redesigns that promote and advance primary care, not just a patient to provider. It sounds like there's been a lot of effort already to try to tweak this, and in fact, you have policies that are building on this with rural clinics getting additional payments if they're in these HPSA designated. So in some ways, we continue to extend maybe what I would consider a flawed policy.

So my sense is that our best opportunity in terms of this group and strategy is to think about what could its replacement be rather than trying to spend a lot of time changing something that people have been trying to change for 15, 20 years and have not been successful.

MR. KUHN: In terms of your questions on your next steps, I, too, kind of like Mary, I'm really interested in the population-to-provider ratios, particularly with mid-levels and their ability to operate at the top of their license. But as we know, there's a great variation of State
licensure laws and I just don't know how we would manage through that whole process. So if there could be some more thinking about that one, I think that would be useful to look at. But I think it could be very complicated, to be sure.

The second issue I think you teed up here was the issue of kind of Medicare-specific measures, looking both at the quality and kind of access. Is it equitable out there? And I think that just would probably be a much more accurate forecaster of kind of the way to target, I think is the way this was set up. So I'm kind of like Mary, as well. Rather than trying to kind of fix a system that seems to be intractable, it might be to look at a different way to kind of do targeting for the Medicare dollars that are moving here. It might be worth looking at, as well.

MR. HACKBARTH: So as we proceed through the rest of this round, I invite comments on that, in particular. Does it make sense to start clean or not? And for me, one of the fundamental questions there is how do you measure access? Is provider-to-population count a good measure? For all the reasons we discussed in our rural report, I don't think it is, and if that's the case, then that's an
argument in favor of the start clean path.

Alice.

DR. COOMBS: So I think what we have is HPSA. We don't have a lot of other information. Because of that, I think there are some opportunities for improvement with some of the information we've gotten.

And I agree that the access issue is really something that all of us are struggling with because we know that utilization and access are two different things, because you can have data that actually shows that there's X-number of visits a year, but that does not correlate necessarily with the comprehensive availability of access to all parties within a given community. So I think that's one of the questions that needs to be answered in terms of being able to tease out some of the subsets within this area if you were to look at this.

If I had a magic wand and I could actually drill down into a community, I would want to know if there's, like, a 25 percent driver for that utility in terms of the visits that are seen in the office. And if there's a preponderance of people in a population that say, "I can't get in to see a doctor," I'm really interested in the wait
times for -- the average wait time for the general community as being another proxy for access.

Well, you can't look at the ratios always, but I can tell you one thing. If the ratio is really low, that tells you right off the bat you have to travel 30 or 40 miles to get to a place, or if the doctor goes away on vacation and it really kind of -- it cripples the system.

So all we have right now is the HPSA, and when it's really low, it tells you that we're in a crisis situation. When it's average or high, I don't know what that means, either, because we've seen where, in some regions, where some doctors are part-time equivalents and there's a whole lot of other things that enter into the equation for workforce.

But I think the most prevalent thing is there are specific shortage areas, and this thing with surgery, the American Surgical Society -- I passed it on to Craig so he could see it -- there was 1,050 doctors being produced in the training program, of which less than 500 were going out to be general surgeons in the real world for 310 million people.

So I think there are some struggles within the
workforce, and Health Affairs actually presented a couple of
-- had some great articles on nurse practitioners and P.A.s,
where they go and what they do. And I think there are some
lessons that we can learn from those two studies.

One of the things of interest is just the
specialties that are being pursued by -- and I work with
physician assistants and nurse practitioners every day in my
practice, and there's a propensity for them to leave out of
the primary care profession and migrate into the specialty
care. So there are some things that -- there's a moving
goalpost all around us in terms of what happens in the
community. So I think it's an issue.

MR. HACKBARTH: I agree, Alice, that the dynamics
here are really complicated, and if we were -- the task was
to do a biopsy, you know, do a research study on how good is
access in particular communities and what are the variables
that you'd look for, it'd probably be a long list of things
that you might do as part of that effort.

The issue here, I think, is a little bit
different. In order to run a payment adjustment, you can't
do biopsies of all communities and especially targeted
studies. You need to rely on readily available data that is
routinely collected and, hopefully, reliable. And so we need to think about the payment adjustment task, not just the research task.

DR. COOMBS: I guess what I'm saying is that HPSA is one of the things that other benchmarks, I mean, use for Public Health Service and all the other things that we use, and I don't see that starting all over is any different from you taking a pilot to prove that what's being reflected there is actually robust enough for you to go on, and that would be my contention right now, is that with that tweaking and actually looking at some of these other issues as you go along, it's probably going to be as important as starting from ground zero and saying, let's create something new and build it from the ground.

DR. HOADLEY: Yeah, I think it's a tough question to figure out, starting new versus -- I mean, because any time we start new, the idea that we could create something that we could actually pass into law and implement could be decades, or at least years. Fixing it, obviously, you know, is not proved easy to get the things right.

I mean, one of the things that strikes me is on the relationships that we were looking at on Slide 10 don't,
in a sense, speak directly to the question of whether shortages are correlated with access. They focus on whether HPSAs are correlated with access. And so part of what some of the questions raise is whether HPSAs are actually capturing access for a couple of reasons. One is the definitional, the designation, the designation issues. One is whether -- the underlying question of all these things people have raised, you know, Medicare versus not Medicare, primary care physicians and other kinds of professionals, et cetera.

So I don't know whether -- and, as you said, there may be some other literature or other studies we have done that go more directly to the availability of practitioners versus access kind of thing. So one thing would seem like to make sure that we know what the literature overall says about this question of shortages, relationship of shortages to access, and you may already have most of that from other things we have done.

The other thing that I don't know how much you can do when you think about the map that you can show or the other issues of designation, is how much could you go in and measure how many of those HPSAs are correctly designated,
whether from their own criteria -- in other words, do you have enough of a database of number of physicians, number of primary care physicians and nurse practitioners and other kinds of professionals to sort of go back and revisit those measures, or is that, because of data limitations, far too massive to be able to do, or is it something you could do from the Medicare perspective, the number of providers that are providing Medicare services in these areas. Is there a way to look at that and figure out, maybe, how many of the HPSAs from either of those kinds of measurement approaches are incorrect today.

So is part of the problem that the designations are so out of whack that, therefore, it's not working very well, or the designations are actually close, although we can pick out the flaws and the mistakes, and then that says, at least, well, okay, what's there is there, whether it works for Medicare or not.

So it seems like there's a bunch of things that could be done to sort of figure out whether the HPSAs are actually capturing shortage, actually capturing Medicare shortage, actually capturing shortage in the rest of the health system, but also the question of whether shortage is
related to access in any way. So there's those things I would throw out.

DR. SAMITT: So my feeling on this is the concept of HPSA is right, but to me, the methodology is clearly wrong. I was frustrated reading this chapter -- it was very well done, by the way -- because I wouldn't know where to start. I mean, I have concerns about the designation, about the de-designation, about the providers included, the payment levels, and the payment methodology. I mean, I think everything, to me, really seems flawed.

And so I don't know if we're allowed to ask for a do-over, but I would clearly ask for a do-over. And I'd start, I think, where others are on this. What's the problem we're trying to solve and let's see if we can measure that. And if we can come up with a good measurement of the thing we're trying to solve and we apply it to the current HPSA methodology, I think what we'll clearly see -- we'll get an answer to Glenn's question. I think we'll clearly see that there isn't a correlation between the problem we're trying to solve and the HPSA bonuses.

And once we've developed that new measurement methodology, base a new and revised HPSA on a methodology
that does meet the underserved and deal with access

problems.

DR. CHERNEW: Yeah, so a few things. The first
thing is, it's sometimes hard to keep front and center, but
our motivation wasn't to do an evaluation of HPSA or even,
for that matter, to do an evaluation of the impact of HPSA
on Medicare. That said, it's hard to read this and not do
that.

And one of the things that jumps to mind, of
course, is for the places that, for example, are HPSA and
rural, then they're getting the HPSA and the rural floor,
because these programs -- I think they are, anyway -- and
these programs are often designed independently. So our
overlap issues are difficult and it might be worth looking
at, but it's not what we were doing now and I'm not sure how
much I'd recommend doing that.

I think -- I actually had a different main goal
than what Jack said, which was not to understand the
relationship between shortage and access, which I do think
matters a lot, but instead to understand the relationship
between payment and access, and shortage is sort of that
mediating thing, but I could think of a lot of models where
you pay people more but you don't solve the shortage.

And then, of course, we don't know the answer to the question, if we pay them and get people to go there, then we stop paying them, would they stay there, you know, or do they leave? So there's a lot in our underlying model.

So since I have nothing of use to say about much more of that --

[Laughter.]

DR. CHERNEW: But I would be remiss if I didn't say something about research. I will say that one of the things that strikes me is, like, if you look at Utah and Nebraska, which strike me as relatively rural States -- and beautiful -- that they don't have a lot of dots compared to the number of dots that I would expect them to have, and it might have something to do with the nature of people in Utah and Nebraska --

MR. HACKBARTH: Put up the map for a second.

DR. CHERNEW: We should just have pictures of Utah and Nebraska.

MR. HACKBARTH: Yeah, I know a little bit about the geography, and the thing is that in a lot of those white spaces in Utah, there's nobody. There aren't any people.
DR. CHERNEW: Right.

MR. HACKBARTH: It's desert. It's --

DR. CHERNEW: Yeah. So that might be the case, but my comment would be, given the seemingly random aspect of some of these designations, it strikes me that we could find places that look a lot like HPSAs but aren't and work on the Slide 10 comparison in a way that might be a little more precise in the control group. So sort of almost a matching.

It might not work, and I'm not saying we should actually do it, but the ideal research -- longitudinal stuff, which I think is what Herb was asking about, would actually be my preferred thing to do. But in absence of that, trying to find places that are matched as closely as one can in the comparison as opposed to broadly HPSA, not HPSA, or even HPSA in a county and not in a county, those parts of the county might be very different or some version of that. But it might be possible to do. Of course, it's complicated since the organizations get to decide what the unit of geography for a HPSA is, so you're not sure what the right comparison is.

So I don't know if I have a really great answer
for that, but my gut feeling is if we wanted to understand
the impact of adding payment, we would try and do as close a
matching as we could do to see where this happened or -- in
absence of being able to do it longitudinally. And that
might be useful in answering the question I think is the
main question, which is when payment gets bumped up, does
access change a lot, and since we can't do that
longitudinally, trying to do a better cross-sectional thing
might be a way to go.

MR. ARMSTRONG: So I think I see this in very much
the same way Michael does, but I'll use many fewer words to
say that.

DR. CHERNEW: That's always true.

MR. ARMSTRONG: I think I share the frustration.

In particular, it does seem as if this is just one of
several policies within our overall payment scheme that's
trying to deal with the same issue and I just don't know how
they all relate to each other. Having said all of that,
this we spend $275 million a year on? I would just stop
worrying about it. We have much bigger things to pay
attention to that are billions and billions of dollars.

Trying to unwind this and answer some of the
questions we're talking about, I just think aren't the highest best use of our time.

DR. MARK MILLER: I'm sorry. I want to jump in for just a second, because I think some things are being said at this point that I do want to focus you on. So we do -- we're talking about a dollar figure of whatever it is. We're also talking about lots of time, you know, involved in parsing or doing it, with all respect, you know, the cross-sectional analysis.

And I agree with you that $270 million is not a lot of dollars and a lot of time, but remembering where the conversation came from was, it's possible that as you look across the country at a national level, you can generally see that access for Medicare beneficiaries is good, but on a spot basis or a market basis, you could have problems.

That, to me, I think, is the big question. So as you think about where we devote our time -- and now I'm speaking very selfishly for the staff -- do you really want to parse through this? Because even if you could establish information about the HPSA as one way or another, remember the process and the purpose is probably going to always have some tension relative to Medicare, because they're set up
for other reasons, too.

And Mike was correct, that we didn't start out to make this a litigation of, you know, HPSA yes or no. It was more -- somewhere along the line in history it got tied to this wagon and then the question was, well, let's take a look at this wagon.

If you parse it, no matter where it stands at this point in time, there will always be this tension, that it's up to other purposes, and we're sort of looking at access.

So where we devote our time, I would really get you to focus on as I think you're starting to zero in on it.

MR. HACKBARTH: Kate.

DR. BAICKER: So I had a thought about how you could try to disentangle whether this is a program that's working, which we all seem a little skeptical about, or one that's sort of randomly drawing money out. But now I feel silly making that point after this, because I think the bigger point is well taken, that this is clearly not the vehicle for fixing any big problems, but I can't help it.

You could, in theory, even though you can't do the longitudinal thing, look at an area that's designated as a shortage area before its designation and at a comparable
area in the same time period, and then look after. And if,
as we all strongly suspect, the area that is designated as a
shortage area neither looks like a low access area before
nor after, then it's hard to make the case that the
designation as the shortage area was the thing that improved
access.

So I would think that that type of dip and dip
approach might help tease apart the causality. And maybe
there's a bigger point to make there about all of the
different payment tools that we're deploying sort of
haphazardly in an overlapping, uncoordinated way.
Collectively, if you look at all of those payments, is there
a way to figure out what the areas with real shortages are
and how much the collective payment change makes a
difference. And is there a way to harmonize all of those
different streams.

We've talked about that in lots of other contexts
from ambulances to what have you, that coordinating the
streams could really maximize the bang for the buck. And
so, in that sense, being able to say, This stream is not
doing anything on its own that we want it to do, is a --
helps one make the case for harmonizing across them.
MR. BUTLER: So we're all going to say the same thing in little different ways. Several of us said, What problem are we trying to solve, and the title of this started with it's HPSA. That's what we're trying to solve. And then as you weave your way through the chapter, you say, Oh, by the way, we've got National Health Service Corps, we've got FQHCs, we've got all these other things that are part of the picture.

So by the end, you say, Wait a minute. The problem is a different one than we started in the title. And so, I do think -- and also the comment that says, you know, it takes us a long time to get from here to there. I do think we have a tremendous opportunity for an educational role here in defining the overall -- half of the solution is defining the problem correctly.

I think if we do present it as an overall access thing, and as Kate says, show the range of mechanisms, the tools currently being used, whether it's National Health Service Corps or FQHCs or HPSA or whatever, there's a series of tools that we could just lay out and say, These are how we're trying to move physicians and providers around to let -- whether it's synchronized. But just understanding that
portfolio is a great starting point. You can still lead into HPSA and say, You know what? Maybe there's a moratorium on additional ones at this point in time, because this voluntary come get it if you want it kind of thing is, you know, small dollars. It doesn't seem like it's the right tool. Let's not keep using it. That may be one of the kinds of outcomes.

But I would look at this in the longer term because we're going to come back to this through various other things that we're going to address one way or another. So I think the overall access umbrella is going to be increasingly important for us to kind of understand in a more global sense.

DR. SAMITT: Can I tag onto that? Is it feasible to see -- you know, one of the things we do in our own organization when we try to get a handle on who's benefitting from multiple different ways, especially in terms of payment, is really sort of an exceptions grid that essentially says, Where are all the exceptions to the rurals?

So what I've never seen is really a single source that says, What are all the different ways that rural areas
are actually potentially benefitting, or what are all the exceptions? And are we potentially double counting? I don't know if there's a way to really get that summary or whether that itself is too complex, but I think it would be useful to see and it may give some context to what Peter is describing and asking.

DR. MARK MILLER: And I have a vague recollection, Jeff, that when IOM started to look at some of its mandates in the last two or three years, at least early on -- this is the geographic variation broadly written. Early on, there was some work where they tried to line up all of the, you know, special adjustments for rural areas. So we'll start there and see if we can get our hand on that list relatively quickly, and then see if that starts to fit into what you're saying.

MR. BUTLER: If Mitra were here, she'd say, Don't just think about the rural areas. This is an access issue, period, like FQHCs are -- a ton of those are sitting in urban areas.

DR. MARK MILLER: And I knew that. So that list was available so I was going to start there. Peter, I got your point.
DR. HALL:  Maybe just to drill down a little bit, so I work in an area of the country where there are a number of HPSAs and I've seen patients in these areas. So in general, they do a very good job of -- we have a number of rural ones. The whole Lake Ontario area of New York State, you'll notice, is dotted with them. Those are primarily serving migrant workers who come up to work in the crops in the summer and then leave. Tremendous amount of health problems. No health insurance.

Remember, this is not just a Medicare issue. This is the whole access to care issue. And so, it's hard for me to say that the money is wasted in those areas because there really would be no access to care. And the fact that these HPSAs have been initiated by local areas suggest a degree of community engagement that is laudatory. It's not a hand-out. They have to really do some work in order to get the designation.

And then within our urban area, there are also a few. Some are geographic. Mostly are ZIP code based. Service of minority populations that really actually don't get access to health care. Now, it seems to me that the real issue for us in MedPAC is, that segment of the
population that are Medicare eligible are eligible for
benefits, period.

The real question is, do we have to pay an extra
10 or 15 percent? I think maybe that's really our issue,
not so much whether we're going to take on this entire
program around the country. I think that we could really
get lost in this very, very easily. So that's my point of
view on that.

DR. REDBERG: So I agree with a lot of what has
already been said. I will just -- about the concerns. It
seems the goal of this is to get more primary care services
to areas that need them, but it's very hard to look at that
money and say that this is what we're doing with this
program. And so, I think that's giving us a lot of concern.

You know, the National Health Service Corps, I
mean, it seems to me that it's not a lot of money, but it
does -- a fair amount of money and it could be used to
really more directly address the primary care issue. And
so, first of all, obviously as has been pointed out, primary
care practitioners are not restricted to doctors. There
are, you know, advance nurse practitioners and it's a shame
that they're not counted in this and that they're not
benefitting from it.

And also, when I think of National Health Service Corps, I think, you know, more of the model of actually using the money to directly bring primary care practitioners to under-served areas and that seems like a much more direct way to address it and then know that it's actually being used. Because when I look at this and I see that only 31 percent of all the Medicare payments are actually going to primary care, it makes me feel that even the money that we're spending isn't really addressing the problem.

And then just in the bigger picture, it's very frustrating. This program is already here, but if we were certainly doing this today or thinking of new programs, it really reminds us of how important it is to be able to define what the problem is, to have a measure for it, and not to start throwing money at it until we have a measure and then we have a program and a plan to come back and re-
look at it and know whether we're actually addressing and improving the problem, because otherwise, it's very -- we're in this position where we have no idea if this money is actually helping, although it certainly is hard to say that it does help. So that's my kind of specific suggestions and
broader suggestions for future programs.

DR. CHERNEW: So I just wanted to say one thing in response to what Scott said, just with more words, which is, I agree that this is a small program, and in that sense, we have a lot bigger things to think about.

But while this sort of poorly targeted aspect of this is very troubling from a policy point of view, it may be quite soothing from a research point of view if you could think about the type of stuff that Kate was saying and the sort of notion of how to get at this, because the question in my mind isn't so much about HPSA or not HPSA or that, it's about how the provider system and access responds to payment.

And so, if you could do that well, and I'm not sure you could, there's a whole range of questions that we address that are much bigger than just HPSA about what we think about payments in a bunch of ways. So if we knew the general -- the answer to the general question, I think it would help us leverage what we do in programs that are much more consequential at large in the Medicare program.

MR. HACKBARTH: So, we got into this through our work on the report on the floor on the GPCI work adjustment.
And in that conversation, we concluded that the floor was probably not a very effective way of improving the access in areas where there were problems with access. It might be better to have a more targeted program. So now we're looking at HPSA as an effort to target.

I tend to think about these things in the way I might be asked questions in a Congressional hearing. So MedPAC, like the GPCI floor. Is the HPSA bonus program better than the GPCI floor? Does that do a better job? You know, it's really hard to say based on the information that we have, but if I had a choice between we're going to repeal one of these two things, you know, the GPCI floor or the HPSA bonus, which would you ask us to take away, I'd say, take away the GPCI floor and keep the HPSA bonus.

For all of its problems, at least it's an effort to try and identify where there are shortage issues. That's not a very -- that's not very high praise, but compared to that alternative, this is probably a better alternative.

But then the next question would be, Well, should the HPSA bonus be enhanced, increased? And there, I think you'd have to say, based on the evidence, no. It would be hard to make the case that that would be a good use of scarce taxpayer
The next point, to press still further, I would say probably the thing to do is to take a broad look at all of these various programs that are aimed at improving access to care, not just Medicare payment adjustments, but the National Service Corps, et cetera, and look at all of them as a group at their effectiveness.

In fact, this was an issue, a point that we made during our GME work back in 2010, that if you really want to increase the number of physicians practicing in rural areas where you want to change -- or even urban areas, underserved urban areas -- you probably want to move upstream, look at things like medical school, entrance policies, recruitment.

And then a little further downstream National Health Service Corps, Medicare payment adjustments or Medicare GME funding adjustments are probably pretty weak tools for dealing with distribution of physicians and choices physicians make. So those would be sort of the lessons that I take out of this for reasons that Scott and others said. I'm not sure that it's a high value use of our time to dig further into refinements of this. Let me stop
there and just invite reactions to that. Craig.

DR. SAMITT: You know, I would wholeheartedly support a re-look of all of the things that could potentially affect access, not today, but in the future. I mean, I think even the discussion about the SGR fix and sort of the need to re-distribute primary care is as much about solving the future access problem as anything else; that if we envision that there's going to be a deficit of certain physician disciplines, whether it's the disciplines themselves or the geography of the placement of those physicians, I think someone should take a whole broad look at where those barriers are and what policy recommendations can be put in place to address them now and into the future.

MR. HACKBARTH: It's just sort of a technical problem because a lot of them are in the Public Health Service and outside of, you know, our jurisdiction. So that's just an issue. I saw another hand. Jack.

DR. HOADLEY: I mean, I think I would answer that first question you put up the same way you did, and one of the reasons I would give for that is probably that the floor is only a rural -- only addresses the rural issues.

MR. HACKBARTH: In fact, one of my objections to
it is, you know, Denver qualifies, San Antonio.

DR. HOADLEY: Or doesn't do it well.

MR. HACKBARTH: It doesn't really target.

DR. HOADLEY: And I think what the HPSA, at least in concept, tried to do was figure out a way to address urban issues. But the problem is the measuring -- all the measurement tools. I mean, you can think of lots of places that have plenty of providers in the geographic unit, but they're not serving the population.

And, you know, we don't want to go back and redo the rural analysis, you know. And maybe thinking about ways we can try to focus on some of the urban areas is a way to distinguish what we might do from what's already been done on the rural side. It's harder, I mean, because the doctors are often there physically in the community. They're just not necessarily, you know -- they're dealing with other income, higher income patients. So maybe it becomes more of a low-income issue.

But anyway, that's -- it really goes back to the importance of the urban issues.

DR. NAYLOR: So I really like also the idea of framing or re-framing the problem, and even getting to
better clarification of principles to address this problem.
So the thing that I think has guided our work for the last -
- well, since I've been here is the set of principles and
that we can constantly go back to see.

Here it's not -- it's not just access of Medicare
beneficiaries. Here I think we want to really focus on
access of Medicare beneficiaries to primary care. And it
seems to me then we have a set of both payment tools and
newer delivery system tools that we need to be thinking
about as potential solutions and how payment can really
accelerate those tools, including workforce, but also system
redesign.

And then mapping the programs against meeting what
we hope will be the metrics, however broadly. We might not
need to define them. But I think I wouldn't have answered
that, based on reading this, that HPSA is accomplishing it.
I think it needs refinement, and if it becomes the way that
we continue to build and invest, and because so many -- 30
programs are feeding off this. So it seems to me it's not
just the $270 million investment. It's a gargantuan
investment that's being made and building on this block.

So I would say if one of the opportunities here is
then what are the set of policy recommendations to refine this to accomplish that goal, that's great. But I do think we're at a point where we could take a look at our principles, take a look and refine the problem, and that would help us a great deal in evaluating existing options.

MR. BUTLER: So if we kind of go that direction Mary is suggesting and do have the inventory of tools that are currently being used, one way to highlight maybe our priorities might be asterisking those ones that without action something is going to happen. So SGR would be a good one. You know, it's coming up again, or it could be that the temporary add-ons that you mentioned, should we recommend they continue or not.

So at least some of the things may require some input because they're time sensitive and something is going to happen to them one way or another, and our principles might help guide how we would respond to at least those that are in the pipeline that are going to require some action no matter what.

MR. HACKBARTH: In fact, the reason I'm sort of thinking about this in terms of questions that I'm hearing is that I'm going to be testifying at a hearing next week
and I think this probably will come up. One of the things they'll want to talk about is the extenders, including the GPCI floor and our recommendations on that. So that's why I'm very much in this mode and thinking about principles. So I don't think the GPCI floor is well-targeted. We'll elaborate more on that. HPSA bonus, you know, it's a close call for me whether that is better than the floor. I'd be inclined to say yes, it is, but with a critical caveat, resorting to our principles. I don't think that provider to population counts are a good measure of access, and we laid out our case for that in the rural report. So we have this built on what we think -- and correct me if we don't think this -- that it's a weak foundation, but it's probably better than just spreading the money around to everybody that has a GPCI work value of less than 1. Not a very high standard, but it's probably better than that. But if you want to add more money into the HPSA bonus, I'd probably couldn't recommend that. And if you really want to do something that's effective at improving the distribution of clinicians, physicians, and others, you really need to do a much broader look at the array of
programs that exist, many of which are in the Public Health Service, that are a drag to that, do a careful evaluation as appropriate restructuring. That would be my answer. Does that sort of capture the spirit of this conversation?

DR. COOMBS: I just think one caveat, when you're looking at the ratio, has got to be to reserve the notion that when it's very extraordinarily low, I think the World Health Organization, those several legitimizing bodies that actually endorse this as a mean of a rubric to look at sufficiency of workforce.

So I think when it's very low, it tells you something very different than if it's normal or increased. So I would just use that as one thing as an exception.

MS. UCCELO: My frustration in this entire conversation is the -- how are we defining low-served areas? And I don't think we -- we think we know what's not good, but I'm not sure we've come up with something that we think really does a good job of it.

MR. HACKBARTH: We certainly haven't come up with a composite measure that, you know, we can say, Here's the index and, you know, if you're more than 1.3 on the index, you've got a problem. But I do think that we laid out a
rubric in the rural report for how you assess whether people have access to needed services, and it's not just one thing. It's a multi-variable sort of look, but it hasn't been reduced into a payment formula and adjustment. Do you feel comfortable with that? Okay. Craig, anybody else?

Okay, thank you. Good work, Kevin, Kate, and Katelyn.

[Pause.]

MR. HACKBARTH: Okay. Our final topic is shared decisionmaking.

DR. SOKOLOVSKY: Good morning. Lately the Commission has been devoting an increasing amount of time to beneficiary issues, including our work on benefit design. A number of you have been asking for an update on shared decisionmaking since we last looked at it in 2010. Today we are going to summarize some recent developments. Let me tell you what we're going to do today. First, we're going to tell you about what we did to update our past findings and get a better understanding of how shared decisionmaking is currently working. Next, we'll summarize our key findings. With few exceptions these findings held across all the sites we
looked at. In the future, we hope to describe some of the wide variety of other programs being developed.

One focus we had in the course of our work was to examine whether shared decisionmaking had the potential to reduce health care disparities. Today we're going to focus on one particular program that seems to be making progress on that issue.

I want to start by reminding you of what shared decisionmaking is. It's a process that involves giving patients personalized information about their condition, possible treatment options, and the probabilities of benefits and harms from these different treatments, and allows the patients to communicate how they value the relative benefits and harms so the patient can then participate in decisions about their health care.

For example, breast cancer patients learn that, in terms of average survival rates, there is no difference between mastectomy and lumpectomy, but that there are other tradeoffs with both procedures that they should consider.

Shared decisionmaking includes the use of patient decision aides. They can be booklet, DVDs, online programs, or other ways. They are basically tools that give patients
objective information about treatment options for a given condition,

Shared decisionmaking is not appropriate for all decisions. It mainly focuses on questions where the obvious treatment option is not clear.

To update our past findings, staff conducted three site visits. One was to Group Health, which has conducted the largest demonstration of shared decisionmaking, testing whether it could be incorporated in regular clinical practice. Since 2009, they have distributed over 27,000 decision aids, mostly to patients considering elective surgery.

Second, we visited Mercy Clinics in Iowa. While Group Health started with specialists, Mercy focused on primary care as part of their ongoing ACO.

Lastly, we visited the nurse practitioners at FQHC, Public Health Management Corporation. Their clinics, which service a largely Medicaid-eligible and public housing-eligible population in Philadelphia, are organized as medical homes, and they focus on primary care.

We conducted three focus groups with patients who had taken part in shared decisionmaking, and we also
conducted about 20 structured interviews with individuals implementing other programs, researchers, and companies that are developing programs. This presentation focuses on our site visits, including the focus groups.

As you suggested in 2010, increase in ACOs and medical homes has led to an expansion of shared decisionmaking programs. However, progress is slow.

Successful programs, although all unique, have certain features in common: strong support from leadership of the organization, provider champions, and often nurse coaches. Physicians must support shared decisionmaking for it to work, and for that to happen it can't interfere with office work or add to the time that they have available to see patients.

Compared to 2010, more demonstration projects are incorporating shared decisionmaking in primary care but challenges remain.

And, lastly, many believe that shared decisionmaking has the potential to reduce health care disparities, but empirical evidence is limited.

The International Cochrane Collaboration has analyzed 86 randomized controlled trials of shared
decisionmaking with patient counseling and decision aids relating to over 20 different medical decisions. Studies have consistently shown that decision aids used with counseling increase patients' knowledge, give them a more realistic perception of treatment outcomes, increase the proportion of patients who are active in decisionmaking, and improve agreements between patients' values and the options that they choose. In general, the studies also showed a reduction in more invasive treatment options without adverse effects on health outcomes.

Early results from Group Health focus on about 9,000 patients with osteoarthritis who were potential candidates for knee or hip replacement surgery. Researchers compared patients with these diagnoses during the six months prior to the demonstration with those six months after the demonstration began. This includes patients who did not get the decision aids. Compared to patients in the early group, the knee replacement surgery rate dropped 38 percent and the hip replacement surgery rate fell 26 percent. Costs for these patients also fell.

I want to just remind you that patients who don't choose surgery still incur medical costs for alternative
treatments, for example, medication and physical therapy. Physicians we spoke to said that even delayed surgery could be better for patients because the new knees and hips can wear out, and people who have surgery at a younger age may need additional surgery later.

Shared decisionmaking at the three programs we visited were characterized by leadership strongly supporting the program. For example, at Group Health, when the project got off to a slow start, leadership scheduled half-day training sessions to explain the program and listen to physician concerns, rearranging operating room schedules to make sure that physicians could attend.

In all three sites, provider champions who strongly supported the program in individual departments or clinics were a key factor in encouraging others to try the program. They were the ones who could explain that it didn't increase the time they needed to spend with each patient and that their patients were very enthusiastic.

At Mercy, shared decisionmaking depended on nurse health coaches in each clinic. The nurses coordinate care, provide patient education, and could also have responsibility for distributing aids and explaining shared
decisionmaking.

In 2010, the Commissioners talked about the difficulty implementing shared decisionmaking in primary care. You suggested that the development of ACOs and medical homes could provide the incentive and infrastructure to make it more feasible. And to the extent that patients choose less invasive procedures if they were less costly, the ACO had the opportunity to realize savings.

CMS has developed CAHPS sections for medical homes and ACOs within their patient experience modules that reference exactly the activities associated with shared decisionmaking. So we do see an increase happening but at a very slow pace.

For example, CMMI, the Innovation Center, has awarded three shared decisionmaking grants, and PCORI has also awarded two grants. But when CMS recently conducted a survey of their Comprehensive Primary Care Initiative, which currently has 500 sites, only 2 percent of those sites reported having shared decisionmaking programs.

We interviewed organizers from eight primary care shared decisionmaking sites and found that they focused on different conditions, used various methods of decision aid
distribution, and encountered a range of challenges. Some made more progress than others. Mercy has been one of the most successful of these sites and is expanding their program beyond the demonstration. But they still face challenges and report, in fact, that there were somewhat fewer decision aids distributed in the second year of the program than in the first year.

Some of the reasons we were given include: In the first year, physicians were getting an incentive payment to provide the decision aids. They're no longer getting that, although they're still getting it in the P4P program. Secondly, there are now over 30 aids, and that made it harder for both the physicians and the coaches to remember that there was an appropriate aid for a particular patient.

Finally, as the ACO has developed, health coaches have increasing responsibilities, so it has been harder for them to devote as much time to shared decisionmaking. Mercy has responded to this problem by increasing the number of coaches in each clinic.

We conducted two focus groups with Medicare beneficiaries at Mercy who received decision aids. The kinds of things patients said, and this is one quote that I
thought really captured the essence of what we heard:
"Overall, I feel that when my doctor comes in, I don't want
to bug him with petty questions. I think my questions are
just me being dumb so I don't ask them. But after seeing
these questions covered in the material, I realized they
aren't petty. And the doctor gave me straight answers to
the questions when I asked them in the office."

Another example: Sometimes people hearing about
shared decisionmaking and that people are more likely to
choose less invasive treatments think, "Oh, well, this may
just be another way to deny care," so I want to give you
another focus group participant. This was a man who was
over 80 who had been very active all his life, but now knee
pain was making him feel that he was no longer going to be
able to participate in his favorite activities. He thought
he wanted knee replacement surgery. His doctor told him,
"If you were my father, I would advise against it, but I
have some material you should look at."

After seeing the video, he realized that rehab was
much longer and harder than he had anticipated, and success
would depend on how hard he was willing to work at rehab.
He went on to have the surgery, was prepared for the
Now Katelyn is going to talk to you about the use of shared decisionmaking to reduce health care disparities.  

MS. SMALLEY: As Joan mentioned, empirical evidence about shared decisionmaking's ability to reduce disparities is limited at this point, but some programs show promise in both reducing disparities and engaging low-income populations. Your mailing materials provide more information about efforts to reduce disparities in end-of-life care and end-stage renal disease. But today we'll focus on efforts to implement shared decisionmaking with the low-income, low-literacy population.  

In November of last year, staff visited the Public Health Management Corporation, a nonprofit group of federally qualified health centers led by nurse practitioners in Philadelphia. The population served by these clinics is largely Medicaid-eligible and public housing-eligible. A large portion of the patients in one clinic are chronically homeless.  

As required by the FQHC, the clinics are organized as patient-centered medical homes. Nurse care managers coordinate the care provided by nurse practitioners, social
workers, and mental health specialists for the patient.
The care manager is also responsible for distribution of decision aids to appropriate patients and addressing their questions in preparation for a follow-up visit with the nurse practitioner to discuss a decision. Despite initial concerns, nurse practitioners have found that the decision aids have led to more efficient office visits and deeper discussions with patients.

PHMC is unique in the population that it serves and in some of the strategies it uses to engage patients. While the clinics offer many acute-care decision aids, the most widely used are for chronic disease management.

The most popular decision aid is for diabetes. Patients and clinicians reiterated the importance of community in managing chronic conditions, and thus patients diagnosed with diabetes can choose to watch the decision aid with a group of patients like them and participate in a discussion facilitated by a nurse that helps them consider their preferences with regard to lifestyle changes and medication. One of the nurses we spoke with told us that the peer group was an important part of the program, saying, "The patients in the videos were a different kind of expert
Family is also encouraged to be involved in the shared decisionmaking process. Patients often watch the videos with their families so that they can discuss lifestyle changes together. Some patients have also asked for decision aids on behalf of family members.

Patients often reported feeling overwhelmed by their diagnoses. The decision aids showed them that small changes that they make could have a large impact on their health. It was helpful to them to know that it is normal to struggle with managing a chronic condition like diabetes. Because they saw the patients in the videos acknowledge their difficulties, they felt more comfortable being honest with their nurse practitioners about their own challenges.

One of the most striking findings from Philadelphia is that medication adherence in this population after engaging in shared decisionmaking is comparable to other shared decisionmaking demonstration projects that predominantly serve higher-income patients.

On the slide, the green bars show medication adherence for the PHMC population, and the blue bars are other demonstration sites associated with the foundation for
informed medical decisionmaking. The darker color at the bottom shows adherence before shared decisionmaking. Taking cholesterol medication adherence as an example, the Public Health Management Corporation adherence was 46 percent, and the adherence at the other sites was 63 percent before shared decisionmaking. While adherence rose in both groups after participating in shared decisionmaking to 72 percent and 74 percent, respectively, we see that the gains in medication adherence were much greater for the Public Health Management Corporation population in this case. PHMC is still exploring ways to best measure shared decisionmaking's impact on outcomes and other quality measures.

Reactions to shared decisionmaking have been largely positive. However, it is important to note that the evidence base for shared decisionmaking's effects on quality of care and health outcomes is still small. Evaluations of shared decisionmaking generally involve small programs, and while patients are enthusiastic about participating, shared decisionmaking's ability to improve health outcomes is still unclear.

In addition, interest in shared decisionmaking is growing, especially with the adoption of ACOs and medical
homes, but that growth is slow.

Finally, staff has collected much more information about shared decisionmaking and patient engagement than we were able to share with you today. In future conversations, we plan to discuss more work on disparities, patient activation, other innovative programs in shared decisionmaking, and continue to report the progress on developing and testing quality measures.

This slide is a reminder of the major findings on shared decisionmaking thus far. As we move into discussion, we look forward to hearing your comments about what we know and suggestions for directions for further research.

Thank you, and we look forward to your discussion.

MR. HACKBARTH: Thank you. Good job.

Scott, since Group Health is so prominently mentioned in the materials, anything that you want to say to kick off discussion?

MR. ARMSTRONG: No. I think the work that the group has done is excellent. I think this raises some very interesting questions. Obviously, there is tremendous merit in the shared decisionmaking approach, both with respect to the engagement of patients and the application of evidence
to the different alternative courses of treatment. But I think there's a real question that remains, and that is, how does shared decisionmaking actually change the cost trends over the course of time? And while in our organization we believe that this is a good approach to care and that cost trends will be affected over time, we have very little evidence to really affirm that.

You know, for us, in consideration of significant payment policy, I think that is an important thing to keep in mind.

MR. HACKBARTH: Okay. Round 1 clarifying questions, anybody?

DR. NERENZ: Slide 9. Given this Commission's focus on Medicare payment, it strikes me that the first bullet, the first sub-bullet under challenges, lack of financial incentives, may actually be an understatement. Are there any payment streams for this activity in Medicare fee-for-service at all?

DR. SOKOLOVSKY: In fee-for-service, no, although, for example, in Mercy, many of the physicians are paid fee-for-service, but it's within the context of an ACO.

DR. NERENZ: But they don't get paid for doing
DR. SOKOLOVSKY: They don't get paid for doing this, no.

DR. NERENZ: Nor does the nurse coach, nor anybody else.

DR. SOKOLOVSKY: No.

MS. SMALLEY: Right. And in PPACA, there were some provisions for shared decisionmaking, but no funds were allocated.

DR. REDBERG: To state the obvious, it's kind of the negative incentive because, as you saw the data on surgery, the rates go down. The rate was 36 percent or so for knees and 20-something at Puget Sound. And so that is clearly a barrier to dissemination in a fee-for-service environment, the payment goes --

DR. NERENZ: That's why I phrased my question the way I did, to say this is kind of a gentle understatement. There are some clear disincentives in some environment, I would think.

MR. GRADISON: It seems to me I've been hearing about this since I first started to read the work of Jack Wennberg, and I think I was in short pants at the time. And
he had some very good information out there, a video about prostate treatments and options and so forth.

I think it's a good idea. I am troubled in several ways. Of course, I'd like to know more about costs, and I'd like to know more about outcomes. Somehow, also, I'm trying to think through the effect of adding this additional responsibility to all the other things that we want to accomplish. It reminds me a little bit of driver's ed. Driver's ed is a really good idea, but I think when it's suggested -- and I've been on a few school boards -- the question is: Instead of what? What are you going to drop from the curriculum to add driver's ed? And maybe the answer is, well, we're not going to drop anything here. But I'm not so sure about that.

My overall view of the report is that it's excellent and pretty well balanced, but I stress the "pretty well" because it just happens that, by coincidence, the Health Affairs issue that just came out is on this very same subject and has a number of different articles, some of which are cited in the references in the back of this chapter, and you had it available. But I came away from reading those articles with a sense -- a very different
sense than I did from reading this document. And at the risk of just picking out one, I will pick out one, which is the RAND study. Just a couple of sentences:

"Barriers to shared decisionmaking included overworked physicians, insufficient provider training, and clinical information systems incapable of prompting or tracking patients through the decisionmaking process. Methods to improve shared decisionmaking include using automatic triggers for the distribution of decision aids and engaging team members other than physicians in the process,"

and so forth and so forth.

But the reason I go through this is actually I do have a question that does relate to Slide 9, please. It's already up there.

[Laughter.]

MR. GRADISON: And that is, I wonder whether -- because none -- I haven't seen references here to the age of the Medicare patient. What I'm going to say now is a gross oversimplification, but I think physicians years ago were considered God a little more than they are today, and that patients were more willing to accept their recommendations without asking a lot of questions. And that leads me to
wonder whether we're dealing here with a situation in which, in terms of the receptivity to this approach -- and I acknowledge the 80-year-old example. You know, I'm over 80 myself and ask a few dumb questions myself, although I do seem to always end up doing what the doctor initially recommended. I can't sort that one out. But I truly wonder whether this is something that we'll see change over time as people who are more accustomed to asking questions and not just automatically doing whatever the doctor recommends age into Medicare than might be the case with older beneficiaries.

So that is my -- I did have a question, and that is, do we have or over time might we get any information on the impact of the effects of this approach with the old-old as compared with the younger-old?

DR. SOKOLOVSKY: We actually do have that, only I got it like the day before the presentation was in, so it's not yet incorporated. But it --

MR. GRADISON: I'm glad I asked the question then. We did not rehearse this ahead of time.

DR. SOKOLOVSKY: No. It does include surveys from all the demonstration sites, including the one that that
article focuses on. And, interestingly enough, age does not -- is not a barrier to shared decisionmaking. The enthusiasm, the people who say that it's an excellent or very good program, is as high for the elderly as for all the other age groups.

MR. HACKBARTH: Okay. Herb, do you remember the format for questions?

[Laughter.]

MR. KUHN: I'm going to stretch this one just a little bit, but I think Slide 7, just kind of a bit of reference here in terms of physician buy-in. So, a little bit where David was, is there any CPT code that has a descriptor that includes shared decisionmaking in it?

DR. SOKOLOVSKY: There is a code that's about patient counseling that some people have suggested could be used, but I believe that most physicians think that that would prompt an audit if they actually tried to use it for that reason.

MR. KUHN: And then are any of the specialty societies moving to the RUC to ask for codes to be updated to include this and to change the code descriptors and then ultimately the valuation of codes? Are we aware of any
coming forward yet?

DR. SOKOLOVSKY: I'm not aware of that.

MR. KUHN: Okay. Thank you.

MR. HACKBARTH: So, Joan, could you just say a little bit more about your response there? Why do physicians fear an audit if they use a counseling code to do shared decisionmaking?

DR. SOKOLOVSKY: They feel that that's one of the triggers. Now, this came up earlier, in 2010, and our former Commissioner Karen Borman said she uses that code all the time and it's never a problem. But talking to physicians in these different sites, they were worried about that.

DR. HOADLEY: On Slide 3, it really is about the definition. You talk here about communicating values, relative importance of benefits and harms. Does cost benefit come up in these discussions, and if so, how often?

I know that's a politically charged notion.

DR. SOKOLOVSKY: It doesn't come up in the decision aids that we've mostly been talking to, but the Mayo Clinic -- I think I talked about it a little bit in the paper -- has a different approach that involves the
physician directly doing shared decision making, and one of
the issues on their radar is cost issues, and they kind of
go through -- for example, for a patient with diabetes,
there are six or seven different types of medication you
could take and they give you a list of what's most important
to you -- side effects, control of your blood sugar, and
there's a whole list, but one of the things on the list is
cost.

DR. HOADLEY: Okay. Thank you.

MS. UCCELLO: So, on Slide 6, please. You noted
that when looking at the reduction in surgery, that those
numbers included those who did and did not receive the
decision aids, and I was wondering if there was any
reduction even among those who did not receive the aid,
suggesting there might be a carryover to kind of physician
behavior component to this.

DR. SOKOLOVSKY: That's a really good question and
I don't have the answer.

MR. HACKBARTH: Okay. Let me kick off round two.

My mind is focused on two questions. One, I think, is easy
to answer, the other, more difficult.

The easy question to answer is, is shared decision
making a good thing? I think it is. In fact, I would say, beyond being a good thing, I think it's an ethical imperative. By definition, what we're talking about is, for many services, there is no clinical right answer. The right answer depends on patient preferences, how they feel about different possible outcomes and risks, and to me, certainly in that category of services, this is an ethical imperative. That's the easy part.

The second question, which I hope we will focus on, is -- if we all agree that it's a good thing -- what is the Federal role, if any, in trying to promote it, and let me put even a sharper point on that. What is Medicare's appropriate role in trying to promote it?

Clearly, one thing is to change the payment incentives for the reasons that Dave and Rita alluded to at the outset. So let's stipulate that as a given, that if we have a different payment system where there's a higher premium on high-value care, managing costs and increasing patient satisfaction, that's very important in setting the stage for this.

But what beyond that, if anything, should Medicare be doing? I hope people will address that in round two.
Actually, let's start on Rita's side this time.

Rita.

DR. REDBERG: So I want to pick up where you started, because I think that's a key point. And I'll say, we started -- a few years ago, I worked with a Statewide group of cardiologists to try to introduce shared decision-making around the decision to have elective treatment for stent versus medical therapy for elective coronary disease, and the first question that all the cardiologists said was, "What about lost income from decreased procedures?" because the data pretty consistently shows that the use of shared decision-making leads to decreased procedure use, which in itself suggests that perhaps we're not doing as good a job as we should in informing patients at the time.

And I will say, certainly in that particular issue of elective coronary disease, we have a lot of data to suggest that we're not informing patients at the time, because despite the fact that there are 15 years of studies showing that the use of stents for elective coronary disease does not reduce the incidence of heart attack and does not change mortality compared to medical therapy, repeated surveys of physicians and patients, both in 2000 and then
repeated more recently, in 2010 and 2012, show that the
majority of patients think they're getting a stent because
it will help them -- it will prevent a heart attack or help
them live longer, and a lot of them, even though they only
poll ed elective patients, think it was an emergency
procedure.

And so there's clearly a great need for -- and one
could call it shared decision-making, although one could
also say this is part of the informed consent process and
that we're really not doing the job we should be at informed
consent. It's possible that patients were told and they
forgot, but, clearly, people are not getting the information
you really need.

So that is kind of a long way of saying that I
think changing our payment structure would be essential to
the take-up of shared decision-making, because it's clear
that this has been tried, mostly in places where there's not
a fee-for-service structure, and it's ACOs and medical
homes.

I thought it was interesting that even at Puget
Sound, which is not a fee-for-service, it was hard for the
cardiologists to take up the idea of using decision aids for
coronary disease, for other reasons. I mean, there are clearly a lot of entrenched ideas. And you can think of a lot of different ways to incorporate, not just paying for the time for shared decision-making, but also ensuring that procedures aren't done without ensuring that that kind of informed discussion has happened beforehand, because otherwise, unfortunately, I think, patients are getting procedures that they would not have chosen to have.

The last anecdote: A few years ago when I was on the cardiology service, I had an 88, 90-year-old woman who had just recently had a defibrillator, a fancy one, a biventricular defibrillator placed at a different facility and she was DNR/DNI, meaning do not resuscitate, do not intubate, and I said, do you understand that that defibrillator you had placed is going to shock you, and she had no idea. She said that when it was placed. I said, well, why did you think you had this placed? And she said, "Because the doctor told me I needed it to fix my heart." I said, well, it is -- I explained how it worked and that it certainly would shock her when she wanted it -- she was very clear about a do not resuscitate order. So we had to
deactivate this very expensive device that had been put in a
week before somewhere else.

So all I'm saying is I think we really have an
obligation to our beneficiaries and our patients to do
better informed consent, and shared decision-making, I
certainly see as a big part of that.

DR. HALL: Thank you, Rita, for that. Let me just
speak a little bit more from the heart than the head.

I was itchy reading this chapter because it's a
professional embarrassment, at least from my part of the
profession, that we have to have a discussion as to whether
a physician should communicate with their patients, should
let them be informed about making critical decisions about
their lives and their families' lives. But the reality is
that it's a real problem and it needs correction.

If one looks at all of the various quality
indicators, and we'll be talking a lot more about those in
the months ahead, there are quality indicators about, for
instance, the HCAHPS, which is used as a survey instrument.
We ask about the quality of the food. We ask if people
smiled and used their names. One thing we never ask is, did
anybody express any kind of compassion about you as a
person, a very old fashioned idea. It doesn't appear there.

There is no -- in any of the quality indicators, anywhere, there is nothing that captures the essence of why this type of communication isn't taking place.

We can say that we're all busy, that the people don't have the capacity to participate in decision making.

That's all just a cover-up. I mean, I shouldn't say cover-up. They're lame excuses for what really should be an essential part of the contract that started with whoever it was, Asclepius or Hippocrates or whatever.

So I think that this concept should be very much on the tip of our tongues and in our thoughts as we look through a great deal of the inevitable changes that are going to come along as we look at different structures of medical care and want to ensure, again, that triple aim of safety, quality, and cost effectiveness.

So I would think that one of the things that we might want to think about is, given all of the modern technology that's available to us and the complexity of so many people being involved in patient care, is that this become not only just a kind of an add-on and something that's very nice, but really an essential part of any sort
of change in health care systems and in payment systems.

I don't know quite how you sort of pay for compassion. That's also a bit of an embarrassment, too, to have to say that. But I think the time has come, and I don't think it's just something for doctors. I think it's something for the entire health care professions to be involved in.

And I think we could have an enormous impact on that by asking the questions and then trying to creatively think about how one could actually, if we need to do this, pay for compassion. Or, at least let's put it this way. If we're going to penalize hospitals for readmitting patients within 30 days, it seems to me entirely reasonable we might want to not pay them if they haven't communicated with their patients. I think it's that straightforward and that important.

MS. UCCELLO: I was really encouraged by this chapter until I just heard Bill say, well, this should be the default. But I thought it was a good way to kind of wrap things up, and I think it has implications for all of the different things that we talk about.

In terms of how do we promote this, definitely
thinking about how to incorporate this into the quality
metrics. You know, in terms of did you get a decision made
on, or do the providers provide these kinds of things, I
think could be helpful.

What I'm really interested in is thinking about
how these types of tools can be used at hospital discharge,
getting at those readmission issues we were talking about,
and can they be used -- it seemed like some of the things
that Murphy was doing really got at some of these disparity
issues that we're concerned about, and so are there things
that can -- are different organizations pursuing tools,
shared decision-making or similar tools on the hospital
discharge part of care.

But just in general, I was really just encouraged
by the findings in this report.

MR. BUTLER: I'm not sure this will be too helpful
directionally to what to do, but I kind of put three buckets
of shared decision-making.

The first is what we do in our own employee health
plan, and that is we engage every single employee very
directly in shared decision-making by requiring a health
risk appraisal, and if you don't, you pay a penalty. And if
you do surface problems, you are now required to get coaching, required to engage, and, in fact, in some cases, required to show improvements. And so there's a direct engagement. And we can measure the impact over all of our employees over time of engaging them directly in managing their health. We don't have anything like that on the table in this proposition, I think, but you could go that far.

The second is what's been brought up by Bill and others, and that is you're facing an elective decision around a specific acute problem. It could be which way to go on surgery or whether or not to have surgery at all, and in a fee-for-service system, as pointed out, it's hard to kind of get at how to incentivize that.

And then the third is the end of life, which we haven't talked about too much this morning, but may be the most important of all in terms of how do you engage not just the individual patient, but the family, and for that matter, going back to yesterday's competitive premium concept, how do you engage the players on the end-of-life issues where so much of the money and so much of the kind of dysfunction often occurs.

So I look at kind of those categories. I'm not
sure what that means for our work, but it's a different way of looking at shared decision-making.

DR. BAICKER: I had actually been categorizing things slightly differently in my mind and making a distinction -- perhaps a false one after this conversation -- between shared decision-making over choices where there are pros and cons of each and patients with different preferences might very reasonably choose different options based on how they feel about side effects or recovery periods versus patient engagement and disease management for things like medication adherence or lifestyle changes, where it's very hard to argue that you're rationally not controlling your blood sugar levels, or rationally not taking a medication with very limited side effects and big well-known effects on mortality risk.

And there, I think there are different implications for the Medicare system and for the doctor-patient relationship. I would think about distinguishing between those, where, one, it's clear there's a directionality that everyone should be trying to achieve, whereas in the other, it's more about ensuring that the incentives are such that -- and the system in place is such
that patient preferences are what drive the decision between tough choices.

MR. ARMSTRONG: Yeah. I would just add, I really appreciate the comments that fellow Commissioners have made already.

To answer your question, Glenn, yes, I think this is a good thing. How we apply it to our payment policy deliberations, it's kind of difficult to know.

In a way, shared decision-making just offers one window through which we can see all the problems of the current fee-for-service payment structure that we talk about in just about every topic that comes to our table.

I would just add that even in a system that has all the advantages like the capitation and salaried physicians in group health, there are even additional impediments to actually applying this consistently: The system issues alone, for example, that allow us to keep track of the tools themselves and to know which patients should be offered which tool, or a leadership system that says, we have standards here and we are not going to tolerate variation among our cardiologists and we're going to exercise authority to get people in line, or just other
features of a system like ours that simply do not exist in the real world. A reference we haven't heard in a while, isn't that right.

[Laughter.]

MR. ARMSTRONG: I think another point I would want to make is that shared decision-making is also just kind of one vehicle -- I think Kate was getting at this -- but there's so many other ways of getting through, in which you get to a conversation about patient engagement. Whether it's a moral issue or it's an issue about how you actually have a real impact on overall expense trends or improved quality, the truth is that our health care system and the Medicare program will not make it if we don't find ways of engaging patients more actively as owners and participants in improving their health.

This is a topic we get into when we talk about benefit design and when we talk about so many other issues. This, I would just say, is just one more way of kind of contributing to that goal.

I think a final point I would make, which comes back to, well, so what can MedPAC do with this, I do think that it may be that shared decision-making only really comes
to life through ACOs and MA plans and as a product of bigger
restructuring of payment policy. It's just so hard to
imagine making this an add-on payment in our fee-for-service
structure.

But the prospect of applying shared decision-making to end-of-life decisions, I think may be worth
looking at and not waiting for big structural changes to
fee-for-service. The opportunity to have a big impact on
what we know is an extraordinary set of costs and the kind
of enlightened way in which you get into very difficult
conversations that everyone needs to be a participant in
that I think could avoid the political drama that end-of-
life topics tend to have. Shared decision-making just may
be a path for us to get into that, and that, I think, would
be a worthwhile consideration around payment policy.

DR. CHERNEW: So let me start by saying that I
agree completely with Glenn's opening comment about the
moral imperative behind this that I think Bill echoed in
many ways.

That said, I want to focus a little time on the
question about what we should do and say that I'm pretty
much where Scott was, at least in the portion of thinking
about how the broad system changes might encourage this, and
I would be reasonably skeptical of things like adding an
add-on payment or other various things. I worry a lot about
picking particular things. Then you have to define exactly
what is shared decision-making and when certain forms of
engagement are shared decision-making, when are they not
shared decision-making.

The one thing I took from the materials is that
the programs vary in a lot of different places, so then
you're going to be forced to decide which ones have to go in
which places. And I think it just highlights the general
point, which is we can understand from where we sit things
that we think are very good, but it's very hard in broad
Medicare policy to tailor that policy to how things should
work in a whole bunch of places. And when we start to try,
I think we go down a path that often creates more problems
than it solves.

So I would put this generally in the category of
hopefully the types of incentive changes and payment reforms
will push us in this direction. Hopefully, our ways of
measuring quality will include measures that would capture
the extent to which patients were informed and made
decisions that were consistent with their preferences or things of that nature. But I wouldn't try to think of our historical paradigms for encouraging things, shared decision-making or any of the other things that we think are good, and say, oh, we think this is good based on a body of research. Therefore, we need to add a code and start paying for it. I just find that general paradigm a particularly frustrating way to go.

DR. SAMITT: So, I mean, I strongly echo what everyone else has said. You know, Scott used the term that this is a window into the flawed nature of our fee-for-service compensation model, and I would say it's more than that. I think this problem is a poster child of what ails us here.

And I go back to Bill's comment. It just resonates for me when there's an article that says I, as a physician, don't spend the time to explain options to our patients because I'm too busy. So I don't have time for the patient to understand what I'm just about to recommend, not to mention that I'm now going to incur perhaps unnecessary costs because I don't have the time to explain the options to the patients. So that -- it really underscores what is
so broken about a fee-for-service compensation methodology. And so we obviously need to move forward with that as quickly as we can.

I'm optimistic that in the world of ACOs and bundled payments, I think it's too soon to really say that there's low adoption for the reasons that we've described that there are system issues, you know. It takes a while to choose the right tools and implement the right tools and I just think it's too soon. But I'm optimistic that the incentives are aligned with ACOs, that we will see methodologies for greater adoption.

And then, finally, I don't quite know what to suggest to the Commission as a policy recommendation in the intermediate term. There are others who know better, based on prior experiences. Is this a really good pilot for a fee-for-service modification, you know, that we don't specify what shared decision-making is or what tool to use, but we very simply say, we want to apply an incentive for you to do shared decision-making. And I'd actually even apply the incentive to primary care or the people who are referring to specialists that do these procedures because the specialists themselves are conflicted. They're
obviously conflicted because it reduces revenues. But do we incent primary care to significantly utilize shared decision-making if they're going to be referring a patient to an orthopedist or a cardiologist or what have you, and maybe that's what we should consider.

And then, finally, you know, Medicare has very aggressive requirements regarding marketing. You know, before physicians can market to their patients, there are review processes. Well, I see this, is there a requirement the other way, which is there's a requirement that you market to your patients important things like this, shared decision-making, and that it is essentially a necessary stipulation to participate in the Medicare program that you share information with your patients. And I don't know how you would monitor that, and maybe that's a whole other problem, but something else to consider.

MR. HACKBARTH: Let me pick up on Craig's comment about pilots. My recollection is that the CMMI was, I think, directed under PPACA to do pilots of shared decision-making. Could you just tell us a little bit more about what's happening there and exactly what they are testing?

DR. SOKOLOVSKY: They are testing being able to
incorporate shared decision-making in clinical practice. One of them is quite large. It's run out of Dartmouth and it connects 15 large health systems. But there's very little I can tell you about them because it's too soon. They're just getting off the ground.

MR. HACKBARTH: Are they looking to test, you know, if we offer a payment –

DR. SOKOLOVSKY: No.

MR. HACKBARTH: And so what is --

DR. SOKOLOVSKY: They're testing it in health systems that are more like ACOs and --

MR. HACKBARTH: Okay. So if it's used, what's the effect, is their focus --

DR. SOKOLOVSKY: Yeah. Right.

MR. HACKBARTH: -- as opposed to what can you do to increase the use.

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: Okay.

DR. SOKOLOVSKY: I mean, they may get best practices that will --

DR. MARK MILLER: And we had one group in that was showing us their tool and how it worked, all of that. I
think Cleveland --

DR. SOKOLOVSKY: That was Welvie, and that was a very different model that's one of the other demonstration projects that doesn't -- I guess would be incorporated in shared decision-making, but not through the physicians. It's more of an insurer-based design where somebody who's considering surgery has access to an online program that looks at pros and cons. And if you choose surgery, then it talks to you about different places where you could get the surgery and provides information about quality in those different options.

But, again, they're testing it now in Ohio, and again, it's just too soon to say, you know, whether it works or not and to what extent patients adopt it and what are their physicians' response to somebody who is using this.

DR. MARK MILLER: [Off microphone.] Yeah, and the reason I brought it up is I know all of this is way too early to comment on, but that one was not in the context of a system, right? That was more looking across, and that's why I wanted to draw that one.

DR. SOKOLOVSKY: There are a number of other insurer-based programs that we're not looking at this time,
but know that's on our radar to follow up.

DR. HOADLEY: Yeah, this has obviously been a very good presentation and good discussion. The dilemma seems to be the question of how to do this, and particularly how to do it or whether to do it in the fee-for-service Medicare context, although I would add, from discussions not specifically on shared decisionmaking but on some similar things that I've been looking at in the Medicaid context, some of the managed care plans who could do things like this aren't necessarily doing it. So sometimes even once you're in a capitated system from the point of view of the program, like being in a Medicare Advantage plan that's essentially a fee-for-service sort of model in terms of how it interacts with the providers, you know, you're still not getting that. So it really does seem to require either a more integrated system like a Group Health or the ACOs or some of the other things going on.

It strikes me there's two things that have come up that, you know, could be thought about in terms of a fee-for-service and don't have to be shared decisionmaking specifically. I think some of Mike's concerns were, okay, you know, you want to provide a payment for shared
decisionmaking, what does that do and what are the nasty
places you could end up by doing something like that that
wouldn't necessarily work well? But you talked about the
CPT for counseling and people's reluctance to use it, but
other examples of maybe where it can be used. So I don't
know if that's -- and that could be used for shared
decisionmaking, for care coordination, or other kinds of
broader kinds of things.

So if there are some things we could think about,
about how to demystify that code or create clearer
guidelines so that physicians aren't unnecessarily
discouraged from using it, although obviously you have to
worry about all the usual concerns about abuse of it.

And then I think the other thing is, you know, you
talk about the really important role of the coaches, and
I've heard the same thing in terms of care coordination
programs in these Medicaid interviews I've done, you know,
coaches or things that a clinic may be doing at the clinic
level that aren't part of a specific encounter, and it seems
like those mostly end up getting funded by grants, at least
when they start, and they're not easily paid for in the
traditional Medicare kind of world -- or traditional
Medicaid kind of world, for that matter. And are there ways to support that kind of notion better? Is that just a matter of continuing to think about how grant programs can help at least get them established? But then you've still got the issue of sustaining it.

So, you know, are there things we could do within fee-for-service Medicare to make those kinds of activities possible and to be paid for?

DR. COOMBS: So, Glenn, I agree. I think you're spot on. It is a moral imperative that we address shared decisionmaking. And as I think here, I was thinking about what Bill said, and as an ICU doctor, I know that the whole notion of shared decisionmaking is not always the patient. And for me, most of the time it's actually talking to the families, because at that point the patient's unresponsive, on a ventilator. And I can tell you that extra time that's spent, 30 minutes and 45 minutes or whatever it takes, to get the family on board with coming to grips with what the patient would have wanted is so much more important in the whole process of how you take the whole patient's total sum being as a person on a ventilator with multiple support, what do you do with that patient when the family says, okay,
this is what he would have or she would have wanted? That
dictates everything. And to be honest with you, many times
when the patient's in the emergency room or comes in from
home and has aggressive therapy, the family feels much more
comfortable being in the ICU setting talking about it
because they feel like the questions are answered, and they
will withdraw support at that point.

It's that you're giving good quality, you're
really making the family feel that it's okay to really honor
the wishes, and the shared decisionmaking in the ICU is
really huge. I think the chapter was wonderful, and it's a
direction to go for quality, for cost, and especially at the
end of life.

MR. KUHN: I would just join the chorus as well.

I've been a big fan of shared decisionmaking since my time
at CMS, and I think it's a good thing, and I agree with
Glenn it's the ethical imperative.

When you look at kind of where it is now, whether
it's ACOs, MA plans, others, it's obviously in their own
interest to have that part of their tool kit to engage the
patients and part of the good care pattern. But we still
have 75 percent of Medicare beneficiaries in fee-for-
service, and if you look at the work of the CMS Actuary, that is probably going to continue to be the case, at least for the next decade.

So then how do you begin to deploy this tool to help that population? Because it is what it is. They're going to continue to be in fee-for-service.

So, you know, there's a lot of ways you could construct a fee-for-service, but, boy, I tell you, it creates a lot of decision points along the way. So, for example, you could say these are preference-sensitive conditions that you would want to limit it to, and say you take the top 10 or 20 that have the most volume and say, okay, these are the ones we're going to target where we think there's a real opportunity here.

And then you go about the process of how do you create an incentive program to do this. Do you do something like we have with the hospital-acquired conditions or the readmissions policies where there's a penalty if this activity isn't engaged? Or do you go on the incentive side where you try to induce the behavior through additional payment, whether it's through a refinement of the CPT code with the physician or something else as part of the process
to make it happen? Or do you even have CMS create some NOC codes, some not-otherwise-classified codes, and kind of create some things in order to kind of drive this behavior where they could track it very closely in the future?

Then, of course, I think it sets up the whole process of what is the engagement with the patients, and would CMS need to certify the set of tools that are out there? Because you wouldn't want someone just to have something that they got off the Web that they xeroxed and said, here, give is to the patient, and then they check the box and say, okay, give me my extra payment or I've avoided the penalty. You have to get CMS in the business of certifying the tools, and they have to go through a process to have all these vendors come in and say, okay, here's the ones that are certified that we know are most effective.

So it is a lot of work to do this, but, again, I come back to what I said earlier, that with 75 percent of the folks in fee-for-service and for the foreseeable future, I don't want us to give up on this. I want us to think it through a little bit more. But if you go through a fee-for-service design, there are a lot of decision points, and it's very difficult, it's a very clunky system, as we all know.
MR. GRADISON: This is obviously a good thing, and I'm supportive of it. I'm far from clear about what our role might be. I think our main activity ought to be monitoring the efforts of others to implement different approaches.

I started to jot down just quickly a moment ago some of the different things that might be considered tools that could be used in enhancing patient and family participation. And then the question crossed my mind, which Herb mentioned. Can we write regulations around these things? I mean, I wrote down, "Give the family a video."

That was really what Wennberg had for prostate cancer, and it was a video which, as I recall it, had several physicians who had made different decisions about the same procedure for themselves explaining. That's pretty good stuff.

Is that adequate? I don't know. You might give people a series of links if they have a computer and let them go home and do the work themselves, and then come back if they have a few questions. A printout, that was mentioned. Print out some of the stuff.

Maybe what we ought to do is require that every new Medicare patient receive a copy of the updated version
of the Mayo Family Health Book and the revisions -- I think
they're up to the fourth or fifth revision now -- from time
to time, because those are pretty good, actually, in terms
of professionally indicating some of the choices and side
effects. It doesn't cover everything, but it is three or
four inches thick, so it's impressive.

I'm not trying to kid about this. I think that
it's so early in terms of dealing with this that I think it
sort of has to bubble up from actual practice and experience
rather than something that might be a bit top-down.

DR. NAYLOR: So I'm not sure what I'll add, but
let me just highlight that I think about shared
decisionmaking the way that Kate does, which is it's broader
than tests and procedures. It's about whatever treatment
options are available.

So in that context, I really thought the chapter
was fantastic, highlights the complexity of it. I mean,
starting with the very basics of health literacy, which, I
mean, you don't get to shared decisionmaking unless we
measure who is health literate or not, and then how it is
that we get them to informed let alone to then participate
in the decisionmaking.
I think the focus on patients and families, family caregivers, the Home Alone report that shows how critically important, especially for some older adults, engagement of families is.

So in terms of Medicare's role, I think promoting the measurement of health literacy, promoting the measurement of the extent to which practices are eliciting what people want, what they consider most relevant, and their capacity to participate in informed decisionmaking.

In terms of workforce, we're talking about people doing things dramatically differently than before. This is not teaching. This is coaching. And so we need to think about how you prepare the workforce. But I think the Cochrane Review told us a great deal about this will never work just by giving people aids, the counseling that is critical for the outcomes that they have been able to demonstrate so far.

I think we should be pushing PPACA to fund the things that they said they were going to do in the act, which includes building that repository of shared decision tools, that are evidence based, that meet the standards, and creating that entity to do that.
I do think as we think about payment value-based purchasing should have a criteria that we do these things, that practices really do inform patients, and that they are given the opportunity.

Finally, I think some of this is going to come back, and I really do agree that we should be thinking about that last few years of life, and what it is that we can do as a program to promote policies that provide access to what people want that they currently don't have, palliative care, focus more on quality of life. So it's not as simple. At the end of the day, this is going to be about cultural change. It's not easy, but I think it is, as has been described, a moral and ethical imperative. And it's not just about being patient centered. Someone used the word yesterday in another meeting "patient embeddedness." This is where patients are partners, and that's a real big change for us.

DR. NERENZ: I think at the moment I'm much more favorably inclined than Mike is to working out some sort of way of having a payment model for shared decisionmaking in a fee-for-service system. And on that basis, I would encourage staff to perhaps work up two, three examples for
our consideration of tangible ways how that might be done.

Now, I would acknowledge that maybe the reason I'm more favorable is I just haven't given it enough thought, and if in a few more minutes I would come around to appreciating the difficulties. And I will grant there clearly are difficulties and challenges. How do you do it? Who receives it? For what exact body of activity? Clearly concerns.

The reason I think I favor it is that we struggle a great deal to find examples in the fee-for-service environment of where a payment of a certain smallish amount now can be linked to some downstream net savings. We talk about that with care coordination, and it's a struggle. It's very hard. And coming into this discussion, it has struck me that this particular topic may be one of the most promising examples of that happening. The case has not yet formally been made. I appreciate Scott's comments about, in spite of the positive reductions in some of the procedures, that's not quite the same as showing total net savings. But I still consider to think that this is a very promising area for that kind of net offset; therefore, I would like us to keep pushing to see if there's a way to do it.
Okay. Then why fee-for-service? Well, part of it is, as I think either Herb or Bill said, we're going to be in that environment for most beneficiaries for quite a while. So I think we have to look there.

If I understand the ACO payment dynamics correctly, I don't think as currently configured either the CMS shared savings or the CMMI ACO structures are going to support this activity or encourage it very much. The key reason is that although there's a shared savings component, the fundamental payment unit in those is still fee-for-service to all the providers up and down throughout the system.

So an entity that's going to invest in shared savings is, first of all, going to incur the cost just to program development, then will incur the cost of doing it, without any direct reimbursement for either of those things. We'll then see income or revenue reduction if it successful, and only part of that will come back in terms of a shared savings payment. So I just don't see the incentives for this in the current structures.

Now, in different ACO structures, future, maybe so, but I don't see it now.
Finally, I think, you know, Medicare Advantage presumably is a situation where this could be more aggressively pursued, but in that case as well, I think you have to either -- you have to have one of two things. Either the MA plan has to pay providers to do this in the same way we think about Medicare in general fee-for-service, if the providers are the locus at which this activity will occur. So there has to be acceptable mechanisms through which the MA plans pay the providers.

Or there was your comment made about some insurer-based models where maybe that would be a place where MA plans themselves would actually take up the cost of creating and offering the decision aids. So perhaps we should explore that in a little more detail, but I'd basically like, in every respect that we can try, to look for ways to pay for this and make it happen.

MR. HACKBARTH: Let me just ask a question about Dave's last point. There are a number of companies that have been out there using the insurer-based approach where they sell a product to an insurer, usually involves a nurse advice line coupled with distribution of some materials. Is there any empirical data on how well those programs work as
opposed to programs that are embedded in the care delivery system?

DR. SOKOLOVSKY: There is some data for some of the older programs, but I think it's controversial in terms of how to understand that data and the extent to which it's working.

I think we're going to look further at that and how it's going over time, but I don't think we can say too much about it yet.

I guess there's one thing in terms of when Jack brought up Medicaid, there's one interesting new take that some insurers who are wanting to get into Medicaid managed care are talking about having the same people who sign up people for plans being trained to do some coaching, not necessarily on specific decisions but in kind of activating patients to be able to ask questions, what is a decision, and I think that's a very interesting approach as well.

But, again, the data is just not clear yet.

MR. HACKBARTH: Okay. Well, I'm sitting here making notes, trying to sort out what we have said. I think there's agreement on a few broad points, but then it sort of dissolves as we go deeper. We agree it's good. We agree
that probably the most important thing that could happen would be a change in the incentives. At least several people have indicated agreement with, well, it really seems odd -- you know, take this issue of the code for counseling. To say that shared decisionmaking doesn't qualify as counseling, that seems pretty odd to me. So long as we have the construct of fee-for-service, which we're going to have for a fair amount of time -- this does involve time, and we've got 7,000 codes specifying other uses of physician time. Why we would say that this is not a use of physician time that's worth paying for is -- well, it seems odd to me. Personally, I wouldn't expect that even if we clarified that shared decisionmaking was a payable form of counseling, that that would mean it would skyrocket because of all of the other incentive issues that exist. But it does seem anomalous.

Several Commissioners have said, you know, this is something that we ought to be looking at from the patient perspective, we ought to be surveying patients. I'm not sure exactly how to structure the questions, but monitoring how well patients feel like they're engaging with their physicians and other clinicians.
You know, there are questions about communication, broadly defined, as I recall, in the CAHPS surveys and the like, and certainly that's a very important component of the CAHPS surveys. But I don't think there's much that really goes into shared decisionmaking.

So, you know, we could say there should be more monitoring, but that whole area of how you structure surveys and how you really effectively elicit information from surveys is a really technical area that I think is way beyond our expertise and time.

Now, as I dig deeper, I sense less and less agreement. Several people said, you know, we ought to just require it, this is something that should be required. But the problem is what is the "it" that you're requiring? To have a regulatory approach, you need really precise definitions, and even at that, we'll end up with 34 pages in the Code of Federal Regulations that, frankly, will be unenforceable. Nobody will be out there able to monitor adherence to it.

So, you know, I guess my summary of all that is that beyond it's good and the most important thing is to change the overall incentive environment, you know, I think
our agreement sort of breaks down pretty quickly after that.

That's how I heard the conversation, and I welcome other people who heard it differently.

DR. REDBERG: I didn't hear it differently. I just wanted to first say we use a patient counseling code, and I've never heard any discussion of any problems with auditing on it.

But then, more generally, you know, I think we had talked about a few different kinds of shared decisionmaking, because, quite frankly, some of what -- which is still good, but it's not always about a decision, you know, the typical surgery or not, stent or not, because like the PHMC -- there's more patient education, it seemed like, that they were getting than actually shared decisionmaking, which was still good. I mean, maybe they were discussing lifestyle choices, but it seemed a lot more in the patient education realm.

In terms of the code, I think it is tricky because it's not easy to pin down, and just adding on a code saying you talked to your patient is not going to -- there might be a lot of takeup, but I don't think it's going to change the quality of what we're really trying to get at.
What came through in the mailing materials is that physicians right now tend to, when we do discuss procedures, emphasize the positive and don't talk about the negative or, you know, the adverse events. And perhaps in a survey mode, you know, asking patients did your doctor -- or did you understand the risks and the benefits before you had this procedure, it might be one way to try to get at it. You know, we could talk offline because there are a lot of very more detailed -- I mean, that's a general way you could -- and this is certainly a good thing. I mean, patients should understand the risks and the benefits, and there's certainly a lot of data that patients have major procedures without understanding risks and benefits of those procedures or that there were choices.

So that kind of -- oh, and the last thing I was going to say, in terms of physician time -- and I we're all very sensitive to physician time, although this is clearly, I think, a high priority, I would think in the big context of performance measures, perhaps we could relook, because I think right now we're cluttered with performance measures that are not adding to patient -- improving patient experience or outcomes. Maybe get rid of some of those
because this one clearly I think has been shown to improve patient experience and patient outcomes. So I think of it kind of in the quality measures, this is a high-priority one, and I think we have some much lower-priority ones that are taking a lot of physician time. And there's a lot of concern that there are a lot more measures coming down the pike without improving, so there will really be a concern for physicians, and I think we do have to be sensitive to that.

DR. MARK MILLER: I just want to ask this while we're talking about physician time, and I don't know the answer to this question. Particularly with the two of you, I'm always a little worried about asking.

On the physician code and the use of the code, my understanding in a lot of these models is it isn't -- the actual shared decisionmaking process is not the physician being present for it. It happens outside of the physician's office, either through video or some discussion with a nurse or groups of patients. Then they come back into the physician's office and ask a more clear set of questions.

So I think there's -- first of all, right or not? And then that kind of goes back to, well, am I using this
1 code correctly? It may involve the physician spending more
2 time with the patient as a result of going through those
3 questions, but I'm not under the impression that the
4 physician is actually spending the time going through the --
5 MR. HACKBARTH: I think you're right, there is
6 activity that happens outside of the physician's office
7 without any health professional. And then in some settings
8 it may be a nurse or other professional, at least as the
9 initial contact ultimately there needs to probably be in
10 many cases some physician interaction.
11 I just wanted to be clear and beg Mary's
12 forgiveness. When I used the term the "physician fee
13 schedule" here, you know, technically we're talking about
14 the fee schedule for physicians and other health
15 professionals, and having a code for non-physician health
16 professionals who engage in this activity, and not just MDs.
17 DR. NAYLOR: I do want to stress, though, that the
18 data are very compelling that aids alone are not achieving
19 anything. You know, they are -- so it is the addition of
20 the counseling, the interaction, often not necessarily with
21 a nurse practitioner. I mean, most of the data are with
22 nurses. But that being said, I think -- I don't want us to
walk away thinking make more access -- at least is that your
assessment?

DR. SOKOLOVSKY: Absolutely.

DR. NAYLOR: You know, that it's the combination
of the personal interaction with evidence-based tools that
are achieving the outcomes we're seeing.

DR. SOKOLOVSKY: Could I just interrupt for one
second? Because it keeps coming up about survey questions,
and I don't want to leave you with the sense that there
aren't survey questions. In fact, CAHPS has now -- we don't
have any results yet. They're just beginning to roll these
out. But they're very much specifically the kinds of things
you're talking about. For example, just to read three
questions:

When talking about surgery or procedure, provider
asked you what was best for you?

Provider talked about the reasons you might want
to have surgery or procedure.

Provider talked to you about the reasons you might
not want to have surgery or procedure.

And the same set of questions on prescription
drugs, for example, so they have developed these questions
in CAHPS.

MR. KUHN: Glenn, I think you captured it very well, and I think Rita's point was well taken. If you kind of put the check the box things, will you really accomplish what you want? And I know CMS did a demonstration seven or eight years ago that looked at symptom management for cancer patients and looked at fatigue, nausea, and pain management. And there were a lot of reasons that demo was put together, but in terms of kind of accomplishing that kind -- those results, it just wasn't there.

So a couple thoughts as we continue to look at this. One is it may be a distinction without a difference, but is going through the door the conditions of participation? Would that be a better route to go where then you would have the interpretive guidelines that would help manage that for the facilities as they go forward rather than a larger regulatory process, but do it through that stage? Would you accomplish the same thing and would it be less regulatory? And would it be as effective or not? I don't know. That's something that we might want to look at.

And then if now this is part of the CAHPS survey
and since CAHPS are part of value-based purchasing, are we starting to capture that as part of this process? And could the VBP program be enhanced in order to capture this as we go forward? So another possibility.

MR. HACKBARTH: So let me ask the clinicians in the group a question, and I think this would be a question that could arise, Herb, under the conditions of participation approach.

As you said in your first set of comments, you know, you could have CMS or somebody at HHS certifying decision aids. Now, what's not clear to me as a layperson is how much is involved in that certification process. The evidence isn't always, you know, all real clear on exactly what the probabilities are of this outcome versus that outcome, and so the development of aids, it's not like, oh, anybody can do this, or anybody can certify this is a good one, that's a bad one.

I think a big part of the challenge here is there is a lot of disagreement among clinicians about how this information -- what the data show and how it should be characterized. And I suspect, Scott, that was one of the issues that you ran into with your clinician group, even in
a rather ideal environment.

And so the idea that some federal bureaucrat is certifying aids, that this is the right characterization of the evidence, I worry about that. Am I off base, clinicians, on this?

DR. SAMITT: I mean, I'd be worried about it as well, but I want to go back to a comment that you actually made yesterday, which is putting some of the responsibility in the hands of the specialty societies. You know, while you don't do that a lot and there are problem and maybe you do it very little, but I guess my experience with this is that unless some of these are derived by the physicians, then you will get disagreement.

So the question is: Can we require that for a joint replacement, you know, shared decisionmaking tool, that we seek to try to get specialty society endorsement for the optimal tool that does get approved and utilized? And I don't know whether that's just a completely unrealistic option, but who better to be asked to develop that than the specialty societies themselves?

DR. REDBERG: Earlier you said you thought primary care doctors should be the ones doing the decision aids,
and, you know, the specialty society, that's a little
different.

DR. SAMITT: To assure that they're actually
distributed, but not necessarily the design. So the
question is: Do we not feel we'll get an accurate or
unbiased decisionmaking tool if put in the hands of the
specialty?

DR. REDBERG: You don't ask the barber if you need
a haircut.

[Laughter.]

DR. REDBERG: I think to address your question,
Glenn, there are groups -- and you're right, that is a big
issue because clearly, particularly in areas where there
isn't evidence, but even when there is evidence, there's a
lot of disagreement and discussion among clinicians, and I'm
sure that is one of the things that Scott observed.

As you know, there are groups -- I think FIMDM --
the Foundation for Informed Medical Decision Making -- and
Health Dialogues do a lot of the decision aids. I was
involved in the development of a decision aid, and I can
tell you there was a lot of back and forth because we all
saw the evidence differently to come up with that decision
aid. So that is definitely an issue.

You know, I always think more information is still always better, but you're right, a lot has to do with the quality of the information, and that is certainly not something I don't think CMS would want to get in the business of certifying.

DR. SAMITT: Can I ask, are there any other third parties that are viewed as unbiased, Quality Forum or some other committee that is charged with sort of taking a very unbiased view, you know, reviews the potential options for a shared decisionmaking tool, and blesses the one -- whoever creates them, you know, if we believe that specialty societies can't do it, well, let's have someone else do it. But it still needs to be blessed and approved by an unbiased third party who would endorse it and say this is the one we would suggest you use.

DR. NAYLOR: So this is where my thoughts about suggesting that PPACA fund what they've already recommended, which is an independent entity that would rely on -- and they established a set of standards that would be used, what conditions or decisions should be targeted in the initial rollout, et cetera, and recommend that the Secretary convene
I think it's really important that we just don't think about decisions in the way we think about them as tests or procedures. There are decisions around medications and all of those areas. So I don't necessarily -- I think that we don't want to rely on the traditional medical model in decisionmaking, and these provisions I think are quite specific about how this could unfold.

MR. HACKBARTH: So I remember reading the text box that was in the chapter about the PPACA provisions and the fact that they have not been funded. Has there been any discussion within the Department about, you know, if money is made available, you know, what sort of entity, would it be creating a new one, would it be using an existing body like NQF? Can you provide any additional color on that, Joan?

DR. SOKOLOVSKY: There is nothing that has been made public, but, remember, this amends the Public Health Act. It was never considered something that CMS would do.

MR. HACKBARTH: Right. Right, yeah. Okay. Now that we've sorted all that out, Mark?

[Laughter.]
MR. HACKBARTH: You have a plan here, right? I've seen you writing.

DR. MARK MILLER: Yes, I feel we have sorted this out, and I'll get back to you.

I don't have a plan. If the Commission were to say -- one of the things that I heard, but as I was thinking through it, I was already immediately running into problems in my own thinking. But a few ways you could align the comments could work like this.

If there was this sensation on the Commission that there was a place to go, understanding all of the pitfalls, but where do you start? There's obviously piloting. But just to be a little bit more focused, many of you spoke to end of life, and that made me wonder about, you know, the hospice decision as a place to think about is there a tool and use of it there in a payment structure which we've already laid out its problems, but it's not unit payment, you know, service by service. You pay on more of a block payment.

So I started to think if somebody were to force me to think about this and think about it in a fee-for-service context as opposed to the ACO/MA comments, which I took
fairly strongly, I would probably at least sit down and 
think first there whether there was some opportunity because 
of the concerns about end of life.

Now, one of the things that is immediately wrong 
with that thought is it's not after the person gets into 
hospice.

MR. HACKBARTH: That's what I was thinking.

DR. MARK MILLER: It's before they get into it, 
and so this thinking, you know, begins to fall apart pretty 
quickly. But, again, if I were forced to think about it in 
fee-for-service, I would probably at least spend a little 
time circling that problem or that area.

DR. HOADLEY: I don't know, I mean, this wouldn't 
help for some of the kinds of decisions, but the Wellness 
Visit that was created, which has a lot of flaws in other 
ways, but maybe this is something for at least chronic 
conditions decisions aids could be an opportunity. I don't 
know if that has been thought about at all.

DR. CHERNEW: The only thing I was going to say -- 
and I'm sympathetic to a lot of the efforts, and I think 
it's worth thinking about how to go further, but, remember, 
it's not just what you're going to do at one point in time.
Then you get into figuring out, well, how are you going to update it? So now you've decided that this was the right tool for a given procedure for whatever it is. Now a new study comes out. Now someone -- or, you know, a new physician says, "Well, I know you haven't got the official evidence yet, but what we've been seeing in our clinic is that we're bale to get the complication rates down, and the decisionmaking tool we're now supposed to use is a little bit outdated." Then you have a process you have to -- so there's a lot of complexities that arise between the words of "we like shared decisionmaking" to "we like this tool in this context for these people to meet these criteria." And that's why I think for me in the end, the more we can do make sure people get access to the best information or the best care is important, but the more we create structures around how to do that, the more careful we have to be; that it's hard to start with, and even once you start with it, it's hard to update it, and then you get distracted with updating all these particular things, and lose track of the bigger picture. That's my basic concern.

But I am supportive of doing this, and I'm really supportive of the CMI demos and stuff like that.
MR. HACKBARTH: Rita, go ahead and then --

DR. REDBERG: I just wanted to address Jack's point because I found -- it was page 19 in the mailing materials. But Mercy evidently is doing just what you had said. In the Welcome to Medicare physical, they receive a decision aid on advance directives. So it might be helpful to see if they're tracking that and how it's going and what their uptake is on it.

DR. HOADLEY: That's the one-time Welcome to Medicare. The Wellness would at least be an annual opportunity as well. Again, it's a concept that's not as broad as some [off microphone].

MR. HACKBARTH: Sometimes MedPAC's role is to say, you know, here's a problem and here's a fix. But sometimes our role is to say here's a problem and, you know, it's just not a problem that is amenable to being fixed by Medicare payment policy in a targeted way, you know, as we've said over and over again. In a broad way, changing the Medicare payment incentives could make a huge difference. But, you know, targeted, specific solutions sometimes just are not within our reach, and that's one of the things that the Congress looks to us for as well as advice on do this, do
that, and don't do something may be right.

It could well be that activities outside of Medicare, you know, in the Public Health Service, of the sort that Mary was describing would be, you know, good things to at least test, develop. But as far as Medicare is concerned, it may be that what we can do is pretty limited.

So let us think some more about this. This is obviously a very important subject, but not an easy one to get a grip on, and we'll come back with some ideas about how to proceed. So thank you, Joan and Katelyn. We appreciate your work on this.

We'll now have our public comment period, and please begin by introducing yourself and your organization. And when the red light here, when this red light comes back on, that is the end of your two-minute period.

MS. CARLSON: Hi. I'm Eileen Carlson from the American Nurses Association.

I think it's wonderful that you all are looking at shared decision-making, and I'd like to suggest that the staff especially look to some of the models and resources that the nursing profession has created. This has been an enormous priority for us for decades.
And just to give you some examples, the Magnet Program and Pathways to Excellence that the American Nurses Credentialing Center certify hospital nursing programs for. Every nurse in those hospitals has to check off that they've done patient education for that patient during their shift, realizing, of course, that physicians don't use the same charting standard documents, but it's -- there are ways to implement this in the current health care system.

I see the difficulties, because this is a -- this issue raises issues of health care finance and efficiency, ethics, coding and reimbursement, and quality, and you're usually -- there aren't many issues where you really have to look at each aspect of those.

There are payment disincentives for requiring counseling. For example, the Evaluation and Management codes, when you increase the level of your counseling, that changes how you calculate the level of your visit. And I've been working -- ANA has been working with RUC and CPT on several new codes that involved care coordination, immunization counseling, et cetera, et cetera. And, basically, if nobody's going to pay for it, nobody's going to come up with a code.
But I also want to let you know that there is a CPT work group that is looking at doing some tweaking of the Evaluation and Management codes, and I think you all could provide guidance on -- and probably some suggestions that some changes could be made in those codes. Also, I'm glad you talked about performance measures and quality reporting. The Physician Quality Reporting System, you know, I honestly don't know if it has aspects of patient engagement, but that's one area where changes could happen very quickly.

Thank you.

MR. HACKBARTH: Okay. Thank you.

Oh, are you coming?

MS. BOWEN: Hi. Thanks. I'm watching the red light. Good morning. I'm Meg Bowen. I'm the Implementation Management for the Foundation for Informed Medical Decision Making in Boston. Thank you very much for allowing me to be here today, and hi, Joan.

So I worked very closely with the sites that were mentioned today in the report and I wanted to add so many things that there's just not enough time.

One thing I do want to address, though, is the
end-of-life issue and starting that conversation, especially at Mercy Clinics. They have a transition coaching model through their ACO and those nurses actually go into the unit, to the ICU. And when patients have an algorithm of different comorbidities and multiple hospitalizations, they start the conversation about the end of life. And they introduce a decision-making tool to them at that time and then they pass off the care to the local health coach in their primary care clinic.

And another thing that they also do, when the patients are discharged -- this may all be in your materials, I'm not sure -- but what they do is they do what's called -- it's very simple. It's called a tuck-in call. So before the weekend, they'll call the patient on a Thursday or a Friday morning to make sure they have their medications, make sure they have everything they need, they have the resources available to keep them from being readmitted over the weekend through the ER.

So these simple little fixes are coming out of these demonstration projects and I really encourage support for funding and additional grants so we can keep learning about these best practices.
Thanks.

MR. HACKBARTH: Okay. Thank you all.

We're adjourned. See you the first week in April.

[Whereupon, at 11:32 a.m., the meeting was adjourned.]