MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 4, 2013
9:51 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
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WILLIS D. GRADISON, MBA
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DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP
AGENDA

Medicare ACO update
- David Glass, Jeff Stensland

Low-income beneficiaries in a system of competitively-determined plan contributions
- Carlos Zarabozo

Public comment

Preparing private plans to better serve dual-eligible beneficiaries
- Christine Aguiar, Lauren Metayer

Medicare hospice policy issues
- Kim Neuman, Sara Sadownik

Bundling post-acute care services
- Carol Carter, Evan Christman

Public Comment
MR. HACKBARTH: Good morning. Thanks for coming.
We have two sessions this morning, the first on ACOs and then one on low-income beneficiaries and competitively determined plan contributions. So on ACOs, David, are you leading the way?

MR. GLASS: I will start out.

Accountable care organizations, or ACOs, have been in the news and are developing rapidly. Today we will give you a brief update on the Medicare ACOs.

I will very briefly review the background how ACOs came about and where they fit in the payment spectrum. We will then look at the two ACO models in Medicare -- the Pioneer ACO model and the Shared Savings Program model.

We will then look at under what circumstances ACOs may have a comparative advantage vis-a-vis the Medicare Advantage plans, and then open it for your discussion and try to answer questions you may have.

Very briefly, policymakers wanted something like ACOs because Medicare volume growth is thought to be unsustainable, quality in Medicare is uneven, and there is a lack of care coordination.
They wanted to create an MA-like incentive to control volume without requiring an entity that could accept full capitated payment and the risk that goes with it, that does not lock the beneficiary into a limited network, and that does not require an entity to create contracts with providers and pay claims.

There are two Medicare ACO models:

The Pioneer ACO model is a demonstration program created by the Center for Medicare and Medicaid innovation.

And the Medicare Shared Savings Program was created in statute in the Patient Protection and Affordable Care Act of 2010.

First, we will look at where ACOs fit in the spectrum between fee-for-service and MA, and then we'll look in detail at how ACOs are defined in the Pioneer ACO model and the Medicare Shared Savings Program.

Conceptually, if pure fee-for-service is at one end of the payment spectrum and MA at the other end, ACOs are somewhere in between.

In pure (or unaccountable) fee-for-service, payment is by service, it's silo-based; there is some quality incentive as in the VBP program, and no provider is
ACOs are a step toward integration. Although ACO members still get fee-for-service payments, they also have a chance to receive some form of shared savings, and there is a quality incentive. They can also be at some risk depending on the model.

At the other end of the spectrum, we have the MA program. Here entities get fully capitated payments, are at full risk, and have to contract with providers and pay claims. In essence, they're insurance companies.

Another way of thinking about it is moving from individual service-based payment to population-based payment. The ACO payment is kind a mix between service-based and population-based, and as we shall see, the Pioneer ACO is designed to move more strongly to the population-based in later years. But before we get into those details, let's look at where the programs stand.

The Pioneer program started over a year ago. There are 32 ACOs in the program, with 860,000 beneficiaries.

ACOs have to have primary care physicians as members because they are the key to beneficiary assignment.
Hospitals or specialists can be members but are not required.

Beneficiaries are assigned to the ACO based on visits with primary care physicians. They are then informed of their assignment to the ACO and given the opportunity to opt out of having their claims data shared with the ACO if they choose. CMS uses the term "alignment" to avoid any hint of compulsion, but we are saying "assigned" because it is just kind of a more straightforward term.

Now, providing timely claims data would be a real achievement for this program. You may remember that a major gripe of the PGP demonstration was that the groups didn't know how they were doing until 18 months had gone by, which made it very difficult to use the CMS data to manage care or know what was working. So it is not yet clear how this monthly update program is working out.

The Shared Savings Program was specified in PPACA. It is a full-fledged program, not a pilot or a demonstration. Each cohort has been bigger than the last, and there are now 220 ACOs in the program.

Primary care physicians are the key to assignment of beneficiaries as they are in the Pioneer program, and
performance data is provided by CMS quarterly.

Thirty-two of the ACOs are in the advanced payment program which provides some upfront payments to small rural and physician-based ACOs.

Medicare ACOs are already fairly widespread across the nation. All but four states have ACOs, and there are quite a few in states such as Florida, California, and Texas. And Jeff is going to get into where they are located in a little more detail later.

To quickly review:

ACOs are health care organizations formed around a core group of primary care providers serving at least 5,000 fee-for-service Medicare beneficiaries. Those providers could be, for example, physicians, nurse practitioners, or physician assistants.

While an ACO must have primary care providers, having a hospital or specialist in the ACO is optional.

An ACO must also show CMS that it has the capabilities listed on the slide.

CMS will have to make a judgment call as to whether the ACO meets these criteria.

And remember, ACOs' patients are still free to use
providers outside of the ACO. And if they choose to go to a
specialist or hospital outside of the ACO, the ACO remains
responsible for this spending.

There are some differences between Pioneer and
Shared Savings ACOs.

Pioneer ACOs are bigger, they are more at risk,
and they had to compete to be in the program. They can also
receive a higher share of savings in part because they are
more at risk.

Pioneer payments are somewhat experimental so
there are five different designs that differ on what share
of savings the ACO receives, what the caps are on the
maximum amount of shared savings or loss, and how much risk
the ACO takes on. Generally these build over time with
higher limits in year two.

If the savings in year one and year two are both
greater than 2 percent of total spending, then the ACO can
transition to what CMS calls a more population-based payment
in year three. In that design the ACO gets a capitated
payment for the share of Part B or Part A&B spending,
depending on the design, that it provides, but it is still
responsible for the total spending, including that provided
Payments in the Medicare Shared Savings Plan ACOs can also vary based on whether the ACO is in a one-sided risk design, or bonus-only, or a two-sided risk design. Note that almost all the ACOs, 212 of them, are in Column 1 -- that is, one-sided risk or bonus-only design. Here if spending is lower than the benchmark, the ACO shares in the savings. If spending is higher than the benchmark, the ACO does not share in the loss.

Once the ACO achieves savings greater than the minimum savings rate -- which is the third line there, and that varies with the number of beneficiaries in the ACO -- it shares up to 50 percent of savings up to 10 percent of the total spend.

Only eight ACOs have chosen to be in the two-sided design where they have the risk of loss. In that design the limits on savings are higher as shown.

The fact that only eight chose two-sided may say something about the confidence ACOs have in their chances of succeeding in a new untested program.

The Commission has been involved in the development of the ACO concept for many years. We wrote two
comment letters to CMS -- one preliminary to and one in response to the proposed rule for the Medicare Shared Savings Program. Although we raised a number of issues, including risk adjustment and quality metrics, I will only discuss the three on this slide.

First, there are several beneficiary-oriented issues we raised. Our principle is that assignment should be prospective so the ACO knows which beneficiaries are in it and that the beneficiary should know that he or she has been assigned to an ACO and what that means; and if they do not like it, they can opt out. Those issues were partially addressed in the final rule. We also pointed out that the beneficiary should share in some way if savings are achieved, perhaps through lower cost sharing in the ACO, and that is not part of the program so far.

We were also concerned that visits to non-physician practitioners be counted in the assignment algorithm, and this was addressed in a somewhat convoluted way in the rule.

And, finally, we proposed assessing benchmark spending and savings with standardized prices to approximate service use. This helps establish congruence between
targets and performance across the country and avoids problems when things like the wage index change or the sequester hits.

Jeff will now discuss the new issue of ACOs vis-a-vis MA plans.

DR. STENSLAND: David mentioned how ACOs are an intermediate step between unaccountable fee-for-service and capitated MA plans. I will compare ACO and MA plans' comparative advantages.

The primary strength of MA plans is that they have more tools to control utilization and coordinate care. The weakness is they have higher overhead than ACOs.

In contrast, lower overhead is the relative strength of ACOs. Some ACOs we have talked to suggest they can run an ACO for 2 percent of annual spending or less. The overhead can be lower than in MA plans due to not having to market to beneficiaries, not having to enroll beneficiaries, not having to negotiate rates and write contracts with providers, and not having to process claims.

But this advantage of not processing claims is also associated with their weakness of having fewer tools to control utilization. First, ACOs cannot limit networks.
This means they cannot restrict access to fraudulent or inefficient providers, although some ACOs are talking to CMS about ways they can help CMS identify fraud and stop it. They also are not able to require prior authorization before certain services are provided. The most important limitation may be that ACOs can not affect beneficiary cost sharing. This is especially problematic because fee-for-service beneficiaries with first dollar coverage under Medigap have little incentive to consider cost when setting their treatment plan. One option to address this would be for Medigap plans to offer lower cost sharing for ACO physicians, just like some Medicare Select Medigap plans offer lower cost sharing for in-network hospitals. To the extent differential cost sharing keeps patients within the ACO and results in lower costs, those savings could be shared as lower premiums for those Medigap plans.

Given these strengths and weaknesses, in what circumstances may we expect ACOs or MA plans to be better at controlling costs?

The purpose of this slide is to show the amount of savings an ACO or MA plan can generate and how that is a function of how much excess service use there is in the
First, let's start with ACOs. The yellow line is an illustrative figure, simplified to make the point of this slide. In our conversations with ACOs, some have said they can operate for 2 percent or less of fee-for-service spending in terms of overhead. So we start with ACO overhead at 2 percent. This means they start out on the left-hand side of this figure at a deficit of 2 percent. As we move to the right, we move to markets where there is more excess service use to cut. The model, for simplistic illustration terms, assumes that the ACOs are limited in their tool kit and can only reduce 20 percent of excess service use. So in a market with 10 percent excess use, under this model the ACO would generate just enough savings to offset their 2 percent overhead. We would expect them to do better financially as they move to right of the graph where there is more inefficiency. The more inefficiency there is in the market, the more room there is for the ACO to cause improvements in efficiency.

Next, let's add a line representing MA plans. This is the pink line. Based on data from MA bids, in this model we assume MA plan's overhead is 10 percent higher than
fee-for-service. So MA plans start with a deficit of 10 percent and must overcome that overhead by reducing inefficient service use. In this graph, the pink line assumes that for every 10 percent increase in identifiable excess service use, the MA plan can eliminate 6 percent of that service use. So at the left-hand side, if the MA plan does nothing, it has 10 percent higher costs than fee-for-service. But on the right-hand side, if it moves to a market with 50 percent inefficiency, they may be able to have 20 percent lower costs than pure fee-for-service due to eliminating some of that inefficiency. The general idea I'm trying to illustrate with this hypothetical is that the more inefficiency there is in a market, the more opportunities there are for both MA plans and ACOs to save money relative to fee-for-service.

An example may help. In Orlando, Florida, MA plans bid on average 15 percent below fee-for-service. This suggests there is significant excess service use that can be eliminated, enough to generate those 15-percent savings and cover their overhead. So we would also expect ACOs to form in Orlando with the expectation that they could use some of those same physician tools and lower service use. The
savings may not be as large as MA plans, but they should be enough to cover the ACO's overhead.

Now let's shift to some actual data.

The message in this table is that ACOs are forming primarily in markets where MA plans have already shown an ability to reduce service use. So the data is following the theory.

Let me take you through these findings. The first column represents -- or each column represents a different kind of market.

The first column is markets where MA plans bid 5 percent or more below fee-for-service Medicare. MA plans are proven cost reducers in these markets.

The second column is markets where MA plans bid close to fee-for-service. In these markets the extra overhead of MA plans is roughly offset by reductions in service use.

The third column is markets where MA bid 5 percent or more above fee-for-service. MA plans can bid above fee-for-service in these markets because the benchmark is often set above fee-for-service costs. As you know, the Commission has recommended against this in the past.
So let's walk down the information in the first column. This first column represents where MA plans have shown they can reduce cost. These markets have 44 percent of all beneficiaries. They have 61 percent of ACO beneficiaries and 54 percent of ACOs. I say here potential ACO beneficiaries, and by that I mean fee-for-service beneficiaries that live in a market with an ACO. So the bottom line is the first column tells us that ACOs are more likely to be in markets where MA plans have shown they can reduce spending.

Now let's look at the last column. These are markets where MA bids are 5 percent or more above fee-for-service on average. These markets have 22 percent of all beneficiaries, but only 10 percent of potential ACO enrollees and only 11 percent of ACOs. So this tells us that ACOs are half as likely to locate in markets where the average MA plan has not shown an ability to beat fee-for-service costs.

So, in summary, we see rapid growth in ACOs. All the ones we've talked to hope they can generate savings by reducing excess service use. However, they're somewhat limited in their ability to do this relative to MA plans.
because they do have all the tools MA plans have to reduce service use, but they do have the advantage of lower overhead. In general, we see the ACOs forming in markets where MA plans have already shown service use can be reduced. And as we illustrated in your mailings, ACOs with 2 percent overhead should be able to be profitable if they can generate at least 4 percent reductions in service use. However, this 4 percent reduction will be much easier in some markets than in others.

Now, this slide lists some potential short-term and long-term issues with respect to ACOs that could be some discussion topics around the table. The first is the beneficiaries' right to opt out of an ACO. As David said, we suggested this in the comment letter. As of now, they cannot fully opt out.

A second issue is addressing how they're assigned to ACOs. Right now they cannot be assigned based on FQHC, RHC, or the use of physician assistants or nurse practitioners. This could be another thing that could be changed.

The third issue we have up there is a way to address the issue of cost sharing. One potential is to have
a new type of Medigap plan, a Medigap Select that could offer lower cost sharing for physicians in the ACO or lower cost sharing simply for using a certain set of physicians. And the other short-term issue we have up there is measuring performance use, and one way to do this is right now we're measuring performance based on costs, and that has some problems because prices can go up and down. An alternative would be to measure performance based on service use as opposed to spending, and that would remove issues such as wage index shifts or distortions due to SGR or sequester and things like that.

Now, there are some longer-term issues also, some bigger-picture issues. One is the issue of setting the benchmarks level across fee-for-service, ACOs, and MA plans, similar to as we have discussed in the past. Now, if this was done, we would expect different types of organizations to be relatively more or less successful in different types of markets.

I'll open it up for discussion.

MR. HACKBARTH: Okay. Thank you, David and Jeff. We'll do two rounds -- a round of clarifying and then a round of more open comments and questions. I propose
that we use the modified version of Round 1, by which I mean I'll just ask people to raise their hands if they have a clarifying question as opposed to going around the table. And in Round 1, please limit it to clarifying questions, you know, "What does Slide 14, Row 2 mean?" That sort of thing. So, with that, Round 1 is open.

DR. NERENZ: Yeah, this is very nice. Thank you.

If we could go to Slide 14, I just want to clarify the interpretation. Where the yellow line crosses the zero line, that's actually where the net savings match the overhead. But it's not the point, if I read this correctly, where the ACO actually breaks even financially.

DR. STENSLAND: That's right.

DR. NERENZ: Because in the shared savings model, they actually have to do double that. As you pointed out in the materials, savings of 2 percent doesn't get them there because they share half of that with CMS, approximately. So I just want to understand. This is an illustration of net savings, but it's not an illustration of ACO break-even, right?

DR. STENSLAND: Right.

DR. NERENZ: Okay. Thanks.
MR. GRADISON: In the paper you distributed earlier, on page 13, it says, "As an example, in the Boston market, under the alternative quality contract with Massachusetts Blue Cross Plan, some ACOs could reduce spend by shifting patients from high-cost facilities to lower-cost facilities." And then it says, "That avenue is not open for Medicare ACOs to the same extent." Could you explain that to me, please?

MR. GLASS: You understand what the Massachusetts market is?

MR. GRADISON: Yes.

MR. GLASS: So your question is, how could they -- to what extent and how can they share that? So I guess the thinking would be, I guess on teaching hospitals --

DR. MARK MILLER: David, this is the point about -- we talked about this specifically.

MR. GLASS: Right.

DR. MARK MILLER: This is the point about in Medicare if you move people from one hospital to another hospital, you don't necessarily get --

MR. GLASS: Yeah, unless they're --

DR. MARK MILLER: Unless you take them from a
hospital to an ACO or -- I mean an ASC or something like that.

MR. GLASS: Yes.

DR. MARK MILLER: So in the private market, Hospital A could be more expensive than Hospital B, and you could create savings by moving to a lower price. In Medicare, the prices are set nationally, so moving from Hospital A to Hospital B won't necessarily save you money.

MR. GLASS: Right, yeah. In Medicare, you can still move from Hospital A to Hospital B, and in some cases, there may be some savings because of, you know, Hospital A has a higher wage index or Hospital A gets some DSH payment or something like that. But that potential is much more limited than in the Massachusetts example.

And then, of course, the bigger savings would be site of care. If you can move patients through a lower-cost site of care, then you can save -- but that's true in either one.

MR. GRADISON: Thank you.

MR. BUTLER: On Slide 11, please. So I want to understand -- you made the point only eight have picked shared risk. Maybe the 60 percent versus 50 was not a
strong enough incentive to get people on the right-hand side. But the bottom right-hand corner, I want to understand that. In year three, so where it says there's 10 percent sharing, does this mean that if they're 10 percent over expected or the target spending, they will have to eat 60 percent of the loss? How does that work?

MR. GLASS: I'm sorry [off microphone].

MR. BUTLER: So let's say-- because it's a two-sided risk, now you're all the way up to year three. And it says the maximum -- limited to 5 percent year one, 7.5 year two, 10 percent year three. Explain what that means if you were to have your spending -- you know, how much risk then is being swallowed? Is it the 60 percent of the 10 percent?

MR. GLASS: The final sharings rate thing is complicated because, as I remember, that had to do with how they did on their quality score. So, in other words, the sharing rate -- say you had a 60 percent maximum sharing rate but you did poorly on your quality scores, so you really only get a 40 percent shared rate --

MR. BUTLER: Okay. So then maybe I'm looking at the wrong line, even performance payment limit. How many
dollars are at risk as a percent if you perform -- you blow
the -- you know, you're way off the mark in your spending in
year three in the double-sided --

MR. GLASS: Well, the most you can lose is 10

percent of the total spend.

MR. BUTLER: Yeah, okay.

MR. GLASS: Yeah.

MR. BUTLER: And some of these groups are really
small, they got 5,000, and they could have one physician
group behind them. I'm trying to get an anticipation of --
what did a lot of managed care in in the early 1990s was
these small groups that were taking on capitation and had no
cash reserves, and one bad year and they're out of business.

MR. GLASS: Right. Well, that --

MR. BUTLER: I'm trying to anticipate whether this
could head that way if you were, in fact, you know, one of
these small groups and in that right-hand column.

MR. GLASS: Right, well, perhaps the small groups
didn't -- aren't among the eight that chose this path.

MR. HACKBARTH: So at this stage --

MR. GLASS: That's why only eight are there, I

think.
MR. HACKBARTH: So at this stage in the evolution of ACOs, sharing -- taking downside risk was an option for people to do, and you did that in exchange for getting more upside potential.

MR. BUTLER: 60 percent versus 50 percent.

MR. HACKBARTH: Right. And so as indicated here, only eight did it. I don't know the size of those, but, you know, they may -- in deciding to go for the two-sided risk, they may have taken into account their size. Nobody is being -- small practices aren't being forced at this juncture to take downside risk.

MR. BUTLER: Not forced, but some of the ones in the 1990s are the ones that shouldn't have and they did. So I'm trying to anticipate also the bonus-only column not lasting forever.

MR. HACKBARTH: Yeah.

MR. BUTLER: And then is this a model where we're going to suddenly have to have reserves associated with those that are taking on these risks versus just kind of passively saying there's an upside and downside?

MR. HACKBARTH: Yes.

MR. BUTLER: I think you get the gist of what I'm
trying to anticipate.

MR. GLASS: Well, I think they don't have to put aside reserves legally, because they're not insurance companies. And I think that's one of the advantages of --

MR. BUTLER: That's kind of my point. So if you take a 10 percent hit in a small group in one year, it may be, oh, my God, you know, the whole thing collapses.

MR. GLASS: Right.

MR. BUTLER: Because we've either -- you know, size, we permitted groups to take on risk that they had no business doing.

MR. GLASS: Right, which is why almost all of them are choosing to get three years of experience in bonus-only, and then I guess they'll have some idea of, you know, whether they can take risk or not.

MR. BUTLER: Yeah. The question is: Should you require -- okay.

MR. GLASS: Yeah.

MR. BUTLER: There will be people that say, "I'm going to take a run at this," and unwisely do that.

MR. HACKBARTH: Yeah, and, Peter, you're absolutely right that that happened in the 1990s. People
took on risk that they really didn't know how to manage, and there were blow-ups because of that.

MR. BUTLER: Or they get the first three years and said, "I've done all I can do. I'm out of here. Now I'll go back to fee-for-service or some other model."

MR. HACKBARTH: Right.

MR. GEORGE MILLER: Yeah. Two quick ones on Slide 10, please. I thought I heard in the presentation, in the last bullet, that after year three, they could go to a capitated rate. Did I understand that correctly?

MR. GLASS: Yeah, but it's not full capitation. It's capitation for the share of the services they provide--

MR. GEORGE MILLER: That's what I --

MR. GLASS: -- either in -- in one model, it's the part of the Part B services they provide --

MR. GEORGE MILLER: Okay.

MR. GLASS: -- a share of Part B, and in another model it's the share of the A and B services they provide.

MR. GEORGE MILLER: Okay. So there will still be fee-for-service on the A side.

MR. GLASS: Right, yeah, depending on which model it is, yeah.
MR. GEORGE MILLER: Okay.

MR. GLASS: And so -- but remember -- so if the beneficiary gets 20 or, say, 60 percent of the services in the ACO and 40 percent outside of it --

MR. GEORGE MILLER: Right.

MR. GLASS: -- they're only capitated on the 60 percent.

MR. GEORGE MILLER: On the 60. I've got it. I just want to be clear.

And then on your last slide, please, I just need a couple of definitions. Sixteen. Help me with the definition of a non-physician practitioner. Who could be -- where they could be based. I would understand the FQHC and the RAC. They're going to be physician-based. But give me an idea of what a non-physician practitioner. Would that include -- what would it include?

DR. STENSLAND: So this is mostly nurse practitioners, physician assistants. So somebody might go --

MR. GEORGE MILLER: Yeah. I understand.

DR. STENSLAND: And that might be their primary care source of care.
MR. GEORGE MILLER: Right.

DR. STENSLAND: They're getting it at a physician assistant or a nurse practitioner. Right now, the way the law was written, it was written so that it had to be assigned by a physician, and so CMS took that literally and doesn't allow patients to be assigned based on their use of a nurse practitioner --

MR. GEORGE MILLER: Right.

DR. STENSLAND: -- or a physician assistant as their primary source of care.

MR. GEORGE MILLER: So just for clarity, then, you're saying the non-physician practitioner would be a nurse practitioner or a PA, as allowed by law in that particular State, right?

DR. STENSLAND: Yeah.

MR. GLASS: It gets complicated, because --

MR. GEORGE MILLER: Yeah. Yeah.

MR. GLASS: -- the way they wrote the final regulation said that you have to have a triggering visit with a primary care physician in the ACO and then you could count all the other visits to non-physician practitioners after the triggering visit --
MR. GEORGE MILLER: After the triggering visit.

MR. GLASS: -- to determine whether there's a plurality or not. But it got -- we were trying to go for a simpler definition.

MR. GEORGE MILLER: Yeah. Yeah. But they, then, would be counted -- no matter where they went, they would be counted in the quality measures for that ACO, their outcomes?

DR. STENSLAND: Right.

MR. GEORGE MILLER: Yeah. Okay.

MR. HACKBARTH: Okay. Clarifying questions?

Further clarifying questions? Alice, then Herb.

DR. COOMBS: So, Slide 11. In the eight who elected to take the two-sided risk, do we know anything else about the eight in terms of suburban, what they looked like --

MR. GLASS: We didn't enumerate which eight they were and what their characteristics were. We just thought that the number 212 versus eight was --

DR. COOMBS: Oh, okay.

MR. GLASS: -- told the story. Maybe they made the mistake. I don't know.
MR. HACKBARTH: Just got in the wrong line?

[Laughter.]

MR. GLASS: Just filled out the wrong form.

MR. HACKBARTH: This one's shorter. I'm going to get in this line.

DR. MARK MILLER: All right. Let's take that off the record.

[Laughter.]

MR. HACKBARTH: Herb.

MR. KUHN: Two questions. On Slide 5, when you talk about the Pioneer ACOs, there was some news recently about the Pioneers, a large number of them had written CMS about either participating or not participating, I think, on a quality reporting component, if I remember right. What's the current status of that activity and where is the real status of the Pioneers as a result of that?

MR. GLASS: I don't think we're absolutely sure where it stands. They apparently called a truce and they're figuring it out, I think. They had some kind of meeting about it. But I'm not sure what the final status is. The issue had to do with quality, moving from the quality reporting to judging performance on quality, and it had to
do with how you set the thresholds or not and whether there was enough experience to do that.

MR. HACKBARTH: That was my understanding, was that in order to get the rewards, you have to meet quality standards, and the Pioneers were arguing that those standards were set at arbitrary levels without any empirical foundation.

MR. KUHN: So it is moving forward, but still to be resolved, it sounds like, so -- and the second question I had was on 13. When you talked about the ACO weaknesses, the one issue that always kind of lays out there is that of the no ability to limit networks. And I've always been concerned about the fraud aspect of that, and I think you mentioned that the ACOs are identifying ways for them to talk to CMS about fraudulent providers so they can work on that.

Can you talk a little bit more about what programs they're putting in place on that, or is it just strict identification and then CMS turns this over to their contractors or the IG and they investigate, or do we know what's going on for sure there?

DR. STENSLAND: They are just starting to develop
ways to work together on that, and I don't think it's
anything that's solidified as, this is our strategy. This
is how we're doing it. It's more just now that the ACOs
have just started in their first year to get this data back
from CMS, and this is all the spending and what kind of
spending your people are getting and where they're getting
their things, and the ACOs in some cases have talked about
running some of these claims through their own screens and
saying, whoa. Wait a minute. Wait a minute. Why is all of
this DME coming out of Dr. Jones there on Palm Beach Avenue?

[Off microphone discussion.]

DR. STENSLAND: Okay, Main Street.

[Laughter.]

DR. STENSLAND: But they're just working on it and
they haven't actually -- a lot of them even haven't had
their own procedures even in them and the ACO deciding on
how they're going to do it. Some of these are MA plans and
they have their own screens available and they're saying,
maybe we could use those in our ACOs. But it's just
starting.

DR. DEAN: It's probably too early to answer this
question, but it always seemed to me that the fact that ACOs
could not limit in any way where the beneficiaries actually received care -- do we have any information as to how often that's actually been a problem and what percentage of their costs are outside their own organizations? Like you say, it may be too early to answer that.

MR. GLASS: We don't have any real data on that. But we've talked to a couple of ACOs and it depends really a lot on where they are, and if they're kind of isolated from everyone else, then the people go there a lot. And if they're in different circumstances, maybe they don't.

But, I mean, if they're primary care physicians, it still has a lot of influence with the patient, with the beneficiary. I imagine the beneficiary tends to go where -- you know, to where he's referred.

DR. DEAN: I mean, but they don't always go where they're referred. I can attest to that.

[Laughter.]

MR. GLASS: No, I'm sure that's --

MR. HACKBARTH: Clarifying questions? Cori, then Rita and Scott.

MS. UCCELLO: So, the text box in the chapter talked about the opt out of the data sharing. Is there any
even anecdotal evidence about other beneficiary negative reactions and whether people have decided just to go to different primary care providers altogether?

MR. GLASS: Well --

MS. UCCELLO: Even though I think it still counts for --

MR. GLASS: Right. That would still count. The general number seems to be under five percent are choosing to opt out. I mean, there are always some anecdotal things that are kind of interesting, that some places thought that the language in the CMS letter was such that it would really turn off the beneficiaries and make them want to go away.

MS. UCCELLO: And another question was, when these were starting to be pursued, there was concern about the hospital-based versus the physician-based ACOs in terms of market power and those kinds of things. Is there any information about, like, the distribution of those? Are they locating in the same place or different places as the physician-based, because I think it's too early to tell kind of what their impact has been, but just location-wise, is there anything?

MR. GLASS: I think -- well, we'll try to pursue
that, because we looked and it's about 50 percent seem to be
physician only, or physician-based, if you will. But what
markets they're in, we haven't analyzed yet.

MS. UCCELLO: And just a quick question. For the
bonus only, so it had originally going to just be for the
first two years and then the third year was going to be
shared, and then it went to three years. So now for the
next three years, do we just not know what that's going to
be yet in terms of bonus only versus the split?

DR. STENSLAND: At least I think the way it stands
now is it's supposed to have some sort of downside risk in
that second three years. But the idea for all of -- at
least the shared savings, and even the advance payment
savings, is you get to have a three-year look at it and then
you can just drop out after the first three years and not
sign up for the second three years if you, A, don't think
your experience was good, or after those three years, if you
talk to CMS in terms of what they're proposing for their
regulations and you think, oh, that's going to be too hard,
you can just drop out.

MR. HACKBARTH: But the precise parameters of the
second three-year cycle are not clear yet at this point.
There will be some downside risk, is what CMS has suggested, but exactly how it will work is not clear, is that correct?

Rita.

DR. REDBERG: The chapter was excellent, really helped clarify a lot of things.

My question, you can get back to me on because I don't think you'll have this detail now, but I was interested in the performance, the quality measures. I think it was good that it went from 65 to 33. It was disappointing to me there were really no meaningful clinical outcomes measures. You know, there were a lot of things you measured, but it wasn't clear whether they were actually having an impact on patients.

But I was curious on how, for the patient survey items -- it's number six and seven, shared decision making and health status, functional status, is actually how those will be determined by patient survey. Like, how do they know if someone's had shared decision making? Are you going to check a box or what are you going to do?

DR. STENSLAND: We'll get back to you on that.

DR. REDBERG: Thank you.

MR. ARMSTRONG: My apologies if this question is
redundant to questions asked already, but I'm on Slide 10
and I'm not quite getting how the risk is defined. And my
sense is that what the ACOs are doing is identifying a
subset of the total costs for a population of patients and
going at risk for that, or is for the total per member, per
month, for that population, regardless of where those
patients actually experienced their care?

DR. STENSLAND: So they're always at risk for the
whole cost.

MR. ARMSTRONG: Okay.

DR. STENSLAND: There's a -- in year three,
there's a potential for them getting up-front payment for a
portion of that cost, expected cost. But in the end, at the
end of the year, they're going to say, what is the total
cost of everything, and if it's below, you're going to get
some savings. If it's above, you're going to have to pay
in.

MR. ARMSTRONG: All right. So the different
arrangements are really around these items here, the share
of savings, the caps, and so forth, not on what subparts of
the overall cost are really being put at risk. Great.

Thank you.
MR. HACKBARTH: So, let me kick off round two. As you reported in both the presentation and in the written material, one of the issues that we raised about the proposed rules, or even before the formal publication of the proposed rule, had to do with how beneficiaries are notified of ACO participation. And our concern, my concern at the time was that this could be unsettling to beneficiaries. They get a letter saying that you've been assigned to something that they're unfamiliar with, and to the extent that they understand it at all, it may be, well, they understand that the payment rules are changing and that their physician and hospital are going to be paid differently and they're going to share in savings and the government is going to share in savings, but oh, I, as the patient, I don't get anything out of this. Do we know how this process has worked in practice and how beneficiaries are reacting to these notifications? And is CMS doing anything to try to understand in a systematic, as opposed to anecdotal, way how this is going down with Medicare beneficiaries?

MR. GLASS: I'm not sure about the latter, about CMS's, but we can look into that, how CMS is collecting data
on it. From talking to some of the ACOs, it does get the beneficiaries' attention and they do get a lot of telephone calls. So they've had to put in extra resources to make sure that there's someone to answer the phone who knows the answer to the question and can reassure the patients what's going on.

MR. HACKBARTH: Mm-hmm.

DR. STENSLAND: I think the general process is CMS says, here's a list of the names that have been aligned with you. Then the ACO has the option of sending these people -- they first have to find out what the addresses of these people are from their own systems.

MR. HACKBARTH: Right.

DR. STENSLAND: Then they have an option of sending them out this letter. And then when the letter comes in, they say some people call because they're just confused. It's a confusing concept, even for non-elderly people.

[Laughter.]

DR. STENSLAND: And some of them opt out, just saying, you know, because I think a lot of it is about data sharing. You know, you're going to share your data, and
some people might just have a negative reaction to people seeing their data. And, generally, we have a small sample, you know, whatever, ten different ACOs that we've talked to, but generally, they're saying, maybe five percent say that they don't want their data shared. Now, we've also heard that in some cases, after they talk to their doctor, some of them go back and contact CMS and say, okay, go ahead and share my data because now I understand what this is all about.

MR. HACKBARTH: So my concern about this, and I'm old enough to have lived through the managed care backlash of the 1990s and came away with some, I think, hard-earned, learned, lessons about that, and one of them that I think I learned was that patients are uneasy about their providers having a reason to reduce care and save money, particularly if they have no choice in the matter and the savings are all going to somebody else. And I'm afraid the ACOs, as currently structured, tick all those boxes. They don't have any choice. They don't share in the savings. And my fear is that this is sort of ripe for -- especially if the communication is kludgy -- really ripe for, over time, creating a backlash.
And I fear that, much as in the 1990s, there will be people who have a reason to foment a backlash, because if an ACO is going to work, it is going to take income from some people and redistribute it to other people, and the people who are losing income -- subspecialists, radiologists, interventional cardiologists, whoever -- are going to have every reason to whisper in their patients' ear, this isn't in your interest. They're saving money at your expense. You don't have any choice, and you're not even getting part of the savings.

And so that is my fear. I think we're too early in the program for that to have manifested itself in any big way, but this is my single biggest design concern about the way the program is structured. No choice. No saving in savings. And sort of a kludgy notification process.

Round two. David.

DR. NERENZ: I would be interested in your thoughts on where this goes a few years down the road, to the extent you can see that. I start with what's on Slide 11, but actually it's in a few other places, just in how the savings are calculated, because the core through financial appeal element or incentive is this shared savings
It is correct, I think -- but it's in the text -- that this two to four percent is calculated against the year prior spending of the group of people assigned to the ACO. So you're not competing against market. You're not competing against the national number. You're competing against yourself, basically.

So the observation would be that a fully highly integrated system that is already very lean and efficient will find it more difficult to achieve savings than a newly forming ACO in an environment that just has a lot of excess. So that's right.

And it also would be the case that a fully integrated system that included all the various delivery components would find that the savings are, in fact, revenue losses for themselves, which also creates some difficulty, as opposed to it being a revenue loss for someone else.

So now, finally, the question. If those general observations are so, it would seem like this is a mechanism that would incentivize a certain type of integration, meaning perhaps centered on primary care but not including everything, and it would incentivize integration for a
while, up to a point. But then it would sort of cease being attractive because of these components I mentioned earlier. Is all that reasonable, or is there some way which this continues to be attractive several years down the road after the initial low-hanging fruit, so to speak, has been harvested?

MR. GLASS: Well, I think your analysis is correct, for the most part. But eventually, they might want to become an MA plan. If they're truly fully integrated, they control everything, and all that, they might become an MA plan instead of an ACO.

DR. NERENZ: Well, except -- yes, but --

MR. GLASS: That would be a possibility if they don't --

DR. NERENZ: Except that the key distinction, though, is that the ACOs are delivery system entities --

MR. GLASS: Right.

DR. NERENZ: -- and are not legal insurance entities.

MR. GLASS: Correct.

DR. NERENZ: So they would have to actually create --
MR. GLASS: That's right.

DR. NERENZ: -- or merge or buy an insurance entity.

MR. GLASS: Correct.

DR. NERENZ: Okay.

MR. GLASS: Yeah. I mean, so that would be one aspect of it. The other is the benchmark they're going against is the past spending for their patients, but it gets increased by the increase in fee-for-service across the country. So there is that.

DR. NERENZ: Yeah, I understand, but that's slack that they could perhaps save against.

MR. GLASS: And also, if they bring in patients from other providers in their area who are less efficient and that sort of thing -- well, under the way we had designed it, the way we think of it -- they should take -- those patients would bring their benchmark spending with them. That's not quite the way it's working at the moment.

DR. NERENZ: Yes. That's -- so if there's some inflow of patients from relatively less efficient --

MR. GLASS: Right.

DR. NERENZ: -- into --
MR. GLASS: Yes.

DR. NERENZ: -- that could be potential -- yes,
that is correct. So there is some possible --

MR. GLASS: Yes, that's correct.

DR. MARK MILLER: That was kind of a trigger. The question, in some ways it's been implicated indirectly in your own conversations on and off, of in three years, how do you start thinking about the benchmark. And the other thing, and I think it was implicit in your exchange, is it may become more difficult to perform well, but also, what will be happening in fee-for-service and will that be a more or less attractive environment to be in.

MR. HACKBARTH: I think, David, you've raised some really key issues, and one that I focus on is how this relates to Medicare Advantage. To me, one of the principal potential strengths of Medicare Advantage is that plans have the ability to steer patients to high-performing providers by using limited networks or differential cost sharing, whatever. And I think to get where we want to go in terms of elevating delivery system effectiveness, that steering patients to high performers and away from low performers is a very important thing to do.
Now, switch over to ACO. As you say, the payment structure here is built on historical costs, and as opposed to the efficient providers being differentially rewarded, either in payment or volume, we don't have either of those mechanisms that work. They're not getting rewarded for their past efficiency nor are they getting any volume because the patients aren't rewarded for going to high-performing providers.

So I think the ACO structure, while appealing in many ways, and I think a positive step in many ways, really falls short of what we need to accomplish in order to really elevate delivery system performance. It's an incremental step in the right direction, but the current rules are constraining in very important ways.

MR. KUHN: Can I comment on that? Just on that, I agree the current rules are constraining on that, but I think the market also is helping level this out somewhat, in that I know in some of the ACOs, they are actually taking their own staff -- let's say it's a hospital-based ACO -- and placing APNs and others in long-term care facilities to help them elevate their game and get better in terms of their performance. Otherwise, they would see potential
readmissions from those facilities.

So I think the market is helping kind of lift all boats, and so we'll see in three or four years how much that has changed the market. But I think there are some advantages to ACOs that we won't know for a time yet.

MR. HACKBARTH: Let me be absolutely crystal clear. I think this is a step in the proper direction, but I think that there are design features that affect its potential to move us where we want to go.

Bill, round two -- or Jack.

DR. HOADLEY: Just on kind of this last discussion, I mean, one of the things that strikes me is we get back to that question of the downside risk and the reserve issue that was being brought up earlier and are we back in the sort of PSO world of a decade ago that didn't work out very well, and so just sort of remember -- connect that little point.

The other point I wanted to make really, I guess, picks up off of Glenn's point on the beneficiary involvement, and I know from conversations in the focus groups I've been in over the years talking to beneficiaries, beneficiaries have trouble telling us when they're in a
Medicare Advantage plan, which is an entity that means they have an ID card and a bunch of other things, and they have trouble knowing that they're in MA versus their Medigap or whatever. And so with whatever, I mean, you're relying with something like the point is trying to make sure that they know that they're in it and what it means and that's a pretty steep ask, I think, and could lend to some of the things Glenn was raising, or could just lend to general confusion. And I don't know the answer beyond that.

I don't know where you go, because I think it's going to be really tough to have somebody, like you said, you know, something that we even have trouble explaining what it is, how do you explain it to a general beneficiary and what it means to them. So I think that's something that we really need to think hard about, how that informing process and what it is we're expecting them to learn about.

I guess another thing that is -- what can we learn as you look forward, and that's one of the questions you asked, and I guess it strikes me that there's enough variation in the types of entities that are out there that we ought to be able to pick up some things. I was struck by a couple of examples that were in the chapter that weren't
otherwise mentioned, but you had said there were a set of ACOs that had a -- Universal American had a Medicare Advantage plan company that was involved, and sort of what are they doing differently? Does that create a different kind of dynamic going on? There's a couple that involved a pharmacy as part of the unit. What does that involve? And on the broader group is sort of the questions that we've talked about over time, is the payment relationships between, especially where there's hospitals and doctors involved, how is that all being organized and what opportunities do we have, or what is CMS doing to sort of really study these varieties of models and understand that when you do something, that one is not going to work, and so in the future, we should say that's not a good model. This is a model that works better. So, yeah, we ought to encourage that kind of model, or it would work only if we made this adjustment.

I gather you've done some interviews of some of the ACOs. I don't know whether you have more plans to do sort of more systematic interviews or whether CMS has any plans, but it seems like those are directions that would be really helpful.
MR. GRADISON: Three quick points.

First of all -- and, Herb, your comments are extremely helpful in my thinking, but overall I can't quite see what's in this for hospitals. It seems to me possible, if not likely, that a very successful ACO will achieve most of its savings by reducing the income of the hospitals. And I may be wrong about that. We'll see how that plays itself out. But I really do wonder.

The second thing that bothers me, again, I'm just trying to think this through. If I am being measured against my performance year by year and to get any kind of a chance for making money out of this deal, I've got to achieve savings of at least 2 percent year after year after year, I don't get it. Isn't there some point -- I think the same thing, frankly, about hospital readmissions. Isn't there some point where maybe it can still go lower but it kind of levels out? Just thinking that through into the second and three-year cycle, again, I don't exactly get it. And my final point is that, as I think about when will we have enough data to be able to really understand what's going on here and what it may be for policy, it may be so far off as a practical, realistic matter, that the
pressures for major changes within the program will overcome our ability to interpret what we've already done through very well intended and hopefully very effective initiatives such as this.

So these are just things that I'm just trying to think through in my own mind.

MR. GLASS: It may not be quite so grim because -- they get a benchmark of historical spending, and then that gets updated each year by the increase in fee-for-service funding in the rest of the country, either the absolute or a mixture of absolute and percentage. And so if they save 2 percent right away, that will continue to accrue to them. It doesn't lower their benchmark for the first three years. So it isn't quite as grim --

MR. GRADISON: [off microphone].

MR. GLASS: Okay.

MR. HACKBARTH: And, Bill, you understand the reason for the 2 percent threshold.

MR. GRADISON: Yes [off microphone].

MR. HACKBARTH: Okay.

DR. HALL: I think this was a very well done chapter for us to look at, and I think continuing to look at
the development of ACOs as it affects Medicare patients is going to be really, really important. I was recently at a meeting of some of my colleagues, professional colleagues in geriatrics, the field of taking care of older people, and there's virtually no major medical center around the country now where they're not engaged in an ACO formation or having discussions about ACOs.

But the interesting thing is that there's very little distinction between whether the one-size-fits-all in terms of particularly important things, such as quality indicators, how you really keep score, whether you're meeting your own benchmarks in terms of quality, particularly if quality is tied to reimbursement.

And the problem is there's a sense that we don't really know what we don't know in this whole arena of taking care of particularly the segment of the Medicare population that is going to be the biggest bulge in the next 20 to 30 years, the 75 and 85 and above.

But out of that, almost in a parallel universe, there's a lot of activity going on in terms of trying to understand a little better what kind of differences would be important if you were structuring a health system that was
Accountable Care-oid or -- what would it really look like? And part of that are things that we've talked about, but I think it's going to be very important for us to keep a focus on this. This would be such things as a tremendous surge in interest in interprofessional -- at the present time, interprofessional education, but interprofessional dialogue in any part of a health care system, a lot more interest, as you all know, on transitions of care. One very interesting marker is 30-day readmissions rates. And there's a lot of very, very good information based on not just singular trials in one hospital but in many, many hospitals that are almost totally irrelevant to the below-65 population but are quite relevant for older people.

Just to give one example that's getting a lot of attention lately, a number of health systems have decided to take a look at how they are repairing hip fractures in older adults. Perhaps sort of the paradigm of an event, a single event that can make things go wrong in every aspect, not only in terms of life but the morbidity and maybe, and more importantly, the cost to the health care system. And it becomes abundantly clear that with relatively simple things of health care personnel talking to one another, agreed-upon
quality indicators that would be totally irrelevant to a 25-year-old, that you can reduce costs in half, you can reduce complications, sometimes by 90 percent.

I think we need to keep score of what's going on in these two universes as we start saying what's in it for the Medicare recipient in terms of the structures of ACOs. That's going to be my mantra for the next year.

MR. BUTLER: So I will try to make five quick points or so from the proprietor perspective, some redundant but maybe a little different.

This is great that you're bringing it forward. We're starting to pick apart an idea that we were among the first to support, but it's a good -- as Glenn said, I think this is advancing the field and providing a lens that we hadn't been looking through previously.

So why do people do this? I'd say first it's not because they view a market that is ripe. I think they look at their own base. These are all providers or physician groups that are saying, "I can do better than I'm doing now." And, ironically, they're almost looking for those chronic illness -- they're looking through the sick patients that they see not being managed well, which, by the way, if
you get to the Medicare Advantage, those are the very ones you're going to want to maybe not have in your plan. So suddenly the ones you're trying to attract in the early days of ACOs are the very ones that you're going to want to stay away from later on. So there's kind of a perverse incentive. But I think it's provider-specific. It happens to be in markets where there's higher fee-for-service utilization, but I think the motivation is from the individual proprietor's perspective.

Second, as Bill said, the economics don't really work, particularly if a hospital is in this. So they don't look at this and say, "What an opportunity." Your example in the chapter doesn't do the revenue loss on the provider side. It shows the, you know -- it's more of a physician group perspective on it. But the economics don't work. And I think the other side of that is it's not just the money for the infrastructure. It's the competing management time. This is a subtlety, but the hospital world has got value-based purchasing increasing in numbers. They've got the readmissions rates penalties going from 1 percent to 2 percent. They've got meaningful use. They've got hospital-acquired conditions, also a whole series of metrics that
they're trying to hit on one side of their management ledger, and at the same time trying to get 33 quality indicators and an infrastructure for managing an ACO together, and it literally not only can be kind of confusing, just an opportunity -- a management time opportunity and energy. Where do you want to put the real efforts, and trying to do both, but it's tough.

The third point is, so if the economics don't work and in the end, you know, this is not the endpoint, why are they still doing it? Primary care physicians alignment. If you get primary care physicians in there, they're locked in for three years, and it's not just the Medicare business. It's the rest of the business associated with those primary care physicians who are in short supply, so they said this is a mechanism that I can, you know, offer to primary care physicians who themselves are saying, "Who should I align with?" That's not to be underestimated.

Fourth, I think people are saying, hey, this is a way to -- the training wheels, it gets me started, and if I punch the Medicare ACO ticket, I have much -- I need that as credibility with the commercial insurers. Because you could say you're not even in a Medicare ACO, why should I talk to
you on the commercial side? Or if you have experience there
-- and this is a positive thing because it creates a --
Medicare is creating a catalyst and, frankly, a legally-
easier-to-comply-with structure to get started than the
commercial world has provided up so far. So you're getting
a big push of jumping not just to Medicare ACO as, oh, by
the way, we're doing this, but good entré into the
commercial world.

And then the last point I'd make is that the MA
world, yeah, providers are saying, "I'm giving all this
money up. And the MA plans actually are still priced above
the fee-for-service plans. I'm missing all the" -- "If I'm
good, I'm just leaving so much money on the table." But
then you are moving into, as pointed out earlier, an
insurance product, and it's that whole different equation.
But that's the kind of series of thinking that I think
providers are going through, but on balance, I think they're
saying they're learning a lot, it's still the right thing,
it's forcing me to reorganize my system in a way that
ultimately is going to improve the health of the population.

MR. GEORGE MILLER: Yes, also let me echo that
this is an excellent chapter, and I appreciate the work that
staff has done, and it really crystallized, at least in my mind, where we are with ACOs.

To that degree -- and I appreciate the comments of all my colleagues before because it also helps with the discussion and understanding. But reading the chapter, I was struck with what the impact of the future of ACOs could be on the program and how we could expand it to make it work better. And I'm struck with the fact that in the chapter, and as we've discussed many times, the MA plans, while appears to do a great job, it still costs us a premium to provide them. And so at least in my mind, do we see a future where we have a world of just ACOs and no MA plans? Or will they co-exist together? How do we make that evaluation? How do we make that determination? But some of the things I'd like to think about or have us consider and think, and what would be those metrics? How do we compare the metrics in the ACOs? And Peter was right on. I started to write down all the things we had to do on the hospital side and then try to marry that with the ACO and try to determine what is best for our patients. I think Bill said it exactly correct, that the ACO models or MAs or anything else, any other providers, should be what's best for the
Medicare beneficiary first.

And so with that said, where do we take the ACOs in relationship to MA plans? And at what cost, what quality? And those type of discussions I'd like to see us evolve to at some point.

MR. HACKBARTH: Yeah, and I think those are really important questions, George, and ones that we will come back. I think we'll have both MA plans and ACOs as far as we can see into the future, but right now little attention has been paid to how to synchronize the two with one another in a way that's effective.

DR. NAYLOR: So let me just echo all my colleagues' comments about what terrific work you have done in the past and continuing now. I also like the reminder that this ACO is an effort to and a path toward a more integrated care delivery system that places a premium on prevention, primary care, and capitalizes, if right, on all the players. And I think Bill's comments about how important teams are in making this happen, in professional teams, in collaboration with patients and in direct engagement with beneficiaries is critically important.

I really thought Dave's comments about
benchmarking were important and Glenn's and Jack's around beneficiaries' sharing and beneficiary education are critically important. I would like us to pay attention in the short term on the issue of access, and especially, you know, we are an evolving delivery market and model, and we have federally qualified health centers, rural health centers, we have nurse-managed health centers, a whole array of places and sites that are attempting to promote better access of Medicare beneficiaries to primary care. And I know what the law said, and I know the convoluted path of triggers to get to this, but I think we need to figure out a way to smooth that.

I also think performance based on key outcomes and service use is critically important so that element of advancing, you know, this care delivery model makes a lot of sense. How we get to leveling the playing field, promoting two-sided models, figuring out why four states and many markets are not covered by ACOs is, I think, really important. I mean, if we believe that this is at least one path toward integration, what are the barriers to moving ACO development in markets that are not also competing with MAs?

And, finally, I think we have all been talking
about this, but maybe explicitly think about, you know, if this is really the delivery innovation among others that we need to be focused on, how do we create the learning health system so that there is the kind of collaboration among ACOs, the pioneers and the newer ACOs as they are developing to really take what they're learning and share it with each other in a very deliberate way.

DR. BAICKER: There are obviously a lot of first-order issues in terms of how the pricing is structured, how the incentives are structured, and I just wanted to pick up on the really important point you raised about communication with beneficiaries, and that's obviously important to convey what the program is trying to do and to reassure people, like it could be described in very scary terms that are not warranted, and avoiding that seems important not only for beneficiaries to understand what is going on, but also to avoid undermining the integrity of the program by selective disenrollment and selective opting out, and that would really -- no matter how well we try to risk-adjust things, that could really undermine the financial stability of that arm. And I don't know how much of the beneficiary -- individual level beneficiary information is really crucial
to the operating of the ACO versus what parts could be reported in aggregated ways that would give them a base of information to work on that might be less -- whether there's an intermediate step between opting out and opting to withhold all of your data and fully participating, is there some way to mask or aggregate sensitive data and communicate that in a way that's not even more confusing for the set of options available to people. But I think having -- adequately conveying the upside of this to beneficiaries, which is not dollars in hand necessarily but the higher quality and devoting the resources that are spent on them to the highest-value care seems like a message one ought to be able to convey, and to the extent that we can remove whatever little parts might disincentivize or scare people away from participating, that seems important.

DR. CHERNEW: So first let me say I get this feeling that as we redesign the health care system, we're building different pieces of it in different workshops. And I worry that what's happening in some of those workshops isn't going to be consistent with what's happening in others, and when it comes together it's not going to look all that good. And so I really commend this chapter as at
least a first step to beginning to think about how to
harmonize all of these pieces, not for 2014 but for 2020 and
beyond, or whatever it is. And I think this is just great
for that reason.

I want to emphasize two points. The first one in
that spirit is we really have to begin to think about what's
going to happen three years -- it's a little disturbing to
me that we don't know what's going to happen three years in
a while bunch of ways that both affects incentives for
people to get in, and I think now is the time you should
begin to think about what that's going to look like in turn
for the payment rates. And what I would say is we really
need to think about the connection between the ACO program
and sort of the other portion of fee-for-service and how
they're tied together and, you know, how we set the rates
and all those types of things.

The other thing that I think is really crucially
important to me is to understand the interaction between the
competition between ACOs and MA plans, and one point that
hasn't come up much is you mentioned in your presentation
that the negotiation with providers that MA plans have to do
as kind of an administrative overhead thing, and that's
certainly the case. But in the grand scheme of things, I think the bigger issue is that providers get to charge MA plans rates that they negotiate, but in the ACOs, you're getting paid fee-for-service rates. And if I'm an ACO and I'm competing with an MA plan but I get to control how I negotiate with that MA plan in a variety of ways, there's interactions that might have significant effects that I'm not sure we've completely thought through, not to mention how ACOs and the formulation of them influences what happens in the commercial market in a variety of ways.

So I don't have any great answers for all of those things, so I'll just stick with commending you that we're at least beginning, in my view, to scratch the surface on really important questions about how we're going to have a coherent system going forward, and I think that's great.

DR. COOMBS: So we have an opportunity to look at these 250-some-odd ACOs. My biggest concern is looking at the components of the ACO and seeing what works and what doesn't work. And this is an infinitesimally small portion of the Medicare population. What lessons can we learn?

One thing that struck me that was very interesting is being able to say that what is the representation of the
ACOs that are now on the books, what do they look like? And what does the rest of the Medicare population look like in terms of parity? Whether it's parity in terms of the income levels, parity in terms of racial composition, what does -- I mean, how does the 250 look like? Does it look like the Medicare population, the 49 million, or not? And I think that's really important in terms of lessons that are learned.

There are 33 quality indicators, and one of my concerns is that if you had an ACO that was doing very well and they did very well from year one to year two, are you going to go out and try to recruit those ones with six or more co-morbid conditions or, you know, are you going to be more strategic in your selection of patients? So that is a question that I have in terms of just the natural inclination of what one might decide in terms of components.

There are internal portions of the ACO that, being in Massachusetts, we had to deal with, and there are external parts of the ACO. One of the internal components of the ACO is when you have geographic isolation of providers and how those providers see themselves as being either eliminated from certain groups or in the inside of
the ACO family within their geographic region. I think that
creates new paradigms that we haven't seen before.

Specifically, if you have ACOs that write
contracts or agreements that have exclusivity clauses in
them and you're in close proximity to a DSH hospital and now
maybe you only had two to three nephrologists on staff and
they have an exclusivity clause where they now have to be
with this other ACO, that takes a highly specialized
provider from an entity, and now you're at a deficit for the
specialized person who would come in to dialyze a drug
overdose, but they don't have access to that. Or for
whatever reason, that patient now cannot come to that
hospital and stay at that hospital; they have to be
transferred to a hospital where they have this specialty
care.

So there are internal dynamics within the ACO that
changes the paradigm for Medicare beneficiaries, and we've
actually talked about this. I mean, they're very complex
contractual agreements, and there's some new thoughts as to
some of the specialists having a capitated agreement with
some ACOs, say an ENT surgical group might decide that they
would like to have this kind of permanent arrangement for
this defined population, whereas the manager of the ACO
knows that they're very limited with, say, orthopedic
surgery or neurosurgery. They may have a different defined
relationship with specialties under the umbrella of ACOs.
So there's a lot of versatility on what an ACO can look
like. It doesn't have to be all fee-for-service. It can
have components that are hybrids of any mixture based on the
geographic availability of resources.

And then this whole notion of virtual ACOs. We've
talked about this in Massachusetts and how it works. I'm
not sure that there are any prove models for that, but
certainly it's applicable possibly for geographic isolation
of primary care doctors as well as doctors who are doing
primary care that's very unique, say, for instance, an
internist who's doing addiction medicine. How do they
become incorporated or integrated into an accountable care
organization?

And then there's the whole notion of mental health
services. How do we address mental health services within
ACOs? And that's a factor because a lot of mental health
services have not been incorporated within the structure of
the ACOs.
I'm concerned about selection. I am also concerned -- what Glenn said was very true -- about how this message gets to beneficiaries, because that's really huge. If you impair access to physicians based on the design of the process for them being incorporated in the ACO, it can result in adverse events and delay of care or, you know, challenges with access.

So I think there are lots of reasons for us to look back at those 250 and really study them and say is this on par with what the Medicare population looks like.

MR. HACKBARTH: I just want to pick up on one of Alice's points. Remind me what happened if the risk profile of the ACO's patients changes within the three-year contract cycle? Let's say that it's a very successful ACO and they've figured out how to do things better when caring for patients with a chronic illness. And so the word gets out, and they start to get more of those patients and have a higher proportion of them than they did at the start of the period. How does the payment formula accommodate that?

MR. GLASS: Well, as I remember it, the risk score of new patients comes with them, so that would increase the payment. I don't think the historical spending of new
patients comes with them, so it doesn't change that part.
MR. HACKBARTH: So they have a dollar value on a base year, but that is adjusted for risk over time.
MR. GLASS: Yeah. So we had suggested that a new patient bring his or her historical spending and risk score.
MR. HACKBARTH: Yeah.
MR. GLASS: And I think they made it -- they bring their risk score.
DR. COOMBS: But in the case of new enrollees, you may not have that history.
MR. GLASS: Oh, you mean someone just turning 65, aging in, yeah, right.
MR. KUHN: I'd like to kind of speak a little bit to something that Mike raised as well as, I think, Glenn and George, and it's captured up here on Slide 16 that's up on the longer-term issues, and that really is kind of this alignment with ACOs, MA, fee-for-service, on a go-forward basis. I think it's been talked about here as the fact that we've got a unique opportunity. We've got these three-year contracts. We know in three years that we're going to have a set of policy questions to deal with on kind of the next generation of these programs and how we get this kind of
alignment on a go-forward basis. So whether it's setting common benchmarks, whether it's setting common performance goals, I think some good work for the Commission in the future will be to look at those set of questions that are appropriate that CMS, Congress, and other policy and law makers could be thinking about, but also maybe even go far enough to start thinking about making specific policy recommendations in this area as we prepare for three years from now. Let's stay ahead of this game and be kind of advancing the common goals that we have.

DR. DEAN: I would just echo the comment you made, Glenn, that if we don't make it clear to beneficiaries how they're going to benefit from this, this whole thing could go up in flames very rapidly, as we've seen happen with a couple of other programs that had solid theoretical bases, but were not well presented or well managed as far as the beneficiaries are concerned.

DR. SAMITT: So for full disclosure, of the 228 ACOs I should say that we are one of the eight. So I didn't realize we stepped in the wrong line.

[Laughter.]

DR. SAMITT: So it's good to know that. It's very
helpful information. I'll have to go back and do something about that.

So, you know, I'm actually quite optimistic about ACOs as a real catalyst to change the paradigm of care delivery. I think it motivates, as other people have described, greater system integration, primary care, and just a care model that supports value over volume. You know, I see it as a methodology with multiple on ramps to help delivery systems wherever they are, wherever they're starting to become a bit more familiar with a different approach to care.

I guess my greatest worry -- and I think it echoes what a lot of other people are saying -- is that we will look at the performance of ACOs in three years, and we will say, "This didn't work," because on average, we don't see improvements in quality or we don't see reductions in cost. And it's the same concern I have about Medicare Advantage and why I'm interested in more detailed information about Medicare Advantage, because we want the pearls in these systems. We don't want to see things on average. You know, I want to see the variation.

And so I think we're going to learn a lot. I
think there are going to be some very high-performing systems. I think there are already high-performing systems in Medicare Advantage that we should be studying more carefully. And there will be some very high-performing systems -- hopefully we will be one of them -- in the ACO space that the rest of the market will learn from and will adopt over time.

I also think that ACOs are a way station that, you know, even organizations like ours, you know, we're a track 2 ACO right now, but ultimately, you know, where we really want to be is in Medicare Advantage, you know, that that's the ultimate end state and we'll get there eventually.

So I think the sooner we can -- I don't know if I'd tweak a whole lot right now. I'd like to wait and give these ACOs a chance to perform. You know, we haven't gotten a lot of negative feedback from the marketplace or from our members. I think we need to give it some time to see if these work, and then we should study the high performers and really understand what it is they're doing and create additional modifications and incentives to make other systems high performing.

A couple other things that -- you know, there's a
lot of venture capital that's going into ACOs, and I kind of
want to know why, that there are these new ACOs without
really any integrated system as an infrastructure. And so
I'd love to understand what their interest level is,
specifically focusing on, you know, we want to protect and
preserve the quality of care and the needs of the
beneficiary. And so I want to be very careful. I want to
tease apart the various ACOs. Are these venture-backed
ACOs? What do they look like and what is their performance
versus integrated system ACOs and so on and so forth?

So I think there's a lot more that we can study,
and I think it is a good strategy to move us all in the
direction that we talk about a lot, which is considering
alternative payment models. I think this is a good start.

MS. UCCELLO: I agree that this approach, whether
it's a way station to MA plans or just another way to
provide coordinated care, it's a big step forward, and it's
a big improvement from fee-for-service. So that alone is a
good thing.

In terms of these issues, I think there's actually
some synergy between the beneficiary notification issue and
the cost-sharing issue. If we think part of -- I mean,
aside from the notification confusion or whatever, but providing more incentives for beneficiaries to participate can be preferential cost sharing when they stay in the ACO. That's one of the flaws of this, the inability maybe to use cost sharing as a way to steer patients into the more cost-efficient providers. But it could also be a way now for the beneficiaries to see a way that they can share in some of the savings, that it's not all just going either the government or to the providers.

So, I mean, I think -- and I also think that we do need to -- I think this may be the one time I want to move more quickly than Craig on anything. I do think we need to be aggressive about looking more into these assignment issues. We're going to talk more about the physician assistants and those issues later today or tomorrow. But it makes sense to be able to assign -- if they are part of this organization and they're in a state that allows them to be the primary care provider, it doesn't make any sense that they're not allowed to be assigned in this way.

So I think we -- and as well, looking at service use rather than costs, all these things I think we should pursue aggressively to see how much of that we can
incorporate into this next round.

DR. REDBERG: I would echo what my fellow
Commissioners have said, that I think it's a great start on
the ACOs, but I do share Cori's more urgency to make some
changes now, because while there good reasons to start out
this way, I'm afraid it's almost doomed to fail unless there
are changes made. It reminds me in some ways of SGR, which
seemed like a good idea until we realized that without any
control on volume, there was no way overall costs were going
to be controlled, because right now, as everyone has pointed
out, you know, the things you expressed, Glenn, you know,
there's no restrictions on beneficiary choice, they can use
wasteful, fraudulent providers, and they have no share in
the savings. So without those elements, it does not relate
a successful environment. And so I do think we'd want to
very quickly try to change those to help the ACOs to be
successful. So I think it's a good start, but we do need
some changes.

MR. ARMSTRONG: Briefly, I would just -- by the
way, sitting here, I realize what it's like to be the
caboose on the Commissioner train.

[Laughter.]
MR. ARMSTRONG: There's not much that hasn't been said. But I would just affirm I think this is a step in the right direction. I think the idea has serious constraints the way that it's built. You know me well enough to know that I believe that even in our conversation today, we've understated the value of the benefit design and the incentives built into the insurance products and the way in which insurance and care delivery, which this is really about, come together to really completely rebuild how a integrated, coordinated system achieves distinctively better outcomes.

In fact, I'm a little concerned that, you know, part of the advantage of ACOs relative to MA plans is they have a very low overhead cost. Well, to me, that implies that they're not taking their cost structure and converting a big chunk of it into capabilities that allow them to prevent unnecessary services and to manage care and to understand where their patients are at all times and so forth. And I think it's still in the right direction, but a naive place that to the degree we can accelerate the advancement of it I think is a very good thing.

The last point I would make is that it may be
beyond the scope of MedPAC and Medicare payment policy, but let's not also be naive to the fact that this payment policy has inspired the organization of hospitals and medical practices across the country in ways that affect much more than the Medicare program. And we just need to be attentive to the fact that in many, many markets, this is actually increasing costs through market power and through the organization of a broader and broader percentage of the providers in a marketplace. And I don't know what we do with that, but it's a reality, and we just shouldn't pretend it's not there.

MR. HACKBARTH: Okay. Thank you. Good job, David and Jeff.

We'll now move on to low-income beneficiaries in a system of competitively determined contributions.

[Pause.]

MR. ZARABOZO: Good morning. Today, we'll be continuing our discussion of what we were referring to as a system of competitively-determined plan contributions, or CPC.

We talked about CPC in our examination of benefit redesign issues in Medicare. What we'll be specifically
talking about today is what the rules might be for low-
income individuals who would need financial assistance in
paying premiums and cost sharing in a CPC system.

Through much of the presentation, we will talk
about dually eligible beneficiaries, that is, beneficiaries
entitled to both Medicare and Medicaid, but many of the
issues would also apply to other low-income individuals.

As you will recall from our earlier CPC
discussions, there are many different ways to design a CPC
system. Today, we will explore the question of whether or
not it is feasible to use Medicare's Part D drug program as
the model for dealing with low-income beneficiaries in a CPC
system. One reason for doing this is that Part D has many
parallels that would apply to a CPC system for this
population. So we'll use the Part D model for our
illustrative models, but at the same time, we'll point out
which aspects of the Part D model may be different from the
Part A/B CPC system that we've been discussing and which
aspects of Part D may not be a good fit for a CPC system.

We'll also look at the status of dually eligible
beneficiaries in the current fee-for-service and MA programs
to highlight some issues that need to be considered.
We are using Part D for our discussions, but there are other options that we will not be discussing today that have been proposed, such as block grants to the States to cover dually eligible populations or having Medicare and Medicaid dual eligibles covered in exchanges and not through the current Medicare and Medicaid system.

To remind you of what a competitively-determined plan contribution system, or CPC system is, it would be an approach whereby the government would determine a set dollar contribution level for Medicare coverage. Medicare beneficiaries would choose among different plan options in the person's geographic area. The plan options would include traditional fee-for-service Medicare and private plans, where such plans were available. A bidding process would determine the government contribution in each area. Some plans will be more costly than others, requiring an added premium payment from the beneficiary. The beneficiary's current plan might be one that requires an additional payment, and the relative cost of a given plan can change from one year to the next. Such a system would have consequences for dually eligible beneficiaries in terms of which options might be fully subsidized, and States would
also see changes in their financial obligations, depending on how the system was designed.

This graphic illustrates a CPC system where the government contribution is set at the weighted average of four bids in a geographic area, with each plan assumed to have an equal level of enrollment. In this example, two plans are at or below the government contribution level of $650, while the two plans on the right side of the slide, Plans 3 and 4, are above the threshold. For low-income individuals, Plans 1 and 2 would be the plans they could enroll in without a premium, but like any other beneficiary, they could enroll in Plan 3 or 4 by paying a premium out of pocket.

If the Part D model is followed, there would be auto-assignment into the lowest-cost plans for low-income beneficiaries, both to ensure that such beneficiaries end up in the lowest-cost plans initially and so that plans have an incentive to participate in the CPC program and have the possibility of receiving a certain volume of enrollment.

As you will recall from last month's presentation by Julie Lee and Scott, the CPC approach may involve significant movement from current options as well as
movement from year to year, in particular for low-income beneficiaries when only some options are fully subsidized. If a limited number of options are fully subsidized, there also may be issues with a plan's capacity to enroll a large number of low-income individuals.

To state a basic principle of a CPC is that through the bidding process, the lowest-cost plans can be identified. As in the current Medicare program, under CPC, all beneficiaries would have a portion of the cost of coverage subsidized in the sense that today, for example, the Part B premium that beneficiaries pay is intended to cover 25 percent of the program costs, while the remainder is subsidized for all beneficiaries. For low-income individuals, there are additional subsidies for premiums and cost sharing and the costs of care that Medicare does not cover is also subsidized for many beneficiaries. Arguably, when trying to determine what is the least costly option for low-income individuals, all program costs should be taken into account: The Medicare Part A and Part B benefit, the drug benefit, and the cost sharing for each of these benefits as well as costs of services, such as long-term care services and supports.
In a CPC system, one way to try to ensure that the least costly option is identified is to have all plans bid on the full package of benefits. As we will discuss, there are a number of issues to consider if CPC is designed in that way.

In the next few slides, we'll discuss in more detail a number of issues that arise for dually-eligible beneficiaries if Medicare is to operate as a CPC system. Among the issues that need to be considered are the lack of uniformity across the States in Medicaid's coverage of Medicare cost sharing and the lack of uniformity in Medicaid benefits. There's also a question as to whether or not it is reasonable to have some level of separate bidding for dually-eligible beneficiaries, and, depending on how much is expected of plans, are plans capable of serving dually-eligible beneficiaries.

I should also mention that another difference between the Part D model and the CPC system that we have been talking about is that Part D plans bid for geographic regions that consist of entire States or multi-State regions. We have been talking about smaller geographic areas for CPC bidding, consisting of metropolitan areas and
units known as Health Service Areas within States. In addition, plans are not at full risk under Part D, but MA plans bear full risk for the Part A and Part B benefits.

There are a couple of major differences between how Part D works for low-income beneficiaries and what occurs today in fee-for-service Medicare and Medicare Advantage and what the situation is in Medicaid in different States. When Part D took over the Medicaid drug program of the States, it instituted uniform cost sharing for low-income individuals who, depending on their income level, can have nominal copayments as their only cost sharing obligation in Part D. In MA and in fee-for-service, beneficiaries are protected by law from being billed for Medicare Part A and Part B cost sharing -- some beneficiaries, anyway. Medicaid pays such cost sharing, but the amount that Medicaid pays providers is often below the amount that Medicare would otherwise allow providers to collect as cost sharing revenue coming from beneficiaries or paid on behalf of beneficiaries that are not dually eligible.

With regard to cost sharing and out-of-pocket costs that can be subsidized for low-income individuals,
here's a listing of those items that could be subsidized. Some dually eligible beneficiaries only have their Part B premium paid, as in the case of the category we refer to as qualified individuals, or QIs. Other beneficiaries have, in addition to premium assistance, cost sharing protections under A and B, as I mentioned.

For the category referred to as full duals, the subsidies include cost sharing for Medicare's A, B, and D benefits, the premiums, and benefits under Medicaid, such as long-term care services and supports, and social services that are not Medicare benefits. Over two-thirds of dually eligible beneficiaries are in the category referred to as full duals. In July of 2012, there were 6.6 million full duals out of 9.2 million dually eligible beneficiaries.

In a CPC environment, the government would presumably continue each of the kinds of subsidies listed on this table.

As I mentioned, there is a lack of uniformity in Medicaid payments for cost sharing under Medicare Parts A and B, and the Medicaid program often pays less than Medicare allows in cost sharing. The consequence of this in the current system is that in fee-for-service Medicare,
providers can decline to accept dually eligible beneficiaries, and in MA, plans may have to pay higher amounts to providers to ensure access to care through the plan's network. Non-dual enrollees may also end up subsidizing cost sharing for dually eligible beneficiaries in MA plans.

There would be similar consequences in CPC in the sense that there is not a level playing field among plans in terms of comparing the bid of one plan to that of another plan. A plan with more dually eligible beneficiaries may have a higher bid than another plan, not because it is less efficient than the other plan but only because it has more dually eligible beneficiaries and is consequently raising its bid to be able to pay its providers more.

A potential remedy for this in CPC is to level the playing field by "federalizing" cost sharing at a uniform level, as was done in Part D. This would apply to both private plans and to fee-for-service, which is a bidding plan in a CPC system. It would be costly to raise cost sharing to Medicare-allowed levels across the States and policy makers would have to deal with the question of how to finance such an approach. In Part D, the federalization of
the drug benefit included a maintenance of effort provision whereby States contributed to the cost based on their historical costs. Other possible options include having the States share in the actual incurred cost. Different options would have different States paying relatively more, depending on how generous they had been in the payment of Medicare cost sharing historically.

A more complicated issue than the federalization of cost sharing is what to do about the lack of uniformity in Medicaid benefits across the States if there is an intention to federalize the benefit package for purposes of having a level playing field in CPC bidding and to have all plans bidding to serve the dually eligible population.

With respect to benefits in taking over the Medicaid drug program, Part D standardized the benefit across all plans, instituting a defined standard benefit for all Part D beneficiaries, for both low-income beneficiaries and other beneficiaries. Plans do not bid on the low-income population as a separate group, but instead a plan bids for all Medicare beneficiaries who might enroll in the plan and whether the plan is at or below the regional low-income threshold determines whether or not the plan will have auto-
assigned low-income enrollees.

In the case of Medicaid benefits such as long-term care and services and supports, there is wide variation across the States in what is covered and how services are provided. The rationale for uniformity in benefits is similar to the rationale for cost sharing uniformity. There would be a level playing field and comparability across plans could be ensured if the intent is to determine the least costly option for the combination of A, B, and D benefits and Medicaid benefits such as long-term care.

As I mentioned with regard to uniform cost sharing, a basic concept in CPC is that there has to be a method by which all plan bids can be compared with each other to determine the lowest bidding plans. A risk adjustment system compares each plan's bid for an average beneficiary. That is, bids are normalized for comparison purposes. That way, the plans that expect to enroll relatively sicker beneficiaries do not have higher bids and therefore, appear to be less efficient solely because they will be enrolling a sicker population.

If all plans are to bid on the Medicaid benefits for dually eligibles, then a risk adjustment model for the
combined set of benefits may be easier to develop if there  
is a standardized benefit package. However, coming up with  
a standardized benefit package is not like standardizing  
cost sharing for A and B benefits. There is wide variation  
in what States cover under Medicaid and there are many  
reasons why there is variation across the States, including  
greater or less reliance on institutional care. Thus, it  
would be difficult to devise a standardized benefit.  

And the financing implications for the States and  
the Federal Government are similar to what they are for the  
standardization of cost sharing. How will this be financed,  
and how different would State obligations be compared to  
what current expenditure levels are?  

If we were to follow the Part D model, all plans  
would bid to cover all populations and the CPC bidding  
process would determine which plans are the least costly.  
As in Part D, for bidding purposes, there would be no  
distinction between low-income beneficiaries and non-low-  
income do not have their costs further subsidized.  

Part D was an expansion of the Medicare benefit,  
but it is unlikely that the Medicare benefit would be  
expanded to cover what are now Medicaid benefits.
Presumably, therefore, plans would bid on the Medicaid benefit to serve only the dual population, though it is possible that the benefit could be offered to non-duals as an optional benefit. Even in that case, though, the option would be very expensive and there would be pricing issues that would have to be addressed to avoid adverse selection.

Another issue to keep in mind that we discussed in the mailing material is that if in a CPC system all plans are expected to be able to serve low-income individuals and beneficiaries may have to switch from their current options to be in fully subsidized plans, we should recognize that there may need to be special attention given to the circumstances of Medicare beneficiaries under the age of 65. While in the recent past, dually eligible beneficiaries have been enrolling in private plans in Medicare in far greater numbers than in earlier years, Medicare beneficiaries entitled to Medicare based on disability, that is, the under-65 population, are less likely to be MA enrollees. Forty-one percent of dually eligible Medicare and Medicaid beneficiaries are under the age of 65, so this is an important issue for the dually eligible population.

So I'll close by restating the opening question,
which is, is it feasible to use Part D as the model for
dealing with low-income beneficiaries in a CPC system, or
should the CPC system be limited to the Medicare A and B
benefits with other benefits dealt with separately? We have
looked at several issues that complicate the situation for
low-income beneficiaries within CPC, including the lack of
uniformity in cost sharing and the lack of uniformity in
benefits that make it difficult to have combined bidding in
CPC. We also looked at different ways combined bidding
might be implemented and discussed whether all beneficiaries
might have access to an expanded benefit and whether all
plans should bid on a combined benefit. We have also
touched on the question of whether there should be standards
for plans to ensure that dually eligible beneficiaries and
the under-65 in particular are adequately served, which is a
point that Christine and Lauren will discuss in their
presentation this afternoon.

Thank you, and I look forward to your discussion
and questions.

MR. HACKBARTH: Okay. Thank you, Carlos. Well
done. It is a complicated topic.

So, let's see, we're going to do round one
beginning with Scott again, because I'm a sensitive kind of
guy and I know he's feeling a little put upon.

MR. ARMSTRONG: There's a benefit to being the

MR. HACKBARTH: Right. Right.

MR. ARMSTRONG: Think about it a little bit.

MR. HACKBARTH: And, actually, let me modify what

I said, Scott, especially given our late time right now.

Let me ask for a show of hands. You may not have a
clarifying question that you want to ask. So we have Cori.

Anybody else on this side? Okay. Cori, you go ahead.

MS. UCCELLO: This was in the text, not the
handouts, but you had three figures in the text of different
scenarios, and the third one had a different government
contribution and I was confused where that came from.

MR. ZARABOZO: What that was doing was there was a
situation where one area had four plans, and then I was
saying, well, let's look at two other areas and use the same
plan bids to see what happens. So one of them, for example,
was $500 and $600 were the two bids, so the weighted average
would be $550. The other example was $600 and $700, so the
weighted average would be a different number.
MS. UCCELLO: So I guess my confusion was, well, I thought these were going to be based on national averages, but it was actually done looking more regionally or --

MR. ZARABOZO: Yes.

MS. UCCELLO: Okay.

MR. ZARABOZO: This is -- the CPC model we've been talking about is local bidding, yeah.

MR. HACKBARTH: Actually, we've said they could do it either way. Obviously, Part D uses the national model --

MR. ZARABOZO: Right.

MR. HACKBARTH: -- but another way to do it would be the local.

Clarifying questions? I have Kate and then Mary.

DR. BAICKER: Just a quick one. When you list as an option making the Medicaid benefit uniform across States for these dual eligibles, does that also imply making the Medicaid benefit for Medicaid non-Medicare people uniform across States, or are you implicitly suggesting that each State would then have two Medicaid benefits, one for the dual eligibles and one for the non-Medicare population?

MR. ZARABOZO: That's a good question.

[Laughter.]
MR. ZARABOZO: Umm --

MR. HACKBARTH: But it's not clarifying, in particular.

[Laughter.]

DR. BAICKER: [Off microphone.]

MR. ZARABOZO: And it is a good -- I mean, you could go either way and say, well, these are two different populations and you would, I mean, it just makes things even more confusing. Now you're saying there will be two kinds of Medicaid benefits.

DR. MARK MILLER: In the instance if you pursued a D-like strategy, then the benefit for the dually eligible would be a Federal benefit and the State would have a Medicaid --

MR. ZARABOZO: And the State could have --

DR. MARK MILLER: -- program for the remaining populations, is the way I had it organized --

MR. ZARABOZO: Yes, that --

DR. MARK MILLER: -- in my head.

MR. ZARABOZO: Yeah.

DR. MARK MILLER: Does that get close?

DR. BAICKER: [Off microphone.]
DR. MARK MILLER: It's a way.

MR. HACKBARTH: Mary.

DR. NAYLOR: Actually, since it was such a good question, I'm going to say that was similar to the one, but I'm now wondering, does the work of the Federal Coordinated Health Care Office to try to align all of these eligibility and benefit programs in States for Medicaid in any way help inform bullet four in the first sub-bullet, you know, what the advantages of combining A, B, D in Medicaid might be, beyond what we've learned from PACE and others.

MR. ZARABOZO: Yeah, and we didn't mention the demonstrations that are going on in this context, but it's very relevant. Is that going to be successful or not, the combination of those things --

DR. NAYLOR: Yes. So, I'm sorry, when will we know that?

MR. ZARABOZO: Well, we have several Memorandums of Understanding signed already, so in terms of knowing the outcomes, you know, a while, yeah.

MR. HACKBARTH: There isn't here, I think, a really important question to which I don't know the answer. This model would tend to -- do all plans need to be prepared
to serve duals as opposed to what is happening in the demos, which may mean that select plans build the necessary clinical infrastructure to deal with dually eligible patients, especially the really complicated ones that have severe physical disabilities or cognitive issues. So are those generalized capabilities that every health plan ought to have, or are they really more appropriately found in specialized organizations? A question. I don't know the answer.

MR. GEORGE MILLER: Yes. I'd like to ask a different type of question for our discussion and that is, notwithstanding that I -- well, first of all, I thought the chapter was very well done and certainly liked the discussion of CPC. But for this population, for these low-income beneficiaries, is the CPC model the right model then to put in things like Part D in, versus the other way around. Is Part D the right model for subsidizing low-income beneficiaries in the CPC? Is there another model that may work better, particularly because of the complexity -- I mean, the extraordinary work that was done in putting this chapter together, I almost felt I needed a Philadelphia lawyer to read it with me to help explain everything that
went through in the chapter. And as a result, for this vulnerable population and all the different things that they need, especially the care coordination, the mental health and all those services, it's just a wonder how they can migrate through all this, the different options and the different things that they would need to do. Is this the best model to help them to do that? That's my question.

MR. HACKBARTH: And that is the question that we're trying to raise at this point, and answering it is a far more difficult challenge.

MR. GEORGE MILLER: Yeah, but the assumption is, at least I think the assumption is that this is the model we should go, and does --

MR. HACKBARTH: No assumptions.

MR. GEORGE MILLER: Well, I would just say, should Part D be part in CPC? So I would think, in my mind, that's a given. We would go with CPC, so shouldn't this work. My question is, is this the right model to proceed for this population?

MR. HACKBARTH: Yeah. So what I meant to say, George, at two levels. First of all, whether CPC is the right model for anybody is an open question. You know,
we're just trying to think through it systematically. And then as we try -- we've done this in a series of meetings now and taken off pieces of it. Now, we've looked at this particular challenge of the dually eligible Medicare beneficiaries and it's sort of a second-level question. Even if you were to do CPC, how do you bring this particularly challenging population that exists now in this dual Federal-State structure into a CPC model? Should you try to do it using Part D, that model as the foundation, or do it the way we do it in Medicare Advantage, which is you have the plans bid and then the State Medicaid programs fill in in different ways, State by State, in accordance with their own rules. Really complicated stuff to think through, and we're just trying to begin the process of thinking through these issues.

Clarifying questions? Peter and then Bill.

MR. BUTLER: I can get you a Chicago lawyer.

[Laughter.]

MR. BUTLER: How do we need to be, if at all, sensitive to and/or coordinate our recommendations with MACPAC? This is as much about Medicaid as it is Medicare.

MR. HACKBARTH: Well, we spent a fair amount of
time with MACPAC on the CMS demos, and so we do recognize
that this has implications for both organizations. We
haven't tried to synchronize positions on things, but we've
shared information, shared perspectives and the like.
You know, if, in fact, we decide to move toward
some recommendations on CPC, this would be an issue that
would be implicated and we would go through a similar
process of talking to MACPAC about our thinking on it. But
in my mind, we're still quite a distance upstream from that.
We're still thinking at a very conceptual level about the
overall issues raised by CPC, and I think it's premature to
go to MACPAC on any particular issue at this time.

Bill.

DR. MARK MILLER: And just for you and for anyone
else, I mean, the staff has briefed -- the MACPAC staff has
been briefed on this and papers shared, that type of thing.
But again, like him, since we're so far from a decision,
we're not up to talking about recommendations or anything
like that.

MR. BUTLER: And I assume that they, too, are very
distant from making any kind of an assessment or
recommendation on this, as well. Neither one of us could be
ahead of each other.

DR. MARK MILLER: [Off microphone.] Yeah. At this point, they may be thinking about the dual eligible issues from different perspectives, and, for example, this afternoon, we'll be approaching it yet again from a different perspective. But, yeah, they're -- but the other thing I would sort of say to you guys is that even if you were to make a decision like the one Glenn just said, it continues to work like MA, in a sense, you've also made a decision to implicate States and Medicaid. You're saying, I'm going to stick with the status quo and the arrangements are going to range there. So any way you touch this, even if you make a decision to say, don't change it, you are making decisions that affect, you know, both Medicare and the States as you do it.

DR. HALL: Just a clarifying point, for what it's worth. CPC is an acronym that's already been taken in the medical world that refers to a specific kind of conference that looks at the sequence of events that led to a misadventure and to a death. Every week, the New England Journal has a CPC conference on the front cover. So you might want to reconsider the acronym.
MR. ZARABOZO: We've actually trademarked CPC here, so you're going to have to stop using it.

MR. HACKBARTH: Henceforth, everybody has to say competitively-determined plan contributions.

On to round two. Scott.

MR. ARMSTRONG: Just a couple of points.

First, I really want to applaud the staff and MedPAC for taking this on. This is an issue that hasn't really been addressed very well anywhere yet, and now I understand why.

MR. ARMSTRONG: I think the questions that you raise are good questions I don't have answers for, but I presume -- this is to George's point -- one alternative that we would evaluate against some other alternatives for handling dual eligibles.

And just the last point I would make is to remind us that serving dual-eligible populations is something we don't do a great job of right now, and it's really complicated. And so it's no surprise that this would be a
particularly complicated part of this, given the coordination issues and so forth.

But I think the work you've done sets us up to explore specific implications of a very complicated section in this overall idea. I think it will advance our work, but I think it's hard to draw too many conclusions right now.

DR. REDBERG: It's hard to follow Scott. I appreciated the discussion. I think it is a very complex issue, and I'll look forward to continued discussions.

Just on the points for discussion, it does seem sort of common sense that there are some advantages to moving towards a uniformity in benefits across states as Part D -- appreciating that there's historical complexity to it, or at least having uniform national tiers of benefits across states so that it did allow for some flexibility in choice.

That's all.

MS. UCCELLO: Well, the chapter states that one of the objectives is to highlight the complexity of the issues. You have more than succeeded.

[Laughter.]

MR. ZARABOZO: Is that a compliment or --
[Laughter.]

MS. UCCELLO: It's meant as a compliment. The chapter is very well written. You know, it's not confusing in that respect. But there are so many things that it's just really difficult to get my head around, and I read it twice, and I'm still kind of struggling with things.

So what I did was try to kind of step back and think about things in terms of principles and what kinds of things do I think matter when we think about this. So I thought about how, you know, I'm comfortable making beneficiaries pay more for more expensive choices. But the caveat especially here is that if the choices we're talking about meet beneficiary needs. So that argues then for the comparison to include the Medicare and the Medicaid benefits when we're talking about this.

And in terms of pooling and segmentation and, you know, how -- do we have different rates for one group than another, I generally favor as much pooling as possible. And when we think about potentially offering some of these long-term-care benefits for the non-duals, the actuary in me, you know, I'm screaming, "Oh, my God, oh, my God." This is, you know, adverse selection galore here. So, I mean, I think
we'd have to be very careful with that kind of thing

So just generally, you know, I look forward to us

thinking through this more, but, again, fantastic job in

just showing how many questions need to be addressed if we

move forward on this.

DR. SAMITT: So great job with the chapter.

Thanks.

You know, as I look through the issues to discuss, my first instinct is to say, well, it kind of depends and, you know, to break them apart. You know, while I think that a Part D-type model has great appeal to it, federalizing this, you know, works in one setting, why would we not have standard benefits and standard cost-sharing methodologies and so on and so forth. That's sort of the optimal approach. But what makes it that I used the language "it depends" is, while it's an optimal approach, is it a realistic approach? Is that something that we could actually recommend and have it implemented?

Likewise, for the second part about segmentation, for me that depends because it will -- how will the plans respond, and how will the providers respond? And, you know, caring for the dually eligible population has great
opportunities for systems that are successful, and care coordination and value-based care delivery. And so will we see a lot of desirability of dual eligibles? And if so, I don't think we should segment them. We should keep them together. But if we are concerned that this population will be less attractive to some plans, then maybe we sort of need a bidding process for Medicare-only and a separate bidding process for Medicare or Medicaid duals. And I don't -- and whether there's some kind of variation on the theme, that it really should be a separate segmented process just to make sure that folks have an opportunity to bid separately, look at the populations separately, and that we have ample participants in both sets of plans.

DR. COOMBS: So my only concern is the federalization and lumping things together, and I think there was some sentence within the context of this that spoke to the plans having difficulty with the dual eligibles.

My first reaction was: Why not have the bidding as a uniform bidding for everyone? But I know that there are some selection issues and there are some issues of overall cost. And the payment-to-cost ratio changes
tremendously in terms of managing these specific patients. So I would say that the demonstration projects that are going on right now are going to be invaluable. I know that Massachusetts has one, and some of the strategies they are employing I think are very helpful for the rest of the states to kind of look at. But Massachusetts in and of itself is very unique with -- it wouldn't be translated to some other states in terms of their challenges.

So I think that while it may be helpful to look at them in terms of some recommended innovations for other states, it may not be the end-all for some of the states in the South who have matching that's significantly different than Massachusetts.

DR. CHERNEW: I agree with all that has been said, explicitly the extent to which you've laid out an exceptionally complex topic, and I think it's just a broader illustration of how hard it is to figure out how to deal with aspects of the duals and cost sharing in different ways in the Medicare program. And my general feeling is we deal with this issue -- even apart from the CPC, we have to deal with this issue for the reasons that Alice said and how we deal with different -- where Medicare and Medicaid rub
together, and when that doesn't work very well, how we might deal with it.

I guess my general feeling is -- and I have no particular answers -- I would start with the premise that we do it the way that's sort of the most straightforward, which is not like Part D, you just have them bid on the A/B stuff, and then ask what are the particular problems that arise, for example, the auto-assignment to the lower-priced one. You raised a bunch of ones. That's just one. And then say what's the best way to deal with that problem that arises, and it might be some of the things that have been said. I just in complete honesty have not gotten my head around, A, the complete magnitude of the problems that arise, and then what the best possible solution is. But I think there are so many complexities with CPC, there are so many complexities with the Medicare Advantage program and the Medicare and the duals in general, how those things fit together, that when you take two really complex things and put them together, you end up with the type of comments that Cori made, which is you have done a great job of explaining how complex it really is. But it's hard, at least for me -- and it sounds at least on this side of the table for others
-- to really enunciate exactly what the clear answer should be, and that's certainly where I am.

DR. BAICKER: Yeah, agreed that the bigger danger seems like creating new benefit structures and infrastructure for segmented parts of the population layered on top of, you know, special needs plans and state demonstrations and MA and ACOs and all of these things we're -- to the extent that we set up different benefits, different rules, different premiums in pricing, that I think just multiplies the opportunities for failure of coordination and also confusion in coordinating benefits. So this all seems potentially problematic. So good luck with that.

DR. NAYLOR: So I have a daughter who's a Philadelphia lawyer, and she would not have appreciated the complexity of this.

[Laughter.]

PARTICIPANT: [off microphone].

DR. NAYLOR: Not at all. Great, amazing job. I do think that this conversation represents an opportunity, and the conversation that we'll have later, to really highlight both the complexity and vulnerability and multiple
dimensions of a challenge of the dual eligibles and maybe some potential solutions. So I don't see it exactly in the same way.

We know that we have good models, such as PACE, that have show how funding streams for Medicare and Medicaid can result in better care and outcomes for dual-eligible populations. And there are a number that think that, you know, this artificial connection between long-term services and supports and health care services have created some of the barriers to the great outcomes that are possible for this population.

So I think thinking about Medicare and federalization of Medicaid benefits for this population, not for all, not for non-duals, et cetera, but for the 9.2 million and especially for the 6-some million that are dual eligibles, is a really interesting opportunity.

The issue of choice is always a challenge, and I think it's an opportunity because I don't think every system is really going to be well equipped to be able to develop the expertise that is essential for this population. And so you allow then through these programs for the competency and infrastructure and all to be really focused on the
complexity of the care needs.

But the second thing is that we might want to think about then if we do this, how do we advance choice even within a market, so not just one plan or one system that's doing this, but maybe a couple that we hold accountable for and spur their -- create the incentives for them to build support for these programs.

I hope that made sense.

MR. BUTLER: I feel so much better. I knew it was above my pay grade, but when it's above Cori's, we all feel better.

[Laughter.]

MR. BUTLER: What strikes me, though, on this is that -- I'd make a comment on how to proceed, but this one is highly political for at least two reasons. No matter what we recommend, it's going to move money across states, dramatically, potentially, and, therefore, you've got, you know, one issue there. And, secondly, it seems like most of the recommendations move towards more standardization, more federalization, and so in another level it kind of leans to the left side of the aisle that we might be headed in terms of a recommendation itself. So it seems like a politically
charged one that you need to think through.

So with that in mind, among other things, I like Cori's idea of a guiding principle. So if we can have a clear definition of the problem, the criteria or guidelines against which you would evaluate the options, put more than one option on the table and talk about the implications, I think the menu of this is a better way to go than trying to say, okay, we want to federalize this piece, or we want to do this piece. And so the framing of it, and then let the political process do what it will, it seems like a little bit more realistic way than trying to get too precise on a specific recommendation.

DR. MARK MILLER: And I just want to say again for the public, this is discussing one option. We're not up to recommendations. I know you were using that term generally, but we're not up to specific recommendations.

And, for example, in the afternoon session, we'll be talking about how to deal with the dual eligibles in the MA context, and in a sense that's sort of the other approach. And so we couldn't pack it all into one thing because then even Cori would have exploded, and we wouldn't have been able to -- so there is sort of another thought on
this that will come up in the afternoon.

DR. HALL: I agree with the discussion that we've had, and I also -- I think I learned a lot from this, but I'll have to read it a number of times. But the reason that the brief is complex is that this patient population is extremely complex, and it represents by far the most vulnerable of vulnerables in the entire Medicare system. And so the challenge is for us to figure out how to work through the complexity. But I'm sure we'll do that next month.

Not next month. Next year [off microphone].

MR. GRADISON: One of the things that struck me about the Medicaid population over the years as compared with -- Medicaid as compared with Medicare is that, in general, as I understand it, people can cycle and do cycle on and off Medicaid from month to month. Now, that may not apply to this particular segment of the Medicaid population very much, but I'm not saying that it won't. Once you're under Medicare, you're under Medicare. And how that additional complication might figure into this is something that boggles my mind, I'll tell you.

Peter raised a point that I was going to raise,
and that is that if we talk about federalizing this part, why not federalize other parts of Medicaid? Why should there be all these variations from state to state? After all, people are people, they have health care needs, and they should be taken care of, regardless of where they live. And I just think that the -- I'm not saying it's a bad idea, but I don't see it being resolved just on the basis of how to make the Medicare program operate more smoothly and efficiently and in the interests of beneficiaries. I think it's a very difficult political issue.

One of the realities, as I understand it, of what's going on right now and has over the years is that at the state level these programs continue to -- Medicaid changes very dramatically. From time to time, the benefits are changed in various directions state by state, but more importantly, today there's this move towards moving at the state level beneficiaries, Medicaid beneficiaries on a mandatory basis into managed care. That's very dramatic.

And that also, I think, affects the environment in which we're operating, because we don't do it that way and are unlikely to in the future.

So, in conclusion -- and please don't throw
something at me for this. I'm just trying to indicate my uncertainty about what to move. I think our premise ought to be subject to a lot more discussion than we've had so far, the premise that this division should be resolved on the Federal side rather than on the state side. Or to be more specific, the question comes to me, comes in my mind: What about trying to figure out a way in which Medicare makes a payment to the states to assure that the states can provide the Medicare level of benefits to the dual eligibles rather than trying to figure it out the other way around?

DR. HOADLEY: So, yeah, as others have said, this was a very complicated chapter that was well put together, and I particularly liked your presentation here today because I think you really set it up well to try to make it clear in what was complex.

I find myself going down a path that says if we're trying to do this kind of a model, it does tend to lead you towards the need for the uniformity. I think without the uniformity in the wrap-around coverage, it's very hard to think about how you do this without creating some very strange outcomes.

But having said that, I think when that was done
in Part D, it really started from a far more uniform base.

For most Medicaid beneficiaries, they had drug coverage, they had almost no cost sharing or no cost sharing. In some cases they had some limits on the number of drugs or some formulary things going on. But the basic core of the benefit was pretty similar state to state, and so you could federalize it, you could standardize it, without creating a lot of disruption. And then you did have that whole clawback system, and the question of the dollar values became a point of contention but actually didn't end up with nearly as many issues over time as it did in people thinking about it. So this is going to be a lot harder to think about how to make things more uniform, if that's the way to go.

I would also say that I think the issues around things like the duals demos and the delivery of care, I mean, I think it's appropriate that we're separating those discussions today because a lot of those are just about how do you better deliver care to a complicated population with particular needs and low incomes and all that, and in things like dual demos, they're done within one state where you don't have some of these other issues and you're not trying
to impose a bidding system on top of it. So I think

separating out the issues around trying to do a bidding

system from just what it means to deliver care in a better

way to this population is a good separation. I think

obviously we'll have to intersect at times.

You know, from what I've looked at on the Part D

program, there are two comments I want to make about how it

relates.

One is that even though Part D is set up to be a

bidding system where everybody bids on the entire

population, there is a fair amount of effective segmentation

that actually occurs within Part D. For an awful lot of the

plan sponsors, but not all of them, their basic plan is

sometimes 80 to 90 to 95 percent low-income subsidy

patients, enrollees; and their enhanced plan is the

opposite. So for at least some of those -- it's not true of

every sponsor, but for probably a majority of the sponsors,

there really has been a segmentation, and we've had

scenarios where sponsors, you know, seem like they want to

get that population, and other years where they seem like

they don't want to get it. But there's definitely a kind of

a segmentation that occurs even in a structure that wasn't
supposed to be segmented. So I think that's something to bear in mind.

The other goes to this whole thing on choices and constraints on choices and the idea that -- there's a couple ideas here. One is there's this churning because every year when different plans qualify as the benchmark plans for which there will be no premium, there's a whole set of people reassigned, auto-reassigned every year, and so there's a lot of churning and disruption for that population in order to try to maintain choice but keep them in the cheap plans. But we also the phenomenon where we have as many as a quarter of all the LIS patients actually not ending up in a benchmark plan and paying premiums. If that were because they're making informed choices that it's worth paying another $5 or $10 or $20 or $30 a month to get the kind of plan they're in, that would suggest that system is working well. But I think we think that that's probably just, you know, at one point they made a choice and now people are sticking -- they don't do their research, and they're kind of sticking to those plans even though sometimes those premiums start to creep up fairly high. Unfortunately, we don't understand very well why that
happens, but it says that even though you're trying to make sure you create a system that keeps people fully subsidized, that seems -- there seems to be a limit to which that works in Part D. And so thinking about how that would play a level of benefits that's potentially quite a bit more expensive, even than the ones that were in expensive plans, they may be paying, you know, $30 or $40 a month, which is a lot of money for a low-income person, but in a full A, B and D kind of world, that's going to be more dollars if they end up in the "wrong" plan, the non-subsidized, the non-low-option plan. And because people tend to be pretty sticky and don't do their research, there's a fair expectation that that could happen.

So I guess I'll stop with those points.

DR. NERENZ: Well, as others have pointed out, there's a lot of very much complexity and detail in the chapter, and it took a lot of thought to lay that all out for us. And so in reading it, I was trying to sort out for myself how much of that complexity is absolutely essential and really must, must be addressed to go down this general path at all. And how much of it is based on certain like intermediary choices where you choose a certain branch path,
and then once you've done that, now no problem?

So I want you to follow just one little line of thinking, and then ultimately I'll get to a question. We start on top of page 10. You've got a table that's in the chapter suggesting that right now certain subsets of the dual population are in Medicare Advantage and even in some cases at higher rates than the general Medicare population. So something right now is working. That's fair.

Okay. Now we go to Slide 9, which I think, if I'm tracking correctly, sort of captures the essence of the problem, that why is a lot of this complexity in there. It's because if you move to this defined contribution and then you bring with it some fee-for-service payment policies, you have problems with access in the sense of providers won't accept the payments that are coming. At least was I was tracking through, that struck me to say here's the problem we're trying to solve, and then we get, you can federalize cost sharing, you can ask plans to bid for the whole package of Medicare and Medicaid, a lot of things you can do that are sort of options.

All right. Now, then I go to page 12 in the report. Sorry to keep flipping back and forth, but I think
this hangs together. There was a very surprising sentence there that I marked when I read it. It says, "In the majority of states, Medicaid payments are limited to the total amount provider receives, which includes Medicare payment and any cost sharing, cannot exceed what Medicaid would have paid."

Now, I'm in a state where Medicaid payment is lower than Medicare payment. This was a very surprising thing to me when I read it. I almost wondered if it was a typo. I thought a limitation would perhaps cap at what Medicare would have paid, but I was very surprised to see a cap at what Medicaid would have paid. So this now is my anchor. Is this somehow the root of a whole lot of the rest of this?

MR. ZARABOZO: What it is, once Medicare has paid -- if the amount that Medicare paid is above what Medicaid would have paid for the same service, the state will not pay any cost sharing that Medicare otherwise would allow.

DR. NERENZ: Somehow I read this sentence to be that the total provider payment was actually going to end up in a Medicaid rather than Medicare --

MR. ZARABOZO: To answer the question whether or
not we will pay any cost sharing, we will look at the Medicare payment and see if it's more than we, Medicaid, would pay. We will not pay cost sharing.

DR. NERENZ: Okay.

DR. MARK MILLER: [off microphone].

MR. HACKBARTH: So if the fee is $100 for a service and Medicare pays 80 percent of that fee, so that means Medicare cuts a check for $80, and then this is a dually eligible patient in one of these -- I think it's 34 states -- limits the payment the way this sentence describes, they compare the $80 to their Medicaid fee for the same service. If the 80 is higher than the Medicaid fee, then they don't pay any cost sharing.

[Off-microphone discussion.]

DR. MARK MILLER: And just one quick point. This is a choice a state can make, and 30-some-odd states have made it. It's not a requirement -- you know, it's not a requirement. They can choose to do that.

DR. NERENZ: Okay. But at least up to that question -- I'm sorry. I then misinterpreted that sentence. The fundamental problem in this that the rest of the complexity would try to solve would be basically the problem
with provider level access, providers being willing to accept patients -- duals as the prime example -- who would come through this program. Okay.

MR. ZARABOZO: And then within the MA program, because you have a network adequacy requirement, you have to have providers accessible. So it's sort of a different situation in MA as to whether I as a provider will say, yes, I'm willing to participate, I recognize the state is not going to pay any cost sharing, and you can pay me just like they're paying me in fee-for-service, that's fine with me, versus a provider that says, well, wait a minute, I'm dealing with duals and non-duals in your plans, the non-duals are paying cost sharing, I want cost sharing coming from the duals also.

DR. NERENZ: Right. But, conceivably, if one fairly direct path to solving the problem would be for states to back off of this policy and say that we will pay cost sharing for low-income beneficiaries to at least raise the payment to the non-dual Medicare rate and address that problem. That would be a way to do it.

MR. ZARABOZO: That's the point about -- yeah, it would be to raise it to the Medicare level, yeah
MR. HACKBARTH: Okay. Two comments -- one specific to the duals issue and then one more broadly about competitively determined contributions, not CPC. And the second comment is more for the audience than for the Commissioners.

On the duals issue in particular, when we worked through the duals issues earlier as part of considering the demos that are now beginning to be created in CMS, one point that seemed really relevant to me is that, first of all, the duals are not a uniform population. One of the challenges dealing with duals is, in fact, it's a diverse population. Some people are duals simply because they're poor. Other people are duals because they have really severe either physical or cognitive issues. And if the question is just poverty, that's relatively easy to fold into a system like CPC. Relatively easy. But when you're talking about people who are either physically or cognitively limited in very significant ways, I think the issues really aren't insurance issues anymore. You know, the critical question is not can you get health plans to bid on them. The question is: Can you get care delivery organizations that are capable of meeting the very unique and demanding needs of this
population or these populations?

And so to think through how you deal with that segment of the duals, which accounts for a lot of the dollars, and the most pressing quality problems through an insurance mechanism, you create bidding, it really seems like a mismatch to me. And this is one of the reservations I've had about saying to states, well, you know, just find health plans that will be assigned dually eligible beneficiaries and then we're all done with this. I don't think the vast majority of health plans are affiliated with the care delivery systems that the really challenging patients require. That is the critical resource here.

And so the whole -- the Part D models are nationalizing this and treating it as strictly an insurance issue. It seems like the medical care and social service issues for the duals are very different from the drug Part D kind of issues for the duals. And so that's just my feeling about this particular issue.

For the audience, on the broader question of what we're up to, it occurs to me that not everybody has been here for all of our serial conversations on this broad topic of competitively determined plan contributions. What we're
trying to do here is take an idea, sometimes referred to as "premium support" by some people, "vouchers" by other people, "defined contributions" by still other people, and there's a lot of heated, emotional, political rhetoric about it, and break it down into pieces and try to think through systematically what the issues are that need to be addressed if Medicare were to go this way.

We're not doing this with an eye towards necessarily reaching bold-faced recommendations either for or against but, rather, to try to elucidate the kinds of issues that the concept raises. The concept is often talked about in a very abstract, high-level way. To make it a legislative reality requires, though, that you deal with a lot of challenging issues, this being one of them, and that's what we're in the process of doing here.

So, with that, thank you, Carlos. It was a very good job on what is an inherently challenging and complicated topic.

We'll now have our public comment period.

I know you know the rules very well, but let me just quickly repeat them for other people. Identify yourself and your organization, and please limit your
comments to no more than a couple of minutes. When the red
light comes back on, that signifies the end of the two
minutes.

MR. KALMAN: Thank you. I’m Ed Kalman with the
National Association of Long-Term Care Hospitals.

I’d just like to add to this conversation about
Medicaid repricing coinsurance and deductibles. That’s what
they call it. There’s a Federal statute that allows that.

What I want to point out to you is when they
reprice, they create a Medicare bad debt. And the Medicare
program pays their percentage of that bad debt. It’s a
declining percentage, you know, it was 70, it’s down to 65.

So it’s not like providers have disincentives to
treating these populations. I think the real problem,
because I’ve been very much involved in this -- I represent
clients -- is that the decrease in the percentage that
Medicare is paying, the allowance of bad debt, has the
premise that providers can be better at collecting their bad
debts.

That is quintessentially not the case for the
dually eligible population because they’re certified not to
be able to do so.
So perhaps it would be a good Federal policy to treat the bad debts created by state repricing, which was permitted by Congress on a different basis.

Thank you.

MR. HACKBARTH: Okay, we will adjourn for lunch, and we will reconvene at 1:25 p.m.

[Whereupon, at 12:25 p.m., the meeting was recessed, to reconvene at 1:25 p.m., this same day.]
MR. HACKBARTH:  Okay.  It is time for us to begin.  The first session this afternoon is "Preparing private plans to better serve dual eligibles."  We are ready to go.  Christine?

MS. AGUIAR:  Today we will begin a discussion on identifying strategies to prepare private plans to better serve dual-eligible beneficiaries.  First I'll go over the context for this project.  As you know, dual eligibles receive Medicare and Medicaid benefits.  The dual-eligible population is diverse, requires a mix of services, and their care is often uncoordinated.  Over the past few years, the Commission has been focusing on how to improve care coordination for dual eligibles through programs that coordinate Medicare and Medicaid benefits.  Throughout this presentation, we will refer to these programs as Medicare-Medicaid coordination programs, or MMCPs.

These programs are typically operated by private health plans that receive capitated payments and are financially at-risk for the services they cover.  MMCPs have the incentive to improve care coordination.  As a reminder,
the Commission recently recommended that D-SNPs that are
MMCPs be made permanent and that the authority for all other D-SNPs be allowed to expire.

The problem, though, is that there are few MMCPs, and, therefore, most Medicare Advantage or MA plans do not have experience managing the full range of services for dual eligibles in a capitated environment. The Commission raised concerns about the readiness of MA plans to serve dual eligibles in a comment letter to CMS on its financial alignment demonstrations and in the June 2012 report to Congress.

In light of the Commission's concerns, we are now beginning a discussion on preparing MA plans to better serve dual eligibles. Our intention is to identify strategies that MA plans can implement over the next few years to improve their readiness to serve this population.

This slide gives an overview of today's presentation. First, we will walk you through background information on dual eligibles, including an overview of Medicare and Medicaid spending. The purpose of the spending data is to remind you of how costly the dual-eligible population is and to highlight how certain types of service
use affect spending.

Then we will discuss findings on key practices of MMCPs from interviews with stakeholders in five states. At the end of the presentation, we will review options for the Commission to proceed moving forward in identifying strategies to prepare MA plans.

Now I'll turn it over to Lauren.

MS. METAYER: Dual eligibles are able to enroll in both Medicare and Medicaid in a variety of ways. In general, for those under age 65, individuals who qualify as disabled under Social Security Disability Insurance, or SSDI, become eligible for Medicare benefits after a two-year waiting period. Those who are age 65 and older are generally eligible for Medicare by virtue of their age.

Individuals under 65 and age 65 and older may also qualify for Medicaid if their income and assets are low enough to meet Medicaid eligibility. Or if they incur high medical expenses, they can deduct the cost of the medical care from their income and spend down in order to qualify for Medicaid. The spend-down population is referred to as the "medically needy" pathway. However, the medically needy pathway is an optional Medicaid eligibility category --
meaning that states may decide to cover or not to cover this


group of individuals.

For example, Mississippi has no medically needy
category to qualify for Medicaid benefits. However, in
Maine, a person who has spent down his or her monthly income
to about $1,000 through high medical costs may qualify for
Medicaid through the states medically needy program.

While there are many different ways a person may
become eligible for Medicare and Medicaid, dual eligibles
may be broken down into partial-benefit and full-benefit
dual eligibles.

Partial-benefit dual eligibles have limited
incomes and assets, but their income and assets are not low
enough to qualify for full Medicaid benefits in their state.
These dual eligibles receive assistance with their Medicare
premiums and cost sharing and no other Medicaid benefits.
They are also eligible for the Part D low-income subsidy.

Full-benefit dual eligibles are eligible for all
the services that Medicaid covers in their state, including
long-term care services and supports, as well as assistance
with their Medicare premiums and cost sharing. About three-
quarters of dual eligibles are full benefit and the
remainder are partial benefit.

More information about partial- and full-benefit
dual eligibles is available in your mailing materials, and I
am also happy to answer any questions you may have.

Medicare is the payer for dual eligibles' primary
and acute care services, and they are eligible for the same
Medicare benefits as non-dual-eligible Medicare
beneficiaries.

Dual eligibles also receive Medicaid benefits,
including services such as assistance with their Medicare
cost sharing, coverage for inpatient hospital services when
Medicare Part A coverage is exhausted, and also vision and
dental which wrap around Medicare services.

Further, Medicaid covers long-term-care services
and supports, or LTSS, for a broad range of services
provided in institutions or in the community. This includes
nursing home care, home health care, and home and community-
based services, also known as HCBS.

Lastly, Medicare and Medicaid covers behavioral
health services for dual eligibles, which include mental
health and substance abuse services. In general, Medicare
covers partial hospitalizations and visits to behavioral
health providers, while Medicaid services generally include social work, personal care, rehabilitation, and preventative services.

Now I will turn to our analysis on dual eligibles' demographics and spending. There is more data in your mailing materials than I will review today, and I'm happy to answer any questions you have on any of the data. Note that the data we'll discuss today excludes dual eligibles enrolled in Medicare Advantage plans and those with end-stage renal disease.

In 2009, dual eligibles were more likely to be minorities than non-dual-eligible Medicare beneficiaries. However, please note that the data in your mailing materials undercounted Hispanics, and we will update this data in a future draft of the chapter.

Moving on to spending, combined Medicare and Medicaid spending totaled $172 billion on dual-eligible beneficiaries, and average per capita Medicare and Medicaid spending totaled just over $29,000. Dual eligibles age 65 and older accounted for more Medicare spending as well as higher per capita Medicare spending than those under age 65.

For all dual eligibles, Medicare accounted for
more than half of combined Medicare and Medicaid spending. Assuming an average federal match of 60 percent, total federal spending on dual eligibles was an estimated $141 billion in 2009.

We also segmented dual eligibles into users and non-users of LTSS, which includes both institutional and community-based services. The majority of dual eligibles, or 66 percent, were not users of LTSS in 2009, and Medicare accounted for 83 percent of combined spending on these dual eligibles. For the 34 percent of dual eligibles who were LTSS users, Medicare accounted for 40 percent of their combined spending.

Lastly, we also analyzed spending on dual eligibles with a severe and persistent mental illness, or SPMI, which we define as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and paranoid disorder. The SPMI population is a subset of the behavioral health population. In 2009, about 16 percent of dual eligibles had at least one SPMI condition. There was a higher prevalence of SPMI among dual eligibles under the age of 65. This is expected because having a disabbling mental health condition can qualify an individual for SSDI, which,
as I explained earlier, is the main pathway to dual-eligible status for individuals under age 65. Medicare accounted for more than half of combined spending on the SPMI population. The literature suggests that Medicare and Medicaid Coordination Programs, or MMCPs, can reduce utilization of certain high-cost services, such as hospital and nursing home utilization, but the Medicare and Medicaid programs may not realize savings from the reduced utilization.

With respect to Medicare, capitated MMCPs are paid through the MA payment system; whether they reduce Medicare spending depends on how the capitation rates compare to fee-for-service. Currently, Medicare spends more on beneficiaries who enroll in MA plans than the program would have spent had the beneficiaries remained in fee-for-service. However, payments to MA plans are projected to be closer to fee-for-service spending levels in 2013 than they were in 2012.

With respect to Medicaid, savings may be possible by shifting beneficiaries that use LTSS services out of nursing homes and into community-based settings. This is referred to as state's rebalancing their long-term-care system. This shift out of nursing homes and into community-
based settings can occur through MMCPs or through state initiatives that are independent of MMCPs. Much of the literature on the shift of LTSS services out of nursing homes and into the community shows that it can result in Medicaid savings. However, much of this literature looks at per user savings rather than aggregate Medicaid savings. For instance, on a per user basis, Medicaid expenditures can decline if it is cheaper to provide LTSS services in the community rather than in a nursing home. However, total Medicaid expenditures can increase if the nursing home beds of the beneficiaries that shifted to the community are filled by other Medicaid beneficiaries.

Christine will now review the findings of the qualitative analysis.

MS. AGUIAR: Moving on to now to our findings about MMCPs from structured interviews, our June 2011 report described key MMCP activities that are listed on this slide. For the analysis I'll discuss today, we interviewed mostly providers and care managers. We learned more about barriers to care coordination, such as the complex physical and non-physical needs that affect dual eligibles' medical care and dual eligibles' many providers that operate in silos of
We also learned more details on the key practices that MMCPs use to overcome these barriers. As I'm reviewing the key practices over the next few slides, please keep in mind that one possible strategy to prepare MA plans for dual eligibles is for MA plans to adopt these key strategies.

This slide describes one barrier to care coordination. Interviewees consistently described dual eligibles as having more complex needs than non-dual-eligible Medicare beneficiaries. Dual eligibles' physical health can be affected by many medical, behavioral, and social issues. For example, one interviewee described a dual-eligible individual that is paraplegic, lives in a car, is addicted to opiates, methadone, and alcohol, and is diabetic. The interviewee stated that this individual is an example of someone whose needs will not be resolved in a few physician or care manager visits.

One key MMCP practice is providing intensive care management in the community. Intensive care management consists of a number of activities that are listed on this slide.

One is providing high-contact, in-person care that is not limited to a few visits. For example, some MMCP care
managers attend doctor appointments with dual eligibles. Conducting home visits to assess dual eligibles' living situations is another key practice. One care manager described visiting a beneficiary's home to identify why the individual kept missing medical appointments. The care manager realized that the individual was physically disabled, lived on the second floor of a building without an elevator, and could only make the medical appointments if someone carried this individual down the stairs.

Care managers' familiarity with baseline status was also described as important for all dual eligibles, but particularly for those with behavioral health conditions as it enables the care managers to distinguish between baseline behavior and an acute behavioral health crisis.

Finally, interviewees across states emphasized the importance of MMCP care managers being familiar with social services and other resources in beneficiaries' communities. Some MMCPs continually educate their care managers on community resources. As one MMCP care manager stated, she can only be a resource to dual eligibles for the community services that she is aware of.

Interviewees consistently described dual
eligibles' providers as operating in silos of care and not communicating with one another. Lack of coordination occurs between all types of providers and is not limited to transitions between Medicare and Medicaid services. Coordination breakdowns generally occur because providers do not have time to coordinate with one another or because they are not aware of all the services dual eligibles receive.

On this slide, we have another key practice of the MMCPs. In general, MMCPs try to coordinate across all of dual eligibles' providers, including those that furnish services the MMCP does not cover. Sharing health information electronically helps MMCPs coordinate across silos, but the ability to share electronic health information across all dual eligibles' providers is generally not available. To facilitate communication with providers, some MMCPs embed care managers in primary care offices, including FQHCs, or in hospitals.

This slide also presents yet another key practice of the MMCPs. In many states, there are care management resources in the community. Some state or county-based organizations and aging services agencies provide care management to dual eligibles or administer or refer dual
eligibles to Medicaid or social services. Some behavioral health providers and FQHCs employ care managers. The MMCPs in our analysis generally leverage these resources by either directly contracting with them for care management or by coordinating with these organizations.

Finally, I'll note that one of the most consistent findings we heard from interviewees in each state was the unique role that FQHCs play in care coordination for dual eligibles. FQHCs are uniquely positioned because they tend to provide primary care, behavioral health services, and care management, often at the same clinic site. Some FQHCs also offer nutrition, pharmacy, lab, or radiology services. Many of the FQHCs we interviewed were in the process of applying to become medical homes. In contracting with the FQHCs, the MMCPs give their enrollees access to a medical home.

The final section of our presentation focuses on directions for future Commission work to improve care coordination for dual eligibles.

As you can see on this slide, the first option is to adopt the MMCP key practices we just discussed into all MA plans. The goal of this strategy is to support MA plans
in offering better care delivery for these beneficiaries
than is currently available through fee-for-service. Note
that the motivation here is to improve care coordination
rather than to achieve Medicare savings. As Lauren
discussed earlier, although the literature shows that key
activities of MMCPs reduce utilization, there is no evidence
of Medicare savings because of the way MA capitation rates
are set relative to fee-for-service.

There are a number of issues to consider with this
strategy. One is to identify which key activities should be
adopted by MA plans. A second consideration is how to
courage MA plans to adopt the activities. Regulatory
requirements, such as the D-SNP model-of-care requirements,
could be placed on MA plans. Or the plans could be
incentivized through quality measures and bonus payments.

The second strategy is to financially align
Medicare and Medicaid benefits. The separate Medicare and
Medicaid financing streams complicate care coordination, as
the Commission has said over the past few years, and they
result in cost shifting between the two programs.

Unfortunately, the MMCP key activities that we have been
discussing today alone do not fix the conflicting
incentives. One strategy is to financially align Medicare and Medicaid benefits under current law. A second strategy is to financially align those benefits in the context of a CPC system, as you were discussing this morning in Carlos' presentation.

With respect to the current law strategy, there are three main pathways to financially align Medicare and Medicaid benefits: federalize Medicaid benefits, block grant Medicare and Medicaid, or the CMS financial alignment demonstrations. Each of these pathways is complex. I will note some of the issues specific to federalizing to be consistent with this morning's CPC presentation.

For one, Medicaid benefits are expensive. Recall from the mailing materials that 2009 Medicaid spending on dual eligibles was $80 billion. The Medicaid benefits would have to be financed in a way that does not significantly increase federal spending. Second, the Medicare and newly federalized Medicaid benefits would have to managed. Therefore, the care coordination key practices that we've been discussing would still have to adopted by MA plans or through fee-for-service.

On this slide, we also list options for which
Medicaid benefits could be federalized. The options are to federalize all Medicaid benefits for dual eligibles, only payment of Medicare cost sharing, or only the Medicaid benefits for a particular dual-eligible subgroup. Given the Commission's concern about the readiness of MA plans to manage all dual eligibles' benefits, federalizing Medicaid benefits for a subgroup of dual eligibles could be a way for MA plans to gain experience with that subpopulation before all Medicaid benefits are federalized.

This slide summarizes the strategies we just reviewed for your reference during the discussion. This concludes the presentation, and we look forward to your questions.

MR. HACKBARTH: Okay, thank you.

So, let me see hands for round one clarifying questions? Why don’t we start with Herb and then work our way around. Herb?

MR. KUHN: Just a question as we look at the attributes for these plans. How many of these attributes is CMS testing now, in terms of its dual eligible demonstrations it’s doing with some of the states?

And then my second question to that, who is going
to be their evaluation contractor, that’s going to look at this work and give a report on it?

MS. AGUIAR: I will answer the second one first. I believe that it’s RTI, but I will confirm that. And Cori is agreeing, yes. But I will confirm that and get back to you, but I do believe it is RTI.

The second piece of that is, from reading the memorandums of understanding that have come out, it’s not clear exactly how many of these key strategies will be in the state demonstrations, or whether the sort of care coordination strategies or key practices will be consistent across states.

The MOUs really do differ in the amount of specificity about the care model that is written in the MOU. Part of that, I think, like for example in Massachusetts, that population is specifically the under-65 disabled. So the care management strategies for there may be a little different than California where they’re dealing with a much more broader population.

We have not -- we’ve been tracking the MOUs but we have not gone to look to sort of see -- done a count of are these -- whether those key strategies are listed. And they
are sort of also sometimes listed in -- I don’t want to say perhaps a little more general terms than we’re able to really able to determine whether or not the plans are going to be asked to do those key care management activities and how it will be measured or regulated.

MR. KUHN: Okay. And I assume -- so they’ve got the MOUs. Are they doing anything in terms of any terms and conditions with the states beyond the MOUs? Or is that as far as CMS is going on these demonstrations?

MS. AGUIAR: So the way that it’s working is that the first stage is that CMS signs an MOU with a particular state. The second piece, which happens afterwards, is that CMS, the state, and the plans that will be implementing the demonstration sign a three-way contract.

MR. KUHN: [off microphone] Thank you.

MR. HACKBARTH: [off microphone] Okay, clarifying questions. George?

MR. GEORGE MILLER: Yes, please, on slide seven. I greatly appreciate the demographic information. One thing, in the reading, if I remember correctly, even though minorities are more likely to be dual eligible but whites make up the larger block of that. But do we have
defining characteristics of each one of the segments of the population that drives them being dual eligible and the type of care? Is the type of care, is it across the board? Is it specific to any one particular bucket of folks? Or it just hits all segments of the populations?

Any learning that we could derive from it?

Because if it’s lack of care correlation, if it’s poverty, transportation, do we know what drivers --

DR. MARK MILLER: I’m just trying to process the question. Are you saying, does the mix of services differ across demographic groups?

MR. GEORGE MILLER: That’s correct. Thank you.

You worded it better than I did. Thank you.

MS. AGUIAR: We don’t have information on that. I think I would like to think a little bit more about if we could get information on that. I think it would -- I’m just not sure. I’m thinking through this out loud.

I’m not sure if we actually could because the MMCP programs that exist now, they are for particular -- some of them are for either all full benefit dual eligible, some for only the aged or only for some of the disabled.

I’m not 100 percent sure, but I want to see if we
could tease out the demographics of the people that participate in those programs.

What I don’t think we’ll be able to do is to see whether or not they are trying to match up -- whether or not, basically, certain minority racial ethnic groups are getting different types of care management models, which I think was --

MR. GEORGE MILLER: That's part of it. But the other part of it I’m trying to determine, is this just a poverty issue that will cut across any race or demographic issue? Again, could it be transportation? Could it be opportunity? Is it disparities? I’m trying to see if you had the opportunity to do that type of research?

MS. AGUIAR: Right. We have heard -- again, for this qualitative analysis, we looked at five states

MR. GEORGE MILLER: Right.

MS. AGUIAR: North Carolina, Massachusetts, Minnesota, Wisconsin and Florida. They all have these Medicare/Medicaid coordination programs. What I personally found to be very striking finding from that was the limitations and the barriers -- because again, we were speaking to people on the ground, so providers on the
ground, care management on the ground -- were really the same across all of those states.

I mean, for example, some states where they deal with more of a rural population, there was more of a transportation in rural areas issue. But didn’t -- the barriers really, that are associated with poverty --

MR. GEORGE MILLER: Right.

MS. AGUIAR: At least as far as we could tell from our research, were consistent across all programs.

MR. GEORGE MILLER: Thank you.

MR. BUTLER: So on Slide 8, I think you do a really good job of painting a picture of some of the characteristics of not only the patients but the specific interventions that are effective.

This one at the time cites that, in fact, there’s evidence that it makes a difference. And in the document, you say that the studies cited said it looked at overall Medicare/Medicaid spending with respect to that first bullet, but not just Medicare spending by itself.

In the past, when we’ve looked at kind of pilot coordination programs in CMS, it didn’t look like they were showing much results. So this one you say does work. Can
you cite any kind of numbers, in terms of the amount of the
impact of the program? Because it’s kind of fundamental to
whether this is a good idea or not.

MS. AGUIAR: Exactly. So here's the caveat. The
literature -- in this section we're talking about sort of
two different types of bulks of literature. One type of
literature that’s looking specifically at these
Medicare/Medicare care coordination programs, the MMCPs.

Then we also had a section of literature that’s
really just looking at from the Medicaid side when states
who balance from the nursing home to the home and community-
based setting, are there savings to the states?

That savings possibility to the state could occur
in an MMCP or outside of it separately, through state
initiatives. So I just wanted to give you that framework.

MR. BUTLER: Right and that's the way the chapter
reads. So the first one, though, is the one that I would be
interested in.

MS. AGUIAR: Sure.

MR. BUTLER: The one that addressed the
combination of Medicare and Medicaid.

MS. AGUIAR: Exactly, that addressed both. Right.
And so what we have seen from the literature is there definitely has been evidence that these programs -- as Mary said, PACE, which we include in our previous reports, more literature review of PACE -- really does reduce more of the expensive, high cost hospitalization, nursing home use, ER visits.

But the problem for the Medicare program though is that those programs are paid on the MA payment system. So what matters is how those plans are paid relative to fee-for-service, as to whether or not the Medicare program recoups savings from the reductions in hospitalizations.

MR. BUTLER: So my question is how much? If there’s evidence under bullet one that it makes a difference, do we know the delta in terms of is it 5 percent aggregate per capita spending? Is it 10 percent? Is it 5 percent of hospitalization -- is there some number that you can --

MS. AGUIAR: Yes, there absolutely are estimates in the studies and we can get them to you.

MR. HACKBARTH: Okay, other clarifying questions?

MR. GRADISON: Is there any information that you’ve looked at or that’s available at the state level
about how managed care plans that they run entirely on their
own deal with these same issues for people who just don’t
happen to qualify for Medicare? It could be a 64-year-old
non-disabled person or something like that.

This focus seems to be on the Federal side, and
that’s fine and very enlightening. But I just wonder what
we can learn from how the states deal with this with
essentially similar, if not identical, populations that just
don’t happen to be Medicare qualified.

MS. AGUIAR: Sure. So, we -- I guess I have a two
part answer to that.

The first one is we selected Florida to be one of
our states for the reason that Florida does not have really
an integrated program. But they have -- they’re moving
towards one. But what they have now is called the Nursing
Home Diversion Program. So that’s a program that capitates
all of the Medicaid, LTSS and nursing home programs.

So we wanted to talk with them really just to sort
of see from the other side, they have the Medicaid side but
they don’t have the Medicare side. So we did speak with
them, and again it was really just a lot of the same issues
about silos of care and just the need of intense care
management, the need of someone minding the shop across the multiple providers.

We didn’t set out really to look at the Medicaid-only population. We did inadvertently a little bit because, since we were speaking with a lot of providers, specifically a lot of FQHCs and CHS that really do focus on the uninsured, the Medicaid population, and the Medicaid population that may become pre-duals.

And so we were able to hear a lot about just the care coordination, but what’s not working there for them and what some of the Medicaid plans are trying to do if they are operating in markets where there are Medicaid plans. But in our analysis, we didn’t really focus too much on that, since we were trying to keep it from a Medicare perspective.

MR. GRADISON: Thank you.

DR. HOADLEY: I should just mention, I’ve got a project underway that’s looking at some similar issues in a purely Medicaid side, and will have something on that later this year, so we may be able to bring that in a little bit.

MS. AGUIAR: oh, that's good.

DR. HOADLEY: On Slide 2, when you define the term MMCP, is that a term with an official, sort of CMS meaning?
Or is it more of a term of art you’re using, as you’ve described it here?

MS. AGUIAR: Yeah. It’s a term we invented.

DR. HOADLEY: Okay, and that’s fine. I just wanted to make sure that I wasn’t missing another official acronym.

On slide 6, when you talk about the behavioral health services that are not provided by Medicare and provided by Medicaid, I think the examples you use are all sort of non-medical kinds of things and that’s why they’re on the Medicaid side and not Medicare; is that right?

MS. AGUIAR: Yeah. I would say that, as well. And I think also some acute mental behavioral health services that would wrap around the Medicare behavioral health benefit.

DR. HOADLEY: Okay. And last, on Slide 9, when you talk about the interviews you did, are all of those cases where you did interviews in things that are under a Medicare Advantage rubric? I mean, I know you were just talking a little bit about the Florida situation.

MS. AGUIAR: Right. No, they really weren’t. We really tried to go into markets where we knew that there was...
at least an MMCP operating, and then to talk with providers. What we didn’t know really, in selecting the providers, whether or not they were working, you know, basically some of them were working with duals that were in these MMCPs. Some of them were working with duals that were in regular MA. Some were working with duals that were just in fee-for-service.

So it actually did sort of give a nice comparison to hear.

DR. HOADLEY: Good, thank you.

DR. NERENZ: Jack asked what I was going to ask but I’ll ask you to expand the answer.

Bottom of 6, the bullet of behavioral services.

What exactly is the defining line between what Medicaid pays and what Medicare pays?

MS. AGUIAR: Oh for behavioral health?

DR. NERENZ: In that domain, yes.

MS. AGUIAR: In that domain.

I’m going to give you a preliminary answer and them I’m going to check with Dana, who is our inpatient psych specialist.

Lauren, do you have that in front of you?
MS. METAYER: I don't.

MS. AGUIAR: Pull that up.

As I understand, the Medicare piece for inpatient psych services and I believe some outpatient services for psychiatrists and things like that, what Medicaid covers is much of -- I believe a little bit more of outpatient mental health care. Medicaid will cover the mental health services by providers that Medicare won't sometimes.

DR. HOADLEY: So an outpatient visit by a psychiatrist, who pays?

MS. AGUIAR: I believe Medicare pays that.

DR. HOADLEY: Because it’s a psychiatrist?

MS. AGUIAR: Yes, that's what we've heard. And then, beyond that, Medicaid -- and again, it differs by all state, which is why we’re struggling to say -- there’s no blanket of what’s covered. But again, Medicaid also does provide some of these more supportive mental health services such as counseling, rehabilitation, targeted case management, and services targeted towards substance abuse. Which is why we call it behavioral health, because that encompasses both mental health and substance abuse.

DR. HOADLEY: I am just curious, since there is
that divide, is that an area of coordination that we should be paying some unique attention to just because of how there might be some hair split distinction?

MS. AGUIAR: I would be interested in what everyone else thinks about that. I mean, I can say on a state level we have noticed, just from -- we have noticed that that is an area that perhaps warrants further research. It was consistently said in our interviews across all states that the coordination between medical care, physical care, and behavioral health care was just really lacking. And there’s a lot of, I think, consequences of that that negatively affects the beneficiary.

So I would think that that would be an area to work, but again that’s not up to me.

MR. HACKBARTH: Herb, do you want to kick off round two?

MR. KUHN: Thanks, and thanks again for the good work here.

This is a -- if you look at slide 17, where you talk about the two different strategies, whether it’s an MA plan of activities, or whether you financially align the two, I think it’s pretty clear what our objective is, what
we’re trying to achieve. And that is both benefit  
coordination and care coordination of a very difficult  
population, in some cases a very difficult population.  

And so, I’m not sure if I come down on one side or  
the other of which one of those strategies would make more  
sense because both, I can see, could deal with the benefit  
coordination as well as a care coordination. The real issue  
is how best to kind of deal with these non-medical services,  
particularly the social services, for some of this  
population are the ones I keep grabbling with.  

So I don’t think I have a lot to contribute right  
now, Glenn, other than the fact that I would be interested  
in kind of learning a little bit more about both strategies  
as we continue to think about this.  

I think there’s too much at stake here, too many  
dollars at stake, too many opportunities when you look at  
this, to not continue to pursue this pretty aggressively but  
I’d like to hear more about both of these strategies and see  
which one aligns best and which one might make sense. And  
also, learn a little bit more about what some of the states  
are doing as they start to launch some of these particular  
demonstrations that are out there.
DR. DEAN: To sort of follow-up on what Herb just said, and maybe this was more a round one type question. But the experience with supporting care coordination programs in the past has been pretty disappointing. And yet, it appears that at least some of these have been somewhat more effective, although whether there’s an aggregate cost savings I guess is the question. Do you have any sense about why these programs were more effective? Was it because they were more intensive? Was it because of a more select population that really had a lot more needs and therefore were more vulnerable to the fragmentation problems and so forth?

MS. AGUIAR: Yes, and so the programs where we have shown evidence that shows that they do have some good outcomes, which are these Medicare/Medicaid coordination programs and, previously PACE, those programs are almost completely integrated, if not completely integrated. So they do have -- they get capitated payments from Medicare and Medicaid. They cover all.

And from what we’ve heard again from plans through this research, their ability to be able to manage the full spectrum of benefits, particularly the home and community-
based service benefits, really helps them we’ve heard anecdotally to keep beneficiaries in the community rather than go to the nursing home.

And it helps them to be able to provide that more intensive care management, since they are financially at risk for the full spectrum, and to provide that intensive care management in the home or to have more contact with them, that then would prevent a hospitalization as well.

PACE has the additional benefit of being able to really merge the funding, since it is a very small program and it is basically a provider-based program rather than an insurance-based program. And so they are, I think -- I won’t say they’re at a more of an advantage than an MCO but I think why there’s a lot of literature on PACE that shows the positive outcomes is because they’re able to blend these financing streams. They’re able to provide not only the long-term care long-term services and supports in the community that the beneficiaries need but they have flexibility to provide other things that beneficiaries need, as well. And because they function out of a daycare center, there’s a lot of focus on keeping a daily eye on these beneficiaries.
MR. HACKBARTH: So let me ask a question, Christine, about the nature of the evidence we have. So we look at organizations with certain characteristics and there are studies that show that they produce savings or improve quality. How much variation is there around those averages? The reason I ask that is it’s sort of alluring to say there’s magic in a particular structure, whether it’s a financial or a type of care delivery program. But my experience suggests that structures really -- they help. They can facilitate. But execution accounts for a whole lot.

And that’s why I ask, is there -- take PACE as an example. There may be some PACE programs that perform better than others. I suspect that’s true. I suspect that’s true for all of these models.

Could you just characterize the evidence a little bit more?

MS. AGUIAR: Sure. I would say, and again this goes back to Peter’s question. I would like to go back, because when we looked at the evidence, it was sort of to see -- we wanted to come with aggregate conclusions about whether or not, in general, these programs are reducing
hospitalizations, nursing home visits. But we weren’t
categorizing the magnitude of that yet. We have the
evidence, so we could go back to that.

What I will say though is the literature generally says that even though these programs are able to reduce
utilization, that’s not translating into savings to the Medicare program. There are some studies out there that
will put that spin on it. They will say well, you know, this program reduced ER visits by this amount. Therefore,
that’s a savings of blank to Medicare.

But it’s actually really not. It only is if that program was able to then bid below fee-for-service.

And I would just say that caveat, if you come across that research because there is research out there
that would make it seem as if there are savings to the Medicare program itself.

MR. HACKBARTH: One of the reasons I asked is on one of the earlier slides, you said well, if we want to
encourage improved performance, do we mandate particular types of programs, interventions that are proven to be successful? Or do we provide appropriate incentives, major performance as sort of two alternatives?
MS. AGUIAR: Right.

MR. HACKBARTH: I guess I tend to be in the second camp, as opposed to the former. Regulatory requirements to do certain things, you know, I tend to be skeptical about because I think it’s so hard to enforce. Execution counts for so much.

DR. DEAN: You know that is so fundamental, I think. I had the experience a number of years ago where there was a new physician-owned specialty hospital being developed in our area. It’s a structure which I think is fraught with all kinds of problems. It turned out that these guys did a very good job. They delivered care, they were conscious of their social responsibilities. And I wrote to them a while later, I said good people can make a bad structure work.

[Laughter.]

DR. DEAN: I mean, leadership is just so fundamental to show much of this stuff.

DR. SAMITT: So I am exactly where you are on this, Glenn. I think going back to Slide 15, you know, I'm very skeptical about a regulatory solution to adopt methodologies. It presumes that there's a one-size-fits-all
solution, which isn't really the case -- how do you know which tools apply where, and the populations are different.

So I don't think we would regulate this. I think time and time again, you know, in our leadership of health systems, administrative rules don't work nearly as effectively as aligning incentives and rewards.

So of the two strategies -- and I assume that they weren't mutually exclusive -- you know, aligning the financial incentives I think is the thing that has to happen first. I think if we can find a way to address the conflicts between Medicaid and Medicare and really align incentives around population health for that population, focusing on quality and efficiency, you would expect that naturally these plans would adopt all the things they need to do to perform well in quality and efficiency.

So I think financial alignment comes first, and a leap of faith, I would say that organizations will do the right thing when the incentives are aligned to understand what the highest-performing MA plans do for this population and then implement them within their own plans and systems.

MS. UCCELLO: I have a clarifying question first. On Slide 12, when we talk about this barrier, is this a
barrier even for -- the silo issue. Is this a barrier even for duals who are already in MA plans? Or are you talking more generally?

MS. AGUIAR: I can't answer that question directly. What I will say is, again, the providers and community-based care managers that we were speaking with, they were talking about duals that were, again, in these care coordination programs and also on MA and fee-for-service. And so this was as fairly common theme, and so I would think that that also does apply to MA. But, again, that's not something that we sort of specifically asked. But my impression is that it does.

MS. UCCELLO: All right. Thank you.

I agree with financial -- the need for better, more financial alignment, but we do need to think more about these kind of coordination issues because I think they apply not just to the duals, but for non-duals who happen to be high-cost and may need the services that Medicaid provides under duals, but they are paying for other ways to pay. So I think that we need to think about this not just in the dual environment but more generally for those with, you know, high-cost, chronic, or long-term-care needs or things
like that, especially because one of the barriers here is that it's not just -- the coordination isn't just between the Medicare and the Medicaid services and providers, but it's within those. And so, you know, more needs to be done even just within those kinds of services and the transitions between those that are covered by one payer in addition to across payers. So I think that's just something we need to keep in mind as we move forward.

DR. REDBERG: So actually picking up on that theme, dual eligibles are obviously a very disparate population because of the under-65/over-65, the mentally ill. But some of those themes Cori was just picking up on I think are not just true for duals but for all patients, you know, that we have a lack of care coordination. It's certainly true in the Medicare fee-for-service system and perhaps more so because, I mean, I see a lot of patients who then tell me, "Well, my other cardiologist gave me this," and, you know, I mean, I don't even know who these other -- because you can see as many doctors as you want under Medicare, and a lot of patients see many, many doctors, and it's very -- there's no coordination at all, and they don't have a primary care physician who's coordinating.
So I think care coordination, it looked like a lot of the -- or some of the FQHCs that you talk to are moving towards patient-centered medical homes, and that would be an interesting group to look at and see how they're handling the care coordination. Is it going better than those? But certainly the silos issue is important, and communication.

But the other thing, you know, I think it's a very difficult group, and I don't know what the answers are, but part of it is these are -- I mean, the patient example you gave, I mean, these aren't health care. These are big social problems. I mean, in San Francisco, the homeless population know that if they come to our emergency room and they say they have chest pain, it's likely they'll have a warm bed for the night. And you know it's a very expensive way to give someone a warm bed, and you would like to be able to do something else. But they can get admitted to the hospital and stay for several thousand dollars, you know, because they said they had chest pain or, you know, the drug abusers come in and allege pain and get a lot of narcotics. And it's very difficult social problems, and they're very expensive ways to deal with it. But the city doesn't have the same social services readily available for people, you
know, where they really need it and where it would really help them. So it's an incredibly expensive way that really doesn't treat, but you have all of the poverty and depression and substance abuse all kind of rolled into, and a lot of them are in the dual-eligible population.

So I think it's a very expensive and, without kind of addressing the bigger social ills, very hard -- I mean, we can make some improvements, but it's a big social, societal problem.

MR. ARMSTRONG: I will echo many of the points made, in particular this seems a really hard issue to solve. I really do believe -- and I know no one is surprised -- that the best alignment and integration of both care delivery and our payment structures I think can happen through MA plans, particularly when we're talking about such an incredible breadth, as Rita was saying, of places to intervene in promoting better health. And I think it requires great execution, but a good structure helps. And aligning the financial kind of payment methodology with a set of resources and a care delivery system that can go beyond actual health care is to me sort of key to this.

I would just also, you know, in arguing against
regulation, remind us that recently, in the last couple of months, we had a great discussion about SNPs and what works and what doesn't. And I think an important part of that conversation reinforced the fact that part of what's happening with SNPs is there was a lack of flexibility in how the SNPs could work, driven by the fee-for-service regulations that existed already, and I just was being reminded of that as we were looking at this.

The last point I would make is that in my three years as a Commissioner, this seems to be a population of patients that has been the most difficult for us to really identify some, you know, forward-moving intervention, some way of really doing something with this group. And I don't really know exactly why. Is it because these are as much social issues as health care issues that we're trying to manage? Is it because the payment structure is broken between the state Medicaid and the federal Medicare program? Is it because this population of patients is just particularly difficult to manage?

I think it's more the first two than the latter, to be frank. If there is some way that we could convince ourselves solving for that population of patients health
care, actually applied and defined solutions that were much broader to a much bigger swath of our Medicare program, our health care system, might be a path for us to figure out how do we, you know, find the wherewithal to really solve this one. But it's hard.

DR. NERENZ: Just until it came up a few minutes ago, I hadn't really thought about PACE as a potential example of how at least a subset of this group might be managed. But as I thought about it a bit, it seems like it's worth thinking about more. And the PACE programs, as currently configured, probably aren't quite right for this, but at least some general features of that might be considered in the sense that what you've got is not an insurance entity but a delivery system entity that receives essentially full-risk capitation at a fairly high rate, but for a uniquely high-risk, high-cost population, and they step into this because they're good at managing the mix of needs and services.

At that level of description, it seems like that would be a way to think about particularly the under-65 disabled. Now the low-income over-65 might actually just be a more natural fit into Medicare Advantage as we currently
see it. But it would, I think, be worth thinking a bit more about a PACE-like structure perhaps in a direct contracting environment where you don't even go through a plan structure to get there.

DR. HOADLEY: This really was a good paper and I think really sets up a lot of interesting issues, and I find myself resonating with a lot of the comments I'm hearing, including this notion that a lot of the issues we're really talking about are not particular to the dual-eligible population, but they're broader issues about how to encourage more care coordination and the example of the physical health/behavioral health coordination, you know, which I'm seeing in the project I'm doing on Medicaid-only situations, and clearly there are plenty of examples where it would apply in Medicare-only. And I think what we get is that the dual just adds the extra layer of complication, so it is something additional where there may be policy levers that we can address, and that's why it's worth focusing on, because where is it that the two streams of money or the two sets of rules get in the way, but there are a lot of other things that get in the way regardless. And the couple of things that I think about are a lot of the kinds of services
you talk about from the examples you use on the care coordination are the things that aren't necessarily paid for by anybody, and that's where, you know, the capitation model offers promise, because they can figure out it's worth our spending X dollars here to save money there even though X wouldn't have been paid for under either of the separate rules. So that's a sort of good thought, and that's both the time spent, the cost of the actual coordinators, but also the things they want to coordinate to when they're -- about housing and nutrition and things that are kind of out of the scope of programs like Medicare and Medicaid.

On the other hand, you know, there are at least some examples where the extra layer of the plan can complicate things, so people that run into a care coordinator that's coming from the plan and a care coordinator based at the FQHC and maybe another one based in the hospital, all of which are not talking to each other and may be giving contradictory information, and so, you know, we also, I think, have to think about sort of where that plays in.

And, you know, my last comment really goes to this leadership thing and some of the other ways we've
characterized it. But when I've gone out and looked at the programs in our Medicaid project, you know, it feels like you get to certain kinds of organizations or certain kinds of individuals and they've got it working. And then you go to another place, and there's like nothing happening. And is it -- and I don't know that I can -- we're not necessarily seeing that that coordinates to a setting, like inside managed care, outside managed care, and things like that. And, you know, that's the question of: Does it take, you know, the particular kind of leadership or the particular skill or ideas that make it work in one case? And then how do you translate that to the next setting? And how do you say -- you know, and so some of that's getting the financial incentives aligned, but that's probably a necessary but not sufficient condition to make some of this happen. I don't know what the other trigger is that says, okay, how do you take what really works in this setting and make it work over there where nothing's happening.

DR. HALL: I agree with the discussion that has gone forward, and, you know, the term "duals" implies that there's some homogeneity in a population, and that's the antithesis of what this population looks like.
So I think at some point we're going to have to figure out some way of subdividing the duals in terms of their needs and -- their medical needs and their social needs. So it's very different if someone has end-stage renal disease and is 50 years of age or someone who is demented at age 85. I don't know how you would say let's develop a health system that will solve their problems. It's too impossibly heterogeneous. It would be like saying let's take everybody with the letter H and see if we could develop a health care system for them.

So this is a great, great start for us, I think, but I do think we're going to have to segment this in order to really come up with some good solutions.

MR. BUTLER: Okay. So I'll get to one precise recommendation. I usually am concise, and I'll try to be, but I can't -- I want to make one comment. You know, 150 years ago, these kinds of very sick people would often go to the hospital, or the rich would stay home, and you would have a doctor, a nurse, and maybe a spiritual leader, and those were the three people that took care of all of it. And if you did a family tree of, like, nurses and doctors and what they have spawned in terms of a workforce to
coordinate these things, specialists and case managers and
hospice and nocturnists, you name it, physical therapists,
you have an army of people that now have lost sight of, you
know, what you're trying to do. That's just on the hospital
side.

And then on the outpatient side, it's a little bit
the same way. You had a family doctor, and maybe you had
some other social support systems, and then to that we've
had this -- we've made everything into a medical model,
patient care, you know, the patient-centered home and things
like that, we've forced these things into a medical model as
if that's where you're going to coordinate things.

And I think what we're struggling with is, as you
pointed out earlier, Glenn, a little bit, this is an
insurance solution and not an insurance problem to some
extent. And we're looking through the lens -- first,
through the medical model versus the social model, to which
medical services have to be added, is another way to kind of
say this. And Bill, too, has kind of tugged me to the right
today and saying that local villages, local solutions with
the local agencies are going to be probably best positioned
to customize to what that community can and should do for
these kinds of patients.

So that leads me to my one suggestion, and that is, in the Medical Advantage plans, I don't see that -- conceptually it's the model, but the pressures to live within capitated primarily medical payments does not invite particularly national kind of plans to reach out and perhaps partner with some of these other agencies that will help, because that's not in their premium dollars. So I don't see an easy marriage of some of the people that can help in the community social issues just, you know, logically easily fitting inside the Medical Advantage plan and together working for the solution. So I'm a little skeptical about the MA plans being the right model.

MR. GEORGE MILLER: Yes, very briefly, because many of my colleagues have said and we're all around the same issue, and primarily what is best for this population, and then the broader population of Medicare beneficiaries, whatever that model is. But I just want to echo that even though we're addressing the health care issue, so many of the social issues manifest itself to become a health care issue. And wherever we end up, we have got to clearly understand -- I liked listening to Peter talk about what we
used to have 150 years ago, and those who are now there -- I
won't let him forget this. Sometimes they're Philadelphia
lawyers who are there as well. But the ultimate goal is to
find the best solution for the patient, whatever model. And
sometimes we drive processes because of cost, and that
certainly is a consideration, as we look at this segment of
this population of people trying to develop and evolve the
best solution. And, you know, I'm not sure I've heard that
yet and certainly look to hear more information. MA plans
may be one solution, but the question is: Do they have all
of the coordinating efforts and all the resources necessary
to deliver the best care for the best patient at the best
time at the best place?

DR. NAYLOR: So thank you. This was great because
it highlighted, on the one hand, the diversity of the duals
and, on the other, it really captures very eloquently the
challenges some of these duals are confronting every day.
So really great work.

I don't have any answers here. I think that the
one thing that we know -- and this is apropos of Scott's
comment -- is we know right now that the differences in
eligibility requirements, the differences in benefits in
Medicare and Medicaid create unbelievable structural and unnatural barriers for promoting the kind of seamless care that this population needs. And so at least, at the very least, we should be exploring the capacity to use financial policies to eliminate or at least drive down some of those barriers.

We also know -- you know, we talked in one session about this being a care delivery system issue and in another about insurance. And so to Herb's point about what are we getting here, are we going to look for the benefits or the delivery system, and I think we need policies that are going to accelerate delivery system redesign as quickly as possible.

The fact that we could learn so much from this that would apply to the broader population, the pre-duals, the other high-risk Medicare beneficiaries, is I think the way we approach it. This is a population that, if we could figure out how to do it right, could have lessons for a whole bunch of people further down in the trajectory.

The last thing I'd say is that we've worked with some of these groups, and they're different subgroups. So the younger disabled and the kinds of incentives that would
help us to get to better integration of mental health, behavioral health, and physical health for the young disabled are quite different than those for the frail, older adults. And I think -- so at least one way, as Bill has already suggested, is really let's think about these not as duals but as complex people at different points in the trajectory, and we need a different care delivery system. We need a whole system redesign, but different approaches to match their needs.

DR. CHERNEW: Thanks. A lot of this is motivated by the observation that private plans in general don't have a lot of experience with this population, which is certainly true. But I think I'd be remiss if I didn't note that the fee-for-service system, which I guess has been handling them by default for ages, so has a lot of experience, hasn't done all that well. So, you know, the bar we're comparing things to matters, and doing better in these plans is really important. But we're comparing them to a fee-for-service system. And in that context, there's a lot of focus on the coordination potential, gains potentially from coordination, particularly across things like the Medicaid and Medicare services and adding other services in. And I think that
that's wonderful. But I think it hasn't really been emphasized much, not to forget that a lot of this type of system coordination can prevent just flat-out abuses.

So you could do better probably, even if you did none of the wonderful things that they're all doing, and I don't mean to say anything about that, but just removing some incentives to do some not so wonderful other things, I think could be helpful. And we've talked about a lot of those in the context of other discussions we've had.

In the spirit of some of the comments that were made earlier, I'm interested not just sort of in the average effect of these programs, but also the heterogeneity of their effects. I'm very much in many ways with what Glenn said, which is I tend to really dislike detailed requirements for plans to do very specific things. Some of it is because sort of flat-out execution things, but also the environments differ. So, broadly speaking, just because some organizations are successful with a particular strategy doesn't mean making the other organizations pursue that strategy will lead to their success. They're different people, they're in different environments, and there's just probably a lot of heterogeneity.
So in response to sort of what Mary's saying about what we need, there's a real question about who the "we" is in that, and the extent to which the "we" is we need to segment a bunch of things out and we need to change the incentives in the systems and a bunch of things versus allow the organizations with the right incentives and the right setup to then figure out how to segment their own populations for their own environment. And I think that there's a lot of regulatory changes and efficiencies we could probably make, but I tend to be on the side of being less prescriptive and less regulatory about how they have to treat the various populations. And I think --

DR. NAYLOR: And I totally agree with that, but I do think we have some policy options to accelerate them doing that kind of system redesign.

DR. CHERNEW: Right, and I agree, and hopefully that's what we'll explore, which would fit into the category here of the incentives and the quality measures and the monitoring and the removing of barriers that are unnecessary, and I agree.

I should say just in response to something Dave said, and others, about PACE, we had -- I mean, Jennie Chin
Hansen was here, but we had some chapters and work we did on PACE the tone of which was typically how come these things haven't diffused and could they diffuse if they didn't have walls or I don't know how the roof would hold up. But, anyway, the point is other aspects of how they would work. And I think what I took from some of that discussion is exactly this point that organizations that you believe are actually really, really good tend not to be as replicable as one would necessarily like, suggesting that it remains a challenge to figure out how to do a good job. And I think the reason why this chapter is so important is, of the populations that we deal with -- and, of course, there's a lot of populations -- this is a population where there's a lot of money generally speaking, a lot of need for, you know, good care, good coordination, and there's just a lot of -- it's an important population because of the financial and clinical implications, and I don't think we're serving them particularly well now. So I think that is great. And the more we can add suggestion-wise, the more we can set up a system that will enable excellence to succeed, I think the better. But I do tend to come down on the side of being less prescriptive when possible.
DR. COOMBS: So I think that one of the things I'm grappling with is that the quantity of labor and what's necessary to do the best product or the perfect product that everyone is talking about around the table is enormous. And I don't want us to get it twisted in the sense that if there is a need or a disparity in terms of access, in terms of plans coming to the forefront to say, well, you know what, this is an area we really want to focus in. If there's a deficit in that area, it speaks to the fact that whatever incentive out there is not good enough. And at some point you have to say what does the incentive do if you're having such a problem with having providers in the area? I mean, that's like basic in terms of just reimbursements or whatever's necessary to get to the next level.

And it's great, I think, to look at all these quality benchmarks, but if there's so much more rigidity than there is on this side in terms of helping providers get to the next level, then that's an unfair product.

And in terms of the social issues, I think when you think about the social issues, sometimes they can be overwhelming, and sometimes there's overutilization with some of the social challenges. But, you know, I'm reminded
of something someone said in my psychiatry rotation in medical school: "Just because you're paranoid and you think they're out to get you, it doesn't mean that they're not out to get you."

And that is to say, just because there are social issues, there are some prevalent co-morbid conditions that patients need addressing, and the reason why people are working in the silos is because what's necessary to get the coordination of care isn't there. And I think we can pontificate all day long, but unless you put the right incentives there and unless we can help this thing come together with some creative innovations, then we're going to be rediscovering this over and over again and talking about these laudable goals that will not be attainable because we haven't gone to really the people in the village to says, "What's not working here and where can we go to get to the next level?"

And I hate to talk about incentives in the sense that, you know, we're talking about quality on this side, but you can't get the quality unless you have good access, and you can't get the access unless you have the coordination. And there's something missing on this end of
the spectrum.

And I do want to speak to the whole notion of the community health centers. We haven't talked a lot about that, but I think that's another place where we need to kind of look into a dissect, because community health centers take care of a lot of the dual eligibles. And the coordinated programs that are listed here are not from states like Mississippi and, you know, Alabama. They're from really, really nice states -- Massachusetts, Wisconsin, I mean, you know, really. Okay? We're looking at states that have, you know, pretty robust numbers in terms of statistics. And I just want to be honest and transparent in that respect, and I think we talk about this quality, and I think it's really good, and I think it's good to look at the benchmarks. But on the other side, what's not working and why it's not working may have something to do with what's out there in terms of incentives.

MR. HACKBARTH: So this is the Medicare Payment Advisory Commission, and I for one wouldn't be here if I didn't think that payment wasn't important. But I don't think it's the only thing that matters. You know, I think that it's important to try to improve payment policy because
it can encourage and reward good things or it can remove
barriers to doing good things, and those are really
important. But in and of themselves, in and of itself,
changing payment policy doesn't guarantee you good results,
would be my thesis.

You know, look at Medicare Advantage where, well,
you know, we've got the right kind of payment. We've got
incredible variation in performance across Medicare
Advantage plans. And I don't expect it to go away anytime
soon. Other things matter.

That's not to say improving payment isn't
important, but it's not all that matters.

And my hypothesis would be that that's even more
true when you're talking about the most challenging
populations with complex clinical and social needs. Getting
the payment incentives right can be helpful, but it won't
guarantee success by any stretch.

Something that Alice said resonates with me. You
know, when you're working within a care delivery system and
trying to solve a difficult problem -- and certainly dealing
with the unique needs of these patients would qualify --
there are barriers that you face that have nothing to do
with incentives, that are, you know, inherent in the organizations that exist or don't exist and social conditions and other things. And, you know, we need to be realistic that, you know, no matter what we do, even if we could envision a perfect policy and snap our fingers and have Congress enact it, those things aren't going to go away overnight.

One of the -- now I'm going to sort of "new paragraph" and approach this from a different direction. One of the things that always has frustrated me about health care in general is that I think -- I can't prove this, but I think there is maybe less aggressive effort to identify best practices and import them than there may be in some other industries. And, you know, I sort of wonder why that's true. You know, we talk about good models, and I don't want to regulate them for reasons that I said earlier. But, boy, I wish people would be actively talking to one another and trying to figure out what works and learn from it and import it. Yet that seems to happen at a very slow pace within health care. And, boy, I wish I knew what the key was to accelerating that. That might be a real useful contribution if we could figure out how to solve that problem.
DR. NAYLOR: I think that -- a couple of us were on the IOM Learning Health System Study Committee and spent 18 months looking at this, and I do think that there is an opportunity in terms of the kind of payment policy that would accelerate a learning health system, meaning make it an expectation if investments are made, and you show the answer, and even if you can't adopt it directly in your community, you can look at what it does contribute in terms of advancing.

So I don't think we should -- I think we might have an opportunity here to figure out -- Rita was on as well.

MR. HACKBARTH: That's something for us to come back to later on. So thank you all. Good job.

For now we need to move ahead to hospice.

[Pause.]

MS. NEUMAN: Today, we are going to discuss several Medicare policy issues related to hospice care that the Commission has had a longstanding interest in. Much of this is continuing research to support recommendations the Commission made in March 2009.

Over the years, the Commission has been very
supportive of the Medicare hospice benefit. The Commission has felt that it's important for beneficiaries to be able to choose the type of care they wish to receive at the end of life, and the Medicare hospice benefit plays a valuable role in expanding the end-of-life care options available to beneficiaries.

In terms of what we'll discuss today, first, we'll review the Commission's prior research on hospice that led to its March 2009 recommendations. Then we'll focus on the Commission's hospice payment reform recommendation and provide an illustrative example of a payment reform model that would be possible to implement with existing data. Next, Sara will present some new analysis, looking at the issue of hospice agencies with high alive discharge rates. And finally, we'll look at the issue of hospice care in nursing facilities with a focus on aide visits provided by hospice staff in these facilities.

One other item of note. While it's not on today's agenda, we plan to have additional discussion in the future about ways to facilitate hospice use among patients for whom hospice fits with their preferences, exploring things like shared decision making, concurrent care, and other
approaches that you discussed at the January meeting.

So the next few slides summarize the research leading up to the Commission's March 2009 recommendations. Analyses found that from 2000 to 2007, Medicare hospice spending more than tripled. This was partly due to the substantial growth in the number of beneficiaries using hospice, and the Commission viewed the increase in beneficiaries electing hospice as a positive sign of increased beneficiary access to hospice as an option for end-of-life care.

At the same time, some other trends raised questions. We saw rapid entry of providers, mostly for-profits. Average length of stay increased due to increased length of stay for patients with the longest stays, while short stays remained unchanged. And providers with longer stays had higher profit margins.

At the same time, some in the industry voiced concerns to us that a subset of providers were taking the hospice benefit in a different direction from its roots, engaged in business strategies to enroll patients with the longest stays who are the most profitable.

We also had information from a panel of hospice
physicians and executives that suggested that the benefit needed stronger oversight. Panelists gave reports of lax admission practices and recertification practices, and some expressed concern about questionable financial arrangements between some hospices and some nursing homes. At the extreme, we heard anecdotal reports of some hospices engaged in aggressive marketing tactics toward nursing home patients.

All of this led us to examine the hospice payment system. We found evidence that the payment system was not well aligned with the cost of providing care throughout an episode. Medicare generally makes a flat payment per day for hospice care, but hospice visits are greatest at the beginning and end of the episode and less in the middle, making long stays in hospice more profitable than short stays.

So in March 2009, the Commission made several recommendations. First, the Commission recommended that the hospice payment system be revised, and I'll discuss more about that in detail shortly.

The Commission also recommended several steps to increase accountability of the hospice benefit, including a
physician narrative requirement and a face-to-face recertification visit requirement. Both types of measures have since been implemented.

The Commission also recommended CMS conduct focused medical review of hospices with an unusually large share of long-stay patients, and I'll come back to that shortly.

In addition, the Commission recommended the OIG study several hospice-nursing home issues and recommended that CMS collect more data to assist with oversight of the benefit.

Overall, these recommendations sought to make the hospice benefit stronger for beneficiaries, to make payments more equitable for providers, and to reduce the potential for fraud and abuse for both beneficiaries and taxpayers.

This next slide shows the substantial amount of Medicare hospice spending that's devoted to stays greater than 180 days. In 2011, Medicare spent nearly $8 billion on hospice care for beneficiaries with stays exceeding 180 days, more than half of all hospice expenditures that year.

The Commission made a recommendation that CMS conduct medical review of all stays exceeding 180 days for hospices
with an unusually large share of their patients with very long stays. PPACA adopted a similar requirement, but CMS has not implemented it. These data underscore the importance of implementing the PPACA medical review provision.

These data also show that Medicare spent about $2.7 billion in 2011 on additional hospice services for patients who had already received at least one year of hospice care. This raises a question of whether there should be a policy where beyond a certain length of stay, providers would be required to demonstrate a patient's hospice eligibility to Medicare before additional payments are made.

So now to payment reform. The Commission recommended that the hospice payment rate for routine home care, which is a flat payment per day, be changed to be relatively higher at the beginning of the episode and at the end of the episode, near the time of the patient's death, and lower in the middle, and the Commission recommended this change be budget neutral in the first year.

Since then, PPACA gave the Secretary of HHS the authority to revise the hospice payment system as she
determines appropriate in fiscal year 2014 or later. To date, no regulatory action on payment reform has been taken, but CMS has a research contract underway to study the issue and is getting input from an industry technical expert panel. CMS has also sought comment from the industry on potentially collecting data on non-labor costs like drugs, supplies, DME, and also has indicated it is in the process of considering cost report revisions.

Since the Commission's March 2009 recommendation, claims data have become available on hospice visits that allow us to estimate the labor cost associated with visits. Claims data are available on the date and length of visits in 15-minute increments for six types of staff: Nurses, aides, social workers, and three types of therapists. Using Bureau of Labor Statistics data on wages and benefits, we can estimate the average labor cost of visits per day and map out the trajectory of the U-shaped curve.

So on this next slide, we have a picture of what the average labor cost of visits per day looks like throughout a hospice episode. What we have here is the data for all hospice patients who were discharged deceased with a length of stay of exactly 30 days. The blue line shows for
each day in the 30-day episode the average labor cost of visits per day, and as you can see, it's U-shaped, higher at the beginning and end, lower in the middle.

Now I'll add the data for a group of patients who were in hospice much longer, patients discharged deceased with a hospice stay of exactly 150 days. And again, we have the U pattern.

And now I've added a few more groups, and we see consistently a similar pattern.

So, if we combine the data for all patients with different lengths of stay, we see an overall picture of the average labor cost of visits per day throughout hospice episodes. The labor cost of visits is highest on the first day. The cost declined quickly in the next few days, and then declined modestly through day 30. Costs are pretty stable from day 30 onward until they increase in the last days of life.

So, with the labor cost of visits data that you've just seen, it's possible to take an initial step on payment reform. Industry stakeholders point out that these data do not include non-labor costs like drugs, DME, and supplies, and they also do not include chaplain visits. But the six
type of staff for which we have visit data account for about 68 percent of hospices' direct costs. Therefore, we can use the visit data initially to adjust a portion, specifically 68 percent, of the hospice payment rate for the U-shaped curve and keep the remaining 32 percent of the payment rate flat.

To illustrate the potential to revise the payment system with existing data, we've constructed an example of a revised payment system. It's important to note that this is just an example. Within the framework of a U-shaped model, there are a number of ways to structure the details, and this is not meant to say the details should be exactly like this.

So here is what our example payment system looks like. There is a per diem payment that starts higher and declines over the course of the episode and then increases in the last seven days of life. The first column lays out the structure. We've created four different payment rate groups, days one to seven, days eight to 14, days 15 to 30, and days 31 and beyond. There's an extra payment for each of the last seven days of life on top of the rate that normally would apply for those seven days.
And in the second column, you can see the relative rates for the different days in the episode based on the labor cost of visits data you just saw. And then the third column shows the payment rates that result when we use the relative weights to adjust 60 percent of the base rate. Note these rate changes have been calculated to be budget neutral in the aggregate. And the resulting payment rates that you see in that third column range from about $255 per day for the first seven days to $139 per day for days 31 and beyond. The last seven days of life would receive an additional $120 per day on top of the regular rate for those seven days.

And then you can look in the very far right column. You can see how these rates compare to the current flat $153 per day. The rate for days one to seven increases 66 percent. The rate for days eight to 14 increases one percent. The rate for days 15 to 30 declines four percent. And the rate for days 31-plus declines ten percent.

So this next slide shows you the impact of the illustrative payment system. As you can see here in the first column of numbers on the left, the 20 percent of hospices with the fewest patients staying more than 180 days
see an increase in payments of about 6.7 percent. In contrast, the 20 percent of hospices with the most patients staying more than 180 days see an decrease in payments of about 3.7 percent.

And the two columns on the right show you the impact on margins. The payment changes are enough to bring the margins from negative to positive for the quintile of providers with the fewest long-stay patients. The payment changes also bring down the margins for the providers with the most long stays by about two to three percentage points. So, overall, the payment changes would lessen but not eliminate entirely the higher profitability of hospices with long stays.

If we look at the effects by type of provider, the majority of provider-based, nonprofit, and rural hospices would experience an increase in payments of more than two percent, and this is because these hospices have fewer very long-stay patients than the average hospice.

So, to summarize, the effects of the illustrative payment model are in the expected direction, but modest. Larger changes might be needed to eliminate the higher profitability of long stays, but a first step in that
direction is possible now with current data. Additional
changes could be considered later if additional data on non-
labor costs or chaplain visits become available.

So now I'll turn it over to Sara to discuss the
issue of hospice live discharges.

MS. SADOWNIK: We have previously reported on the
frequency of live discharge, and I'll now present our
expanded work, focusing on patients with very long stays.

I want to underscore that not every live discharge
can or should be prevented. There are many reasons why a
live discharge can occur. For example, sometimes patients
revoke hospice to pursue conventional care, and sometimes
patients' conditions improve in hospice. Prediction of
survival time is difficult, and accurate prediction has
shown to be particularly difficult for patients with some
non-cancer illnesses.

However, unusually high rates of patients
discharged alive among some providers raise concerns about
questionable business practices. We heard industry concerns
about some providers that seek patients likely to have very
long stays, even if they may not meet the hospice
eligibility criteria of having a life expectancy of six
months or less. Higher rates of live discharge are one indication of this practice, as providers often discharge these long-stay patients when the hospice incurs liabilities towards the payment cap.

We described our methods in the mailing materials and I can discuss details on question. I'm going to move on now to our results.

In 2010, 14 percent of hospice episodes among all beneficiaries ended in live discharge. We found that live discharge rates vary widely by provider, ranging from 11 percent in the quartile with the lowest rates to 38 percent in the quartile with the highest rates.

Certain provider characteristics were associated with higher rates of live discharge, even controlling for patient diagnosis. For-profit hospices were around 20 percent more likely that nonprofit hospices to discharge patients alive. Hospices above the cap were almost twice as likely as those below the cap to discharge patients alive.

Given our concern with some providers enrolling patients who may not meet the eligibility criteria and then discharging them, we wanted to look at patients with long lengths of stay and their trajectories post-discharge. We
found that long lengths of stay were a key driver of live

discharge. Almost one-third of all patients discharged
alive in 2010 had spent at least 180 days in hospice before
they were discharged.

We also found that most patients who were in
hospice for at least 180 days before discharge went on to
have long survival times after they were discharged,
suggesting that their conditions were stable. Seventy-three
percent were still alive 180 days after discharge, and 56
percent were still alive one year after discharge.

Out of all live discharges, those alive one year
after discharge spent an average 213 days in hospice before
their first discharge, with Medicare hospice payments for
this first episode totaling $1.2 billion.

Again, we found a particular relationship with
above-cap hospices. Patients discharge from above-cap
hospices were over 20 percent more likely to still be alive
180 days after discharge, compared to patients discharged
from hospices below the cap.

While these results underscore the need to ensure
patients meet the hospice eligibility criteria before they
are admitted, some patients with long stays and stable
conditions will remain. We wanted to examine Medicare spending outside hospice for these patients if they were discharged compared to the payments Medicare would make to hospice if they continued to remain there.

We found that average daily spending after discharge was lower than the daily payment rate for hospice care for beneficiaries who had long stays before discharge, consistent with the idea that service use for these discharged patients is relatively low because their condition is stable, and the service use they do have is averaged over long survival.

In 2010, the payment rate for hospice care averaged $156 a day. In contrast, beneficiaries who spent more than 180 days in hospice before discharge had average spending after discharge of only $70 a day.

Furthermore, for patients who died out of hospice post-discharge, spending was concentrated in the last days of life, supporting evidence in the literature that savings are associated with hospice when patients are relatively close to death, but not in the case of very long survival times.

These results emphasize the need to ensure that
beneficiaries continue to be appropriate candidates for hospice throughout long episodes.

Today, I've discussed live discharge trends in hospice patients with very long stays. We found that patients with long stays represent a sizeable portion of live discharges and that long stays before discharge are tied to long survival following discharge. These findings support the need to ensure beneficiaries are appropriate candidates for hospice at admission and throughout long episodes. High rates of live discharge among some providers may indicate questionable business practices. And monitoring live discharge rates among providers could support efforts to improve quality and fiscal responsibility in the hospice program.

Now, I will turn back to Kim to talk about hospice care provided in nursing facilities.

MS. NEUMAN: So now I'm going to talk about hospice care provided in nursing facilities with a focus on the issue of aide visits provided by hospice staff to patients in these facilities.

This issue is motivated in part by a recent OIG study. OIG examined hospices that focus on nursing facility
patients and found that these hospices tend to be for-profit and treat patients with diagnoses that tend to have long stays and require a less complex service mix. The OIG recommended CMS monitor these hospices and that CMS reduce the payment rate for hospice care in nursing facilities.

In making the second recommendation, OIG raised the issue of duplicative payment for aide services in nursing facilities. In the absence of hospice, nursing facility residents receive assistance with activities of daily living funded through nursing home fees paid by Medicaid or by patients and families. When a nursing facility patient elects hospice, the hospice becomes involved in providing assistance with activities of daily living in addition to the nursing home, so there is an overlap in responsibilities between the hospice and the nursing facility in this situation.

When we look at the hospice claims data, we see that hospice staff provide more aide visits in nursing facilities than in patients' homes, and it is not clear why this occurs, since nursing facility residents have access to assistance with their activities of daily living through the facility staff.
The provision of hospice aide visits in the nursing home raises questions of duplicate payment, and one question that could be asked is whether the Medicare hospice benefit should include aide visits in the nursing home setting. Or an alternative way to think about this is it seems reasonable to expect that nursing facility residents receive no more aide visits than patients in the home. Currently, we see patients in nursing facilities receive more hospice aide visits and less hospice nurse visits than patients at home. If nursing facility patients receive similar amounts of aide visits to patients at home, the overall labor cost of hospice visits for all types of visits combined would be four to seven percent lower in the nursing facility than in the home.

So one policy option that could be considered is to reduce a portion of the hospice payment rate in nursing facilities based on estimates of the labor cost of visits in the two settings, assuming equal provision of aide visits. This would yield a reduction to the hospice payment rate in nursing facilities in the range of three to five percent.

In summary, hospice spending on stays exceeding 180 days is substantial, accounting for more than half of
all Medicare hospice spending. This underscores the importance of CMS implementing the PPACA medical review provision. It also underscores the need to make progress on payment reform, as a substantial amount of resources are devoted to long stays that are favored under the current payment system. As shown with our illustrative payment model, an initial step toward payment reform is possible now with existing data. The issue of high live discharge rates among some hospices may signal questionable admitting practices and bears further monitoring. Finally, the provision of hospice aide visits in nursing facilities raises questions of duplicative payment. A policy option that could be considered is a reduction to the hospice payment rate in nursing facilities.

With that, we look forward to your discussion and questions and feedback on future research directions.

MR. HACKBARTH: Thank you.

So, Mary, do you want to begin round one, any clarifying questions --

DR. NAYLOR: [Off microphone.] I have none.

MR. HACKBARTH: Let me see hands going down this way. Peter and then Bill and Jack.
MR. BUTLER: So the OIG study you referenced was actually out of a recommendation we made in 2009, right?

MS. NEUMAN: We made a recommendation in 2009 for the OIG to study a host of issues and that is one study that came out after our recommendation.

MR. BUTLER: Right. I think you mentioned three issues that we asked -- or maybe there's a host, but you mentioned, I think, three in the chapter here. But you didn't mention -- I'm just wondering on this live discharge issue if that is one well worth, you are suggesting monitor -- monitoring patterns of over -- is that something that the OIG should be looking at, or how would you zero in on that specific recommendation relative to monitoring hospices with high live discharge rates?

MR. HACKBARTH: Well, in the other issues, you had fairly specific directional suggestions about how the payment policy might change on live discharge. You had observed a pattern, but didn't say what a policy response would be. I think that's what Peter is getting at. What's your thinking on that, that there ought to be monitoring of hospices that have odd patterns of live discharges or what?

MR. BUTLER: I was trying to get to a potentially
more aggressive and more specific recommendation than let's just look at what's going on in these areas, because before, I think you said, you asked that -- we asked the OIG the financial relationships between hospices and long-term care facilities. It was mostly related to, still, the nursing home issue.

MS. NEUMAN: Yeah.

MR. BUTLER: And so I just don't know the path that might be likely to not only just monitor this, but kind of examine it a little bit more specifically. That's not really a round one, but I won't say something in round two, but I --

[Off microphone discussion.]

DR. MARK MILLER: What I would say to this is you've obviously paid very close attention to both the paper and the presentation, which is good. On the --

MR. BUTLER: But --

[Laughter.]

DR. MARK MILLER: No, that's good. On the live discharge thing, of the three things that we have presented here, we did not have more specific direction. On the other two, it's much more clear. We think the data suggests
there's a U-shaped curve and then we have brought it to a finer point on the nursing facility.

One thing I would take you back to, and I'm going to make sure this is correct, is we did make a recommendation previously on hospices that have patterns of very long stays which, in turn, may increase the likelihood that you're going to have a live discharge. So we have something sitting out there that PPACA said the Secretary should do. The Secretary has not.

I suppose the other thing could be trying to have a more direct medical review of hospices that have clear patterns of live discharge, but that's as far as we --

MR. BUTLER: So I -- and I won't say anything in round two, promise --

[Off microphone discussion.]

MR. BUTLER: I'll stop now if you'd like. You're the Chairman.

I would think that we want to not just lead to a payment modification to make sure that this is under control, but perhaps understanding, as you suggest, maybe some fundamental things that are going on that need to be corrected that maybe the payment by itself won't.
MS. SADOWNIK: I think it's also worth noting that another panel that we had convened on hospice quality experts had suggested monitoring providers with high rates as something that would warrant looking at as a quality measure in and of itself.

MR. HACKBARTH: Do you have any real --

MR. GRADISON: Yes, a quick question about nursing home reimbursement. Could you please explain to me how the 80/20 rule applies? My recollection is that one of the definitions of a hospice for Medicare purposes is that 80 percent of the patient days have to be outside of an institution, and I want to -- I never really thought about how that's defined. Would nursing homes as well as hospitals be, or hospice physical facilities all be part of the 20 percent?

MS. NEUMAN: So the 20 percent that I think you're referring to is the cap on the amount of inpatient days that will be paid under the Medicare hospice benefit.

MR. GRADISON: Yes.

MS. NEUMAN: So it's -- Medicare will only pay up to 20 percent of the days to a particular hospice at the higher inpatient level of care, and anything above that gets
paid at the regular home care rate. That's a little bit different from the vast majority of care that's going on in the nursing facility setting. Most of the nursing facility hospice care is at the routine home care level. So it is already at that home care level. It's not in that 20 percent and --

MR. GRADISON: Thank you. That's what I wanted to make sure. Thank you.

DR. HOADLEY: Yeah, two quick questions. On Slide 12, I think you said that the rates you have set up here are done on a budget neutral basis, and I assume that when you look at the percent change from the current rate, which on the surface doesn't look very budget neutral, it's because there are so many days in that 31-plus category.

MS. NEUMAN: Yeah. It's over 70 percent of the days in that category.

DR. HOADLEY: So that minus ten percent is -- weights a lot.

And then on Slide 18, when you make a comparison like this, $156 per day for the hospice rate, is that the rate paid to the hospice specifically and are there other Medicare payments being made for those patients during the
period they're in the hospice that are not reflected on this?

MS. SADOWNIK: The $156 is -- exactly, is Medicare's hospice payment to them, and that's an average of all types of hospice care. And so I think it is worth noting that it doesn't include the things that would not be covered by the Medicare hospice payment rate. So all of --

DR. HOADLEY: Do you have a sense of how much that would amount to?

MS. SADOWNIK: So the Medicare spending for conditions that -- besides the terminal condition -- do you know? Do you have a sense of that?

MS. NEUMAN: We don't have an estimate of the non-hospice spending while someone's in hospice. It is something that we'd like to do in the long run. My sense is it's small relative to $156, but how small --

DR. HOADLEY: That's what I would guess, yeah. But it would be useful, I mean, to make sure that's as good an apples-to-apples as possible in that kind of comparison.

DR. REDBERG: I'm just trying to understand better what particular services, if someone is in a nursing home and is in hospice, are there different services, because it
seems like there's almost total overlap between what the
nursing home staff aides and nurses could do and what
hospice aides and nurses can do. Is there anything --
except for kind of a philosophy, is there anything that
differentiates them?

MS. NEUMAN: So, I think some of the philosophy is
key, especially with regard to the nursing. You know, in a
nursing facility, often, the focus is on rehabilitation,
whereas hospice nurses will have a focus on symptom and pain
management. And so the nurses will bring a different kind
of expertise to the care of the patient.

On the aide front, that feels to me like the most
clear overlap. There's also social workers and there could
be some overlap in that area, as well, although, again,
there may be some different focus in philosophy between the
social worker in the nursing facility versus hospice and how
much time a patient would get from the facility versus the
hospice for social work services.

And then the last piece, of course, is the
chaplain or spiritual services and that is exclusive to the
hospice benefit, as far as I know.

DR. REDBERG: Sure. It just seems like there is
potential for a kind of even cross-training or dual and
reduction in payment because it could be more efficiently
coordinated and collaborated between nursing home and
hospice. Thank you.

MS. UCCELLO: So, I've asked and you've answered
questions along this line before, but I'm going to ask
again, especially because again this month we've got -- we
received more stories in our mailing materials about people
being turned away from hospice because they had certain
conditions or things like that. And your Figure 3 in the
chapter shows how the labor costs don't really vary by
diagnosis. So I'm just wondering, are there -- how much is
the heterogeneity in these costs across these diagnoses and
is the non-labor cost an issue here, or is it just expertise
in certain areas which is causing hospices to perhaps be
less receptive to taking in certain patients?

MS. NEUMAN: I think that there are certain niche
services, specialty services, that can be high cost that a
small portion of the hospice population might be candidates
for. So I think of things like palliative radiation for
bone metastases as being something that can be expensive and
that a small segment of the population would have need for.
And I think that that is what is the source of the things that you're seeing articles about. And hospices are not like, for example, with palliative radiation, they're not required to provide it. They need to tell the patients ahead of time what services they offer and the patients can decide whether or not to go with that hospice.

MS. UCCELLO: And remind me, if they do provide those services, they don't get any extra payment for that. That's all rolled up in that per diem --

MS. NEUMAN: That's true. Exactly.

MS. UCCELLO: Okay. Thank you. I hope I will remember not to ask this again next time.

DR. SAMITT: So on Slide 11, please, the materials talk about this is an interim step based on current data. What I didn't understand is how additional data would materially change the minimal impact that a change in the payment methodology actually results in in terms of the discrepancy between short stay and long stay.

So I didn't quite understand. If we already take 68 percent of the costs, which represent the majority of the labor costs, why is that methodology not consistent to say, we want to go a whole lot further than just an initial step?
Is that a clear question?

DR. MARK MILLER: [Off microphone.] This is what I heard.

DR. SAMITT: Please reword it for me.

DR. MARK MILLER: Well, you know, you tell me if this is right. So what I think Kim was very carefully trying to lay out here is that the claims data does not represent 100 percent of the services that are provided in the hospice, so that this was clear to you that this was built off data that was 68 percent of the experience. And using that data, it seemed to confirm what we had suspected all along, this U-shaped curve, and then she tried to quantify it.

I could take your question to be, don't we have enough data just to say this is how the payment should work, and perhaps the response would be, well, these services that are not included perhaps could have a different pattern. But is that what you think you were asking?

DR. SAMITT: I'm not sure.

[Laughter.]

DR. SAMITT: No --

DR. MARK MILLER: And I'm sorry if I took you way
off. I thought your point was, you've got 68 percent of it --

DR. SAMITT: No, I guess I'm questioning the methodology a little bit. Even if we have complete information on the 100 percent, if we applied the sort of the repricing methodology for the U shape, would it materially change the impact from the methodology that's currently being used, which is taking 68 percent, the ones that we do know --

DR. MARK MILLER: [Off microphone.] So the impact on the change in payment --

DR. SAMITT: Exactly.

DR. MARK MILLER: -- or the margins --

DR. SAMITT: Because what I read is that the --

MR. HACKBARTH: Put up 15, Kim.

MS. NEUMAN: Yes. This one?

MR. HACKBARTH: Oops, 13.

MS. NEUMAN: Yes.

DR. SAMITT: Right. So the difference between the 4.2 and the 13.8, you know, we say that the data is sufficient for an interim step, but we still have quite a bit of a gap. So I guess what I'm questioning is will full
data offer any additional information as to whether we should skip over an initial step and just go all the way.

MS. NEUMAN: With the data that we have, you could feel pretty secure to take this initial step. With additional data on the other 32 percent, whether it follows a U or a downward trajectory or something a little bit more flat, that, we don't know. You might think it follows a U because we still have a ways to go. But we were trying to demonstrate here that there was enough data to make an initial change now. That was our intent. Yeah.

DR. MARK MILLER: And I thought I heard the second time through you were saying, would it crunch the distribution more, you know, bring that 4.2 and 13.8 together, and my sense is, if it followed a U-shaped curve and you went the rest of the way, you would get some more compression in that distribution, but the notion of having, say, an equal set of -- you definitely wouldn't be there. You would still have that range of, you know, high range of variation.

MR. HACKBARTH: So, Craig asked what I was going to ask. So we've adjusted 58 percent and we get this amount of compression. I don't hear any reason to think the last
32 percent would have a disproportionate impact, or is there a reason why the last 32 percent would achieve relatively more compression than the first 68 percent?

MS. NEUMAN: I don't have any reason to think that it would, but I think that we would need to see the data to know.

MR. HACKBARTH: Okay.

MS. NEUMAN: The one thing I feel on stronger ground about saying is that I don't think it would reverse the direction of what we've done.

MR. HACKBARTH: Okay.

DR. CHERNEW: I guess assumed in sort of your question is that in one way, the goal is to make this picture flat, and I guess I'm not sure that that's exactly true. In other words, imagine there was some unknown payment system that you could put in place that would make the margins across these quartiles the same. It's not clear to me that that's ultimately our goal, although it might be. But I think the spirit of your question was that it would be better if this was flatter.

MR. HACKBARTH: Yeah. Well, let's frame that as a question. So we're talking about making payment
adjustments. We're using as a barometer of success this sort of analysis.

DR. CHERNEW: That's right.

MR. HACKBARTH: How do we know when we've achieved success? What is the appropriate distribution --

DR. CHERNEW: Yeah. That's what I was asking.

MR. HACKBARTH: Yeah.

MS. NEUMAN: And I think that that's a judgment. You might think that you wouldn't want to achieve perfect equality because you wouldn't want to incentivize very short stays. And so you could imagine going part of the way to closing this, but not all the way.

DR. CHERNEW: Mm-hmm.

DR. COOMBS: Glenn, I just wanted to say --

DR. CHERNEW: [Off microphone.] -- behavioral change --

DR. COOMBS: -- one other factor, so that each one of these quintiles may be very different, the chemistry of them. So that's the piece that we don't know. And you want to have a margin that's more compressed, but what do you give up for that?

DR. CHERNEW: And there's behavioral changes in
various ways. So I think it would be harder to make this flat anyway. This is done without big behavioral changes.

DR. MARK MILLER: And I think, to keep in mind the objective, the way I take all of this is it moved in the right direction and kind of the direction we expected when we took this issue up a couple of years back, and what we're trying to remove from the system is the real driving incentive to say more days, more dollars, and getting people into hospice well in advance of when they should be in there. Because the other thing in your press clippings are that there has been some changes in the environment where investigations have gone on there.

This says to me, it moves in the right direction, but it also says some of this other stuff we're talking about beyond the payment system, you know, looking at aberrant patterns, 180 days and that, also plays a role, probably, in the top end of those margins. And so I see this as the payment system reforms will get you down the road and in the right direction, but you probably can't walk away from the program integrity stuff -- not that you were thinking of that.

MR. HACKBARTH: I think we're still on round one -
DR. CHERNEW: But it's a good round.

DR. DEAN: I have truly a round one question. You said, Kim, a few minutes ago that the programs have the option of providing certain services. I guess I would find that -- how much leeway do they have? For instance, I mean, you mentioned the palliative radiation, which can be an integral part of the good palliative care. Do they really have the option of not providing that? And if so, would that be a reason for a live discharge, I mean, for people saying, look, this is a service that can be extremely valuable and tremendously helpful, and if this server is not going to provide it, then I need to go someplace where they do.

MS. NEUMAN: Yeah, that certainly can be a reason for live discharge, yes.

DR. DEAN: How much leeway do the programs have in terms of deciding what they're going to cover and what they're not going to cover?

MS. NEUMAN: Well, there are certain specialized high-cost things like palliative chemotherapy, palliative radiation, and those are the two right now that come to mind
but I feel like there are a couple of others, where they
have the option of covering it if it's consistent with their
philosophy of care but they do not have to. They need to
notify the beneficiaries ahead of time of what they do and
don't cover and they need to treat all beneficiaries equally
with regard to those services.

MS. SADOWNIK: Also, in terms --

DR. DEAN: Does that affect their base rate at
all?

MS. NEUMAN: It's the same base rate for --

DR. DEAN: The same base rate.

MS. NEUMAN: Right. Yeah.

DR. DEAN: So, in a sense, it's a disincentive to
provide these services, like I say, that are potentially
extremely valuable.

MR. HACKBARTH: So, we've focused tightly on the
incentives to over-provide, at least in terms of long stays,
and if we're thinking about how to improve this payment
system, we may need to focus some on the incentives to deny
appropriate useful therapy, as well.

MS. SADOWNIK: We actually found, though, in terms
of live discharge, that -- because both of those,
chemotherapy and radiation, would be Part B services, and we actually found that in terms of live discharge to go on and use a service immediately after, that that was not -- it was really emergency services that were driving the ship and patient stays and mostly and to some extent ER outpatient visits, and the spending on Part B was a fraction of one percent, so --

MR. HACKBARTH: Herb.

MR. KUHN: Two questions. First, both Kim and Sara, this is really terrific work, a great presentation and great write-up in the report. Thank you for this.

On Slide No. 20, please, I was curious about, on the OIG recommendation, that recommendation number two about to reduce the payment rate for hospice. What kind of payment rate were they recommending? Was it just straight across the board or --

MS. NEUMAN: They did not recommend a specific reduction amount. They just recommended a reduction.

MR. KUHN: Because as I read this, I was thinking -- you know, what came to my mind was the multiple procedure reduction for imaging, that you can only gown the patient once. You greet them once. You know, these people travel
to a nursing facility once and there's a certain fixed cost
that one person incurs. I was wondering if they had
specified one way or the other. So they didn't. Okay.

And the second question I had had to do with the
comment that you made earlier about the PPACA provision that
begins in 2014, where CMS has the authority to change the
payment system, and that they have already convened a TEP to
begin the work on this. Is it our understanding that the
TEP will just -- it'll make its recommendations -- whoever
the contractor they have will make the recommendations and
CMS will use that to move forward on regulatory work, or
will they come back and ask for additional work from a
contractor? Do we have any sense of their process to
getting ready for 2014 and possible rulemaking?

MS. NEUMAN: They haven't said what the next step
will be in that work. They're working very hard, looking at
the issue, but it's not clear at this point what will
happen.

MR. HACKBARTH: Remind me, Kim, exactly what's in
the PPACA provision. Has the Secretary been granted the
authority to change the payment system, or is it structured
as come back to us, the Congress, with a recommendation on
changing the payment system?

MS. NEUMAN: The Secretary has the authority to do it without going back to the Congress, and the Secretary has the discretion to do it however she determines is appropriate.

MR. HACKBARTH: And I assume there's a budget neutrality requirement?

MS. NEUMAN: Yes. Yes.

MR. HACKBARTH: So, conceivably, in 2014, the Secretary could take this sort of analysis and say, we want to move towards a U-shaped distribution based on this.

MS. NEUMAN: So that would be within the -- consistent with the statute. That would be acceptable, yeah.

MR. HACKBARTH: Okay. Clarifying questions?

Alice.

DR. COOMBS: I just wanted to ask a question on Slide -- the 14 percent of live discharge, the live discharges. Were you able to say anything about -- I know in the paper you mentioned on page 27 regarding a non-cancer diagnosis. Can you say anything about that 14 percent in terms of just array of diagnosis and just the distribution
of patients in there?

MS. SADOWNIK: We didn't look by diagnosis. There may be -- we can get back to you on that. There's some information on that that we can share.

DR. COOMBS: So my point being, is this skewed toward one diagnosis and you see that there's a pattern, that that may be another clue as to how to best address incentivizing versus what you do with the scale?

[Pause.]

DR. NAYLOR: So, overall, I think the recommendation related to the proposed payment model, at least -- oh, first of all, great work -- preliminarily looks like it's moving in the right direction. I was going to say, tongue-in-cheek, a key finding here would suggest that maybe hospice is the path to longer survival, so maybe we should be promoting it, but --

On the hospice in nursing homes, I really think that this is a very important area for continued inquiry. The thing that I was -- your Table 6 that looked at aides, nurse visits, and then total hospice visits in nursing home versus not suggests, overall, there's more visits going on, but it's not clear to me how much in some cases aides might
be substituting for other. I don't know if that's the case or not. So the nurse visits at some of these time periods, hospice nurse visit looks a little less, but the total any hospice visit looks higher for nursing home versus not. So I was just wondering, you know, to make sure that aides weren't substituting in some cases for a professional.

MS. NEUMAN: I think that would be unlikely. When I talk to the provider community, they're pretty clear about what role the nurse plays in dealing with the patient and their family versus the aide, so --

DR. NAYLOR: I mean, and also, I mean, your question about there are nurses in the nursing home and there are nurses in the hospice. So the question about whether there is substitution is still an important one to pursue.

And I don't know the answer about exactly if the role is different, meaning is it about function, what aides are actually doing in nursing homes, or is it more about palliation. So even if the aides are there, are they doing something different, I think is very helpful to know more about.

But that being said, I think this is a very
important area of continued inquiry, and that's it.

MR. GEORGE MILLER: Yes. Like my colleagues, we think the work is great work and certainly this part of the continuum is very important. My mother was on hospice, and unfortunately, the night before last, my uncle died, and he was in the hospice, as well. They do a fantastic job. So I wanted to get that out there and think this is an important part.

But the spending, live discharges, and the care that is given in nursing facilities are troubling, as this report points out, and I think we're going in the right direction. I, too, think that we need to look at how to appropriately provide for service in the nursing home and not disincentivize more organizations to provide more care than necessary.

And the other thing I think that is critically important, if I remember correctly from the last report, that you got some of these recommendations from the field, which is an important ally that they recognize these things in the -- behavior that takes place in the marketplace, because, again, I think it's a very good program and the fact that there could be tremendous savings in the overall
Medicare program by dealing with palliative care versus heroic efforts to try to extend life when it's just not going to be appropriate to do so. But at the same time, we're responsible for the entire Medicare program and when we see these issues, we certainly need to address them and I think that the staff has done an excellent job of addressing those issues.

[Off microphone discussion.]

DR. HALL: [Off microphone.] -- doesn't really need reiteration, but the hospice movement is one of the best things that's happened to health care in a very, very long time. And that's not to say that we should tolerate abuses of the system, because if we don't do something about it, the really good benefit that most people get will just disappear. It'll be lost in the shuffle.

I guess another place to look at this is -- and I don't remember reading this, but I may have missed it -- did you look at the sort of patterns of physician recertification for hospice care?

MS. NEUMAN: Do you mean the --

DR. HALL: Well, you can't be in hospice care without having a physician recertify you --
MS. NEUMAN: Right.

DR. HALL: -- twice for 90-day periods, 30 days,

and then, unfortunately, the fourth one is indefinite, which

probably should disappear.

So another area of this we might look at is that

there may already be some controls put on this, that a

professional is looking at this pattern, but somehow it

isn't really being -- no one takes it seriously, quite

frankly.

MS. NEUMAN: So when someone is recertified for

hospice, it's the hospice physician --

DR. HALL: Right.

MS. NEUMAN: -- who does the recertification. And

we have not done analysis, like looking at the provider

number of that physician to see if there's different

patterns across different providers, or different

physicians, but it's something that could be looked at.

DR. HALL: So if you looked at those long stays

and you find that it concentrated on a relatively small

number of hospice physicians, one might say -- although we

hope that doesn't happen -- that the sign-off may not have

taken into consideration all of the implications of another
length of stay.

MR. HACKBARTH: We recommended that there always be a written narrative, as I recall.

DR. HALL: Right.

MR. HACKBARTH: And that was enacted in PPACA, correct?

MS. NEUMAN: Yes.

MR. HACKBARTH: And before, there was no requirement for that. So that was one thing we added. We also proposed -- recommended a requirement for a face-to-face visit, which was also added in PPACA, right?

MS. NEUMAN: Correct. Yes.

MR. HACKBARTH: So those were a couple things that we tried to do to make sure that there was some thoughtful consideration given to the recertification decision.

DR. HALL: The hospice physicians that I know -- that's just a very tiny sample, of course -- but they're probably the most conscientious group of physicians that I've ever worked with. They get it. They understand it. But that doesn't mean that they all do.

DR. MARK MILLER: Well, and this goes back to -- and George mentioned this recently, so I think this must
have been before you showed up -- and so this was one of the
things -- I'm sorry, before you were appointed as a
Commissioner --

[Laughter.]

DR. MARK MILLER: Maybe a little too familiar.

Sorry about that. I apologize. We'll strike that.

And this kind of goes back many years, and we did
bring in people from the field, and in a very unsolicited
way we were hearing from people in the field, and that this
process was feeling very loose, that somebody in their
second, third recertification, a physician hadn't actually
gone and visited. It was just kind of coming back through,
well, we'll just recert this person.

And, actually, we had some medical directors from
around the country and there were some pretty surprised
responses when it went around the table and said, yes, there
are people in our marketplaces who are behaving this way.
And some of, I think, what's happening here, and your group
may be different than this, is that new actors were entering
the market and behaving differently, and I think some of the
people who had been around the block for a longer period of
time were saying, this is a very loose way to run the
railroad, that type of thing. And so that's what led to the recommendations that these two were just talking about.

DR. HALL: And I think, just so we all know, that hospice was designed to actually save Medicare money, because when you go into hospice, you waive your rights to other Medicare services.

MR. GRADISON: Before I throw sort of a curve ball at this, I want to make it clear what a strong supporter I am of the program. Frankly, it just may be a matter of history, but it was about 30 years ago, I was one of the leaders in getting this thing put into the Medicare statute with the idea that we would save money, which, by the way, the executive branch at the time didn't agree with at all.

My question here is why this is revenue -- why you set it up to be revenue neutral, because the margins that you show after spreading these are much higher than for many, if not most, other providers. And I think it sets a very bad pattern if we say, well, we've got to have margins, and you've got the numbers up there and another slide, of that level for hospices, but not for X, Y, and Z, other silos. So that's -- I don't mean it as a difficult curve ball, but I think it's a policy issue that I have not heard
any discussion of since you began your excellent presentation.

DR. MARK MILLER: No --

MS. NEUMAN: No, you go.

DR. MARK MILLER: After you.

MS. NEUMAN: I was just going to say, and I'm sure Mark will add to this, that at the time the Commission was considering the payment reform model, they were thinking about sort of how to get the rates right across an episode and it was thought of as being redistributive, and the issue of whether the rate overall needed to be lower or not wasn't one we were thinking about at that time. That does seem to be another issue that could be considered.

DR. HOADLEY: So I think this is some great data analysis and great paper. Those U-shaped curves are almost like a statistics textbook. It's just unusual when the data shape up the way you're expecting it like that.

On the long stay stuff, this provision in PPACA about the medical review and the 180-day, you know, a lot of 180-day stays, you said has not been implemented. Do we know anything about what's going on there? Are there some issues with it?
MS. NEUMAN: We've asked a number of times and we don't have any information as to why it hasn't been implemented.

DR. HOADLEY: Okay. It may just be workload or something.

And then on the nursing home thing, one thing that occurs to me is nursing homes vary in their capabilities and what they try to be capable of doing, what they offer. And is there any sense of differences across nursing homes that might be correlated to something about what the nursing home itself is able to do that might show up along with the sort of data you're looking at? Is that something you've tried to look at at all?

MS. NEUMAN: We didn't look at visit patterns specific to nursing facility providers. Like, it sounds like the idea you're talking about is if you could have the MDS data crossed with the hospice claims, you could see if you saw different patterns in different nursing facilities. We haven't done that. It's something -- it would be intensive. It's something we could think about.

DR. HOADLEY: It may not be worth it. I don't know. It just was a thought I had, because I do hear people
talk about nursing facilities that will do different kinds
of things and whether it could relate to this at all.

MS. NEUMAN: Yeah.

DR. NERENZ: It seems to me that about 15 to 20
years ago, there were some organized efforts to promote
hospice -- I'm thinking of a program from the Robert Wood
Johnson Foundation just as an example -- with the idea that
there were people eligible and appropriate for hospice who
were just not getting into it and also that people were
getting in too late so that the stays were very short. Now,
in reading and hearing this, it almost seems to me that over
that time, the pendulum has swung completely the other
direction, that the concerns now are about long stays and
about people who don't die, who are live discharges.

So I'm just curious. That set of problems that
existed 20 years ago, are they gone or are they still
present?

MR. GRADISON: They're still getting in too late,
and there's a lot of money being spent during those weeks
before they come in and stay five, six days.

MS. NEUMAN: Exactly. So we have an issue on both
ends. We have the very long stays and some patients who are
probably of questionable eligibility. And then on the other end, we have people coming in one, two, three, four days before the end of their life and not getting the full benefit that they might get if they had entered earlier. And some of the stuff I mentioned at the beginning, trying to facilitate hospice use among patients who would be interested, like the shared decision making, concurrent care kinds of stuff that we've talked about exploring, that could be worked to sort of look further at that issue.

DR. MARK MILLER: [Off microphone.] Just in case it's not really clear, I mean, there has been a big increase in the use of hospice from 15, 20 years ago, in the use of hospice for decedents. But we still have the situation that she described.

MR. HACKBARTH: Our initial chapters on this emphasized, as Kim said, that there are issues at both ends, too late admission as well as very long stays. But my sense from that earlier conversation several years ago was the problem of people being admitted to hospice too late, we didn't think was really amenable to a change in hospice payment policy, that there were other factors that needed to
be worked on to fix that, whereas the long stay issue, we thought was more a function of incentives created by the payment policy. Is that fair, Kim?

MS. NEUMAN: [Nodding affirmatively.]

MR. HACKBARTH: Okay. Scott.

DR. NERENZ: Just to circle back on that thought, and I didn't ask that anything about the proposed payment thing be changed because I don't see a way in which what you're proposing here would actually exacerbate any of those early problems, but I just -- in passing, in the background, it might be worth acknowledging that some of these problems that were present are still present.

MR. ARMSTRONG: Yeah. I just would amplify a couple of points. This really is an investment in a good thing, hospice, in that I think we should expect to see a return on this. If I remember correctly, ten, 12 years ago, 20 percent of patients dying on Medicare were dying in the hospice program, and it's up to 45 percent now. I would argue that's still far from where we should get this to, and so there's still work to be done on that.

Nonetheless, we're not talking about that right now, necessarily. We're talking about the per diem payment,
structure changes, and I support the direction that you're
going and I think it's smart.

But I would, like Bill, challenge whether this
should really be budget neutral or not and that these are
margins that are higher than margins we're seeing in other
payment categories.

I also would just say that -- I forget when,
sometime in the last couple of months -- we were talking
about shared decision making and why not lower reimbursement
and pay more to hospice programs that are using shared
decision making tools to get patients engaged in this
program, or figure out some hospice version of a quality
bonus kind of incentive which may be a way of increasing the
percentage of patients dying on Medicare insurance within a
hospice program go up.

MR. HACKBARTH: Rita.

DR. REDBERG: I just wanted to add, also, that I
support the changes that you suggest making to address the U
curve, but that also, although coverage can't really be a
mechanism for getting more patients into hospice, I notice
in particular in my field, I think we under-utilize hospice
care. I think it's most -- or cancer patients are most
likely to be referred to hospice. I couldn't really tell --
you gave the dollar amounts for how much goes into heart
disease and I forgot the other categories, you know, for
heart failure and other.

So I think there could be, though, and perhaps
Scott was onto it, other ways that you could use coverage to
increase awareness of hospice care in other specialties,
like shared decision making for it, because it's certainly
shown that when patients are aware or are offered the
alternative for hospice, many patients would choose it, and
that the reason more patients aren't choosing it is because
they are not aware of it, and perhaps physicians aren't
aware of it. And I think there's still a lot of
misconceptions about hospice care among the profession as
well as among patients, that hospice care means kind of you
don't get anything, which is very far from the truth. I
mean, patients are -- and so I agree.

It's very gratifying that there's an increase in
use in hospice, except for perhaps people that don't
qualify, but that we could, perhaps, through increased
coverage for shared decision making or other non-coverage
mechanisms be increasing it, particularly for non-cancer
patients who would benefit.

MR. HACKBARTH: So when we discussed shared decision making last month, the conclusion that I came to -- maybe I was alone in this -- was it's a really important thing to do and, indeed, an ethical responsibility of the profession, as I see it, but it isn't one of those things that is really amenable to stimulating through payment policy. And so I think it would be a very good thing, indeed, if more patients fully understood hospice and the potential benefits, what it is and what it isn't. That's a different point from saying, oh, there's a payment policy lever we can pull that will result in that good outcome.

DR. REDBERG: I'm not sure. I remember, I think Tom thought it was part of the good patient-doctor relationship, and which is true, but I also think there's some consideration of increased payment for E&M services in general and perhaps shared decision making in that.

MR. HACKBARTH: [Off microphone.]

MS. UCCELLO: So I, too, support the suggestions about the payment reform and the program integrity suggestions.

One thing that -- there was one sentence in the
material about the overlap and duplication of the hospice
and nursing facility services, on how we think about that
with respect to Medicare and Medicaid. And if we're talking
about duplicative services, well, which, you know, what
payment gets adjusted? Do we think of hospice as on top of
the nursing homes? All of the payment changes would just be
to the hospice payment, or do we think about it differently
so that the Medicaid or other payers on the nursing facility
side would have some adjustments there? I mean, I don't
know, but there was -- it was just a quick sentence about
that in there that we may need to think about that more, and
we may need to.

MR. HACKBARTH: The nursing facilities typically
that we're talking about are long-term care facilities as
opposed to Medicare-financed skilled nursing, is that true?

MS. NEUMAN: The patients would be --

MR. HACKBARTH: Residential?

MS. NEUMAN: Not in a Medicare SNF stay.

MR. HACKBARTH: A residential facility.

MS. NEUMAN: Yeah. They'd be a residential,

exactly. And to follow up on that, Medicaid does pay --
typically will pay 95 percent of the room and board for a
hospice patient rather than 100 percent.

DR. SAMITT: So, I also support the payment reform methodology here. It won't shock any of you to hear that I think we should do more. You know, I think the margins look very rich, even though this is a very critical benefit. And I would agree with what everyone else has said, that it's a grossly under-utilized benefit still, I believe, although with that being said, the question is, should these margins really be substantiated.

The only thing that I'd love to see more of is the fact that, on the one hand, we say that we're using hospice -- we're considering hospice too late, and on the other hand, there are some instances where we are probably using hospice too long or too much. And it begs the question about whether there's an accountability problem. So who upstream should be more accountable for the under-utilization or the excessive length of hospice? You would imagine that ACOs should pay attention to this and MA would pay attention to this, I would imagine, if it's all included. But I'm wondering if there is some payment policy that shines some light on accountability further upstream so that whomever is suggesting hospice, referring hospice, or
should, has more effective incentives to follow best
dractices this way. And I'm not quite sure how to structure
that.

But I think that solves both bookends. Yes, the
program integrity issues have to be addressed through
payment reform, but I do wonder whether there is someone
working with the patient to be accountable, and watching out
for the patient's best interests would add greater strength
to this.

MR. HACKBARTH: Help me out. My recollection is
that, actually, the hospice benefit is paid separately from
Medicare Advantage. It is outside what is the
responsibility of the plan.

MS. NEUMAN: Right. So, yes, it's paid like a
regular fee-for-service.

MR. HACKBARTH: Yeah. So that would be a vehicle
for integration and accountability, but, in fact, the way it
is currently structured, it's separate from the plan's
responsibility.

MS. NEUMAN: And that is one thing we had on the
list in January of ways to facilitate hospice use --

MR. HACKBARTH: Right.
MS. NEUMAN: -- considering whether it should be
in Medicare Advantage.

DR. SAMITT: I mean, that's, in essence, what I am
getting at, that if there were a way to include that and
bundle it together with Medicare Advantage, I think it
creates internal alignment.

MR. HACKBARTH: And now under ACOs, this would be
part -- this is a part of the Medicare covered services, and
so, you know, interestingly, it is part of the ACOs'
accountability and could influence their ability to hit
targets on cost and patient satisfaction.

DR. SAMITT: And when we have perfect information
about both Medicare Advantage as well as ACOs --

[Laughter.]

DR. SAMITT: This is an interesting thing to study
when we say, do we see a reduction in late utilization of
hospice or a reduction in length of hospice under an ACO
environment where there's alignment versus under a Medicare
Advantage model.

MR. HACKBARTH: So to a flaw, this is a research
designed. This is an opportunity --

DR. CHERNEW: Can I ask a clarifying question now?
MR. HACKBARTH: If you want.

DR. CHERNEW: Are the codes that are used for hospice, do they impact the assignment of the beneficiary to an ACO or not? In other words, are they --

MS. NEUMAN: Are they kicked out? Is that what you're asking?

DR. CHERNEW: No. Are they -- say they're E&M codes and I have an ACO. I can put my hospice, for example, in a different tax ID number and then that person actually wouldn't be assigned to an ACO because they would be assigned for the hospices and the hospice might not be a part of the ACO.

MS. NEUMAN: We need to get back to you on that.

DR. CHERNEW: No, that's what I was asking. So when you get a visit, how they're coded would depend on where they get assigned.

DR. DEAN: I'd add my voice to the support for the reform and say, too, that it probably could even be a little more aggressive.

But beyond that, I think that one of the concerns, I think, and I don't know exactly how potent this is, but one of the things that I've experienced is that people are
very reluctant to sign onto hospice because they're afraid of giving up conventional curative services. And I just wonder if there is a way to blend some of those payments, or to provide some support -- I mean, we've talked about eliminating that requirement altogether, which may well make sense, but I wonder if there's sort of a halfway step ahead of that that might encourage at least people to become aware of the advantages and take away some of the fear that exists that they're never going to be able to go to the hospital again or whatever it might be.

MR. HACKBARTH: What is -- PPACA mandated a demonstration on this issue of patients being allowed to continue curative care even after electing hospice. What is the status of that at this point?

MS. NEUMAN: So there was no funding appropriated for it, so it's unclear if it will occur.

DR. DEAN: One other question. You know, we've talked a lot about eligibility and appropriateness of people entering into hospice and all that, and we've also talked about how unsatisfactory the criteria of six months of expected lifespan or less really is. Have any of your consultants or your experts talked about ways to make those
criteria better and a little easier to -- I mean, for those of us that have to make that judgment, I mean, it's -- that's part of the reason, of course, that you only -- people come too late, because maybe some of these changes, people are pretty stable, and then when they start on a downhill course, sometimes that's pretty fast. And also, if someone has a severe chronic disease, you say, well, yeah, probably they won't make it for six months, but on the other hand, they may well live much longer than that.

I guess the question is, we haven't talked much about that particular criteria, and to me, it's a very unsatisfactory criteria. We need a better threshold, a better measure. And I just wonder if any of your experts have -- I don't have one, but I wonder if they've brought that up or have ideas.

MS. NEUMAN: So when we did the industry panel leading up to the 2009 recommendations, one of the things we did talk about was the local coverage determinations that the CMS contractors have that sort of spell out the criteria for when someone's eligible versus not, and we had some discussion about whether there was some need to fine tune those. And by and large, the folks -- the hospice folks
that we talked to didn't see gigantic room for changes.

They did do some tweaks themselves in places where they thought that if they thought about it one way, it would make it more precise. But that was not an area where they felt that big changes were needed.

Now, that said, we're a few years past that now and it's something that we could go back and do some more talking and thinking about.

DR. DEAN: For all the problems it's caused, I think that might be worthwhile, to try and see if there's a better way to decide about eligibility.

MR. HACKBARTH: So let me go back to Tom's first issue about patients having to forego other therapy to opt for hospice. So my recollection, correct me if I'm wrong, is that there have been some non-Medicare demos on that. I recall one done by Aetna, and there may have been more than one. And my vague recollection is that what they found was that it did not increase cost and was actually -- it got more patients to opt into hospice. Am I even remotely close?

MS. NEUMAN: That's correct, and the -- there are some differences, though, about their population --
MR. HACKBARTH: Right.

MS. NEUMAN: -- versus the Medicare population that raises questions about what would happen in Medicare. They have a much -- it's a younger population who elect hospice even later than the older population does --

MR. HACKBARTH: Yeah.

MS. NEUMAN: -- and it's mostly cancer in that age group. And so the question is, what would happen in Medicare, and in the fee-for-service environment.

MR. HACKBARTH: And I thought that those reasons for questioning whether the Aetna and other private demos accurately predict what would happen in Medicare made sense to me, you know, and so I thought it was a good idea to do a demo of this. But now we're in a situation where, if we're not going to do a demo, the issue won't go away. What do we do in the face of a lack of Medicare-specific evidence on an issue that I think is pretty important? I don't have an answer. That's a rhetorical question. I don't have an answer to it right now, but I think that's something we need to come back to. Just to say, well, we've always required patients to forego curative care and we'll just mindlessly continue that, may be a significant barrier to appropriate
use of hospice care.

Herb.

MR. KUHN: Although we've spent most of this time talking about payment changes, the fact that the issue of program integrity continues to crop up and be part of this conversation, I think that's useful and instructive.

The second thing is, I've listened thoughtfully to the comments that have been made that while we're able to adjust 68 percent based on the data we have, we might want to have stronger incentives. But I think back to past things that we've seen in the Medicare program that sometimes even small tweaks to the system can bring about big changes. And the one I think about is the one on therapy distribution and home health. And prior to 2008, CMS would pay so much up to ten therapy services, and then over ten, it would change, and guess what, we had a lot of clustering between 11, 12, and 13. Then in 2008, CMS made a change. Now, we had some other clustering that occurred as a result of that, but in that one single year, that first year, we had the swiftest change we had ever seen in that program as a result of the payment changes. So it can have a big impact very quickly as part of the process and we
can't lose sight of that as we go forward.

And then the final thing I would make, Glenn, not as a suggestion but just as -- well, a suggestion, perhaps, to you as Chairman -- is that this is really some terrific work that they've done here. And if, indeed, CMS is right now working with a technical expert panel to work on this issue, would it make sense somehow that we formally communicate this work to them as part of that process, whether it be a letter from the Chairman to the Secretary, whether it is a staff conversation, whatever the case may be. But I want to make sure that this body of work is part of that conversation and it's fully shared with the agency as they continue to go forward.

MR. HACKBARTH: [Off microphone.] Have we been in touch, Kim, with the --

MS. NEUMAN: Yeah, we do communicate with them. In fact, part of PPACA's requirement was that they consult with us on the process, so we're in communication.

MR. HACKBARTH: Okay. Alice.

DR. COOMBS: One of the things -- we talked about this whole notion of bundling the hospice service, but I'm concerned that it might result in some thinking that service
is becoming a part of the general budget of an ACO. I think the stratified approach to the reimbursements in terms of the fee-for-service is the way to go, and you might be able to tailor it once you find out what the under-utilization is in terms of up-front robust build-up versus a cliff at some point that's yet to be defined in terms of over-utilization. The way it is now, it's just a gradual heel, but you might even have a medical cliff at some point if you see that the services, once you include the 32 percent that's not included. So I think there's a lot of room for tailoring this stratified approach, but I like it.

DR. CHERNEW: So, I like this a lot, too, in general and in specifics, and one of the specifics that I like the most is instead of just coming up with a U-shaped payment rate by day, you have a declining rate, essentially, with a spike upon discharge to capture the way that the data has shown, and I think that is exactly the way to fit the data. I like that aspect a lot, so I think it's good.

Just in response to the comment about we should be more aggressive, we have another mechanism, the update factor, to be aggressive, and I think if we thought the margins were generally too high, we would deal with that
through the conversion factor kind of approach as opposed to tweaking this. That's different than trying to flatten out the quartile margins that was discussed here. And I guess my view is, I don't know what the optimal slope of the quartile margins is because of issues that we don't have all the data, there's case mix issues, there's behavioral changes we don't know.

So all that leads me to think that I'm basically very comfortable that this is a step in the right direction and that other issues about over-generosity, or if we think that's true, we should deal with that in another process for which we have recommendations on the table. And I think, although, again, I'm not sure, this reflects existing payment policies, not what would happen if our recommendations for hospice updates were put in place. Is that --

MR. HACKBARTH: So our existing recommendation is a freeze in the rates. This reflects current rates.

DR. CHERNEW: Oh, so it's basically the same, but --

MR. HACKBARTH: Yeah, basically.

DR. CHERNEW: But, of course, there would be
inflation in some sense, so the margins might go down anyway. But, anyway, that --

DR. MARK MILLER: Just in case anyone is confused, would you put up 13 so as they refer to the quartiles, they're referring --

DR. CHERNEW: Yeah. Well, I'm going to move off that now anyway.

[Laughter.]

DR. CHERNEW: So I think this issue of how it fits into ACOs and MA is really important and worthy of a lot more attention, and I would say part of what I think is going on, and we've had other presentations on hospice, is over time, the mix of diseases that hospice beneficiaries have had has changed, which you show and you've shown in the past. That not only affects, say, what you think the length of stay might be, the sort of mean, if you will, it affects the potential variance and predictability. So we're inherently going to run into a problem with predictability when we move to certain diseases relative to other diseases, and that doesn't mean we would just -- if you knew who shouldn't be in, that would be great. But even the best, well-meaning, well-trained physician will have a hard time
predicting someone's length of stay in a hospice program with a lot of diseases.

And so I'm not advocating this strongly now, but one of the things that we thought about in some other work that we had done was that everybody should have access to good palliative care, even if you can't figure out that this person is likely to die with some probability within some window of time, and that every person, particularly people who are nursing home residents, should have someone accountable for their entire spectrum of care, not segmented out to the nursing home portion and the hospice portion.

And so I think thinking about how to -- we, for example, have automatic assignment to people who would get palliative benefits based on some modeling. You're going to get some over- and under-assignment, but the point is, everybody would get access to good palliative care and they wouldn't have to forego other things. They wouldn't have to forgo curative care, because I do think what happened, I think, in the Aetna example was they didn't say they would forego curative care, but as they moved to the hospice process and the palliative care process, their choices about care just generally changed in ways that I believe were
better for the patient, ignoring any of the financial things, which is actually probably the less -- I think it's important that we don't -- the reason I like the budget neutrality of this, I think it's important to understand that the motivation here primarily is, I think, better access to care for people at this stage of their life. And if we have monetary issues, we can deal with that through other mechanisms. But I think this is more about accurate payment and access to important care. And I think that requires some accountability, some honoring of quality, and I think this is really a step in the right direction.

DR. BAICKER: My comment was really much along the same lines as Mike's. I would just add one sentence to that. The goal, I think, is to be neutral about how long patients should be in hospice, except it should be as long as they should be in hospice based on their preferences and their individual health, and the U-shaped curve seems to map to that neutrality, that we're not trying to push people there longer or put them there less time because that captures the real way that costs accrue. And so if that's our goal, we don't have strong views about how margins should look across these quartiles or quintiles. They
should be -- we don't think that it should be related to how long you keep the patients. It should be related to running an efficient operation and providing high-quality care that makes people want to use those services, et cetera.

And so the fact that this flattens the margins, we think is probably good, because we suspect that those original margins were not in line with that neutrality of length, and this looks more in line, but if we got those payments right, it might or might not result in flat margins, and that's okay as long as we think that we've created the incentives for the patients who need access to hospice care to get exactly as much as they need.

MR. HACKBARTH: Okay. Thank you, Kim and Sara.

Very nice work.

We're now to our last session on bundling post-acute care services.

[Pause.]

MR. CHRISTMAN: Good afternoon. Next, we will talk about bundling post-acute care. I would like to thank Craig Lisk and John Richardson for their contributions to this work.

The Commission has been examining bundling as
another possible approach to payment reform. Today's
presentation provides a review of material we have presented
previously and provides additional information about how
Medicare could implement a policy. We are going to review
the reasons bundling could be beneficial and discuss an
illustrative example of a bundling policy based on
Commissioner input from prior meetings. Then we will
discuss issues in setting payment for the bundle, including
how to set the bundled amount, creating incentives for
quality, and policies for addressing beneficiary incentives
in a bundle.

The Commission has been interested in bundling of
acute and post-acute services because it has the potential
to move Medicare away from its fragmented fee-for-service
payment systems, particularly for post-acute care.
Establishing bundling would provide incentives for better
coordinated care, which is particularly important for
beneficiaries that are making the transition from the
hospital to another site of care. Poorly executed
transitions can place beneficiaries at risk for a
rehospitalization that is undesirable for both the
beneficiary and the program.
Bundles would encourage providers to consider the costs of care over an entire episode and not just for their silo. There is no incentive to encourage placing a beneficiary in the lowest-cost PAC setting that meets their needs under current policies, even though there is overlap in the type of patients served and services provided among PAC facilities. Bundling could also help narrow the considerable geographic variation in PAC spending, which is greater than the variation observed for other Medicare services, by creating incentives for the more efficient use of PAC.

For this presentation, we have developed an illustrative approach to bundling. At our prior meetings, Commissioners expressed a preference for longer 90-day bundles that included all of the acute, post-acute, and physician care associated with a hospitalization. Under this approach, Medicare would continue to pay individual providers under the current fee-for-service systems with a small portion of each fee-for-service payment withheld. Medicare would set an episode benchmark or spending level for the episode based on a beneficiary's diagnosis and comorbidities.
Our illustrative bundle is based on current fee-for-service payment systems. Using fee-for-service minimizes the incentive to stint. Providers would still be paid on a fee-for-service basis. If they do not provide a service, they do not get paid. Fee-for-service is also simpler to implement. Such an approach does not require that providers make side payments to each other, as would become necessary if Medicare were to pay for bundling in a single global payment to a group of providers. Our approach does not require that a hospital or other lead provider operate like an insurer that negotiates rates and makes payments to the other providers in the bundle.

A small portion of each fee-for-service payment would be withheld and tied to performance in the bundle. Providers that failed to meet the episode spending benchmark would not get their withhold back. Holding providers to a spending benchmark would also capture some dimensions of quality, as costly readmissions are a significant portion of cost for some episodes. Lowering readmissions would improve care and make it easier for providers to keep below a spending benchmark.

Using a withhold provides some guarantee of
savings even if providers do not meet the episode benchmarks, and using a withhold also means that Medicare does not have to chase providers for a return of funds after the episode is over.

The withhold also limits the financial risk for providers as it places only a portion of their payments at risk. If spending exceeded the benchmark amount by more than the amount withheld, the provider would not be responsible for repaying the excess amounts beyond the withhold.

The return of the withhold could also be tied to quality metrics so that providers would have to maintain quality in addition to meeting spending targets.

Examples of measures that could be used to watch for stinting during a bundle include readmission or emergency department use and change in functional status at the end of an episode. Medicare will also need to be vigilant for other changes that could represent a gaming of the bundling incentives. Other signs of providers responding inappropriately to the bundle could include delaying services outside the bundle window or providing a greater number of bundled episodes. Medicare could develop
measures to watch for these trends and adjust its policies if they appear to be an issue.

Effective risk adjustment would be an important element of setting the episode benchmark for a bundle. Risk adjustment guards against patient selection and facilitates fair comparison across providers. Our review of existing risk adjustment methods suggests that they can explain a significant share of resource use in the illustrative bundles.

Using MS-DRGs to adjust for severity, our model was able to explain 31 percent of the variation in charges. We also added in chronic conditions and functional status, and this increased to 36 percent. These results suggest that all three of these elements should be include when setting episode benchmarks. I would note that the explanatory power of these risk adjustment methods are even higher when they are used to explain Medicare spending for the bundle at the facility level.

Determining the level at which to set the episode benchmarks will be a critical decision. Since the point of bundling is to provide better incentives than current fee-for-service silos, the episode benchmark should be set in a
manner that minimizes or avoids the problems of Medicare's current payment systems. The benchmark should be based on patient characteristics, such as the risk adjusted factors listed previously, and they should not be tied to the specific PAC setting a patient receives care at.

The benchmarks should also keep in mind that current average spending levels may be excessive, as there are many areas with very high PAC use. Benchmarks could be set at levels that are less influenced by areas with unusually high utilization.

Finally, the performance against a benchmark should be computed as an average for all bundles over a period of time. This softens the incentives for patient selection as it averages the high-cost cases in a period with other lower-cost episodes.

DR. CARTER: To incentivize the efficient provision of care, CMS could establish the benchmarks in a couple of different ways. These include basing the benchmark on lower spending on post-acute care and readmissions or basing the benchmark on spending in geographic areas with low resource use, and I'm going to say a little bit more about each one of those.
One way to establish benchmarks would be to base them on lower spending on post-acute care and readmissions. The wide range in whether beneficiaries use PAC, what PAC they use, and high Medicare margins for home health and SNF all suggest that spending on post-acute care could be lower without necessarily compromising quality. The variation in the level and the rate of readmissions suggests that spending on them could also be lower.

Just as an illustration, the benchmark could be based on spending on readmissions and post-acute care that is ten percent lower and this would establish benchmarks for the whole episode that are five percent less than current fee-for-service spending.

Another way to establish the benchmarks would be to base them on the practice patterns of geographic areas with low resource use. Per capita spending on PAC that was wage and risk adjusted found a two-fold difference between
the tenth and 90th percentiles in MSAs, and an eight-fold
difference between the highest and lowest areas. So, for
example, benchmarks could be set using some portion of the
difference between high- and low-spending areas.

We are also exploring the idea of using practice
patterns in managed care plans to establish the benchmarks.
With encounter data hopefully available later this year, we
can pursue this option, as well.

Regardless of how they're established, the
benchmarks would work in the following way. Here, we show
an episode benchmark of $43,000 for the episode with two
scenarios, one where providers keep their total average
spending below the benchmark, which is on the left, and one
where they don't, which is on the right.

Providers would bill Medicare just as they do now
under fee-for-service, with their average bill amount shown
on the first row. With a four percent withhold, the
withheld amounts are shown in the second row. In the case
where actual average spending is below the benchmark, the
$1,600 is withheld from payments going to the provider, with
net immediate payments going to the provider of $39,000.

At the end of the performance period, actual
spending is compared to the benchmark. In this case, average spending was below the benchmark, so CMS would pay the providers the withheld amount and the total program payments to the provider are $41,000.

In the second column, we see the case where the actual spending, $47,000, was above the benchmark. Here, the withheld amount, the $1,880, is retained by the program. The program limited its risk for the amount above the benchmark. It paid out in total the $45,000 instead of the full $47,000 for the episode.

Now, we want to talk about what bundling can mean for beneficiaries and their families. Because providers are at risk for total spending over the period of time, bundling is likely to mean more coordinated care. There will be fewer and more successful transitions between settings and fewer avoidable readmissions.

For example, a family or caregiver is likely to receive more extensive follow-up care and to be given one telephone number with a contact person to ask questions and to have their concerns addressed. Less time would elapse between discharge from the hospital and admission to post-acute care and until the beneficiary receives follow-up
physician care.

Other quality measures could track the patient experience, for example, how well their pain is managed or how well they felt their providers listened to them, or their involvement in making their decisions about their care.

While beneficiaries' choice of providers needs to be protected, there are advantages to aligning beneficiary incentives with the purposes of bundling. Providers may use several approaches to do this. First, they may give beneficiaries information about quality differences across providers being considered for placement after discharge. This could shift some beneficiaries away from poor-quality providers.

Providers may also furnish services to better manage the beneficiary's care after discharge, such as having a care manager assigned to them to oversee their care, someone who would conduct medication reconciliation and give focused instruction on managing the condition at home.

As Evan mentioned before, tying withholds to quality performance could reinforce the importance of
furnishing high-quality, well-coordinated care to beneficiaries.

Once bundled payments have been implemented, down the road, Medicare could create stronger incentives for beneficiaries and providers to encourage high-quality, low-cost bundles. Medicare could influence beneficiary choice of post-acute care providers by structuring beneficiary cost sharing so that cost sharing is higher when a beneficiary decides not to use recommended providers. Beneficiaries would retain a choice about where to receive care, but their choices could cost them more. I think we talked a little bit about this during the ACO presentation this morning. Medicare could also send stronger signals to providers by revising its Conditions of Participation to include high quality standards. In setting higher standards, it could, for example, exclude the poorest quality providers from the program.

Bundled payments will require providers to make many changes to their practices, both internally and between providers. To ease the transition, CMS could consider adopting this reform for select conditions and expand the number over time as providers gain experience with managing
the care across a spectrum of providers and settings.

Another transition element could be to establish benchmarks that represent small reductions from current fee-for-service spending, with larger reductions phased in over time. Likewise, the withholds could start out being a small share of payments and get larger over time. For example, they could start at two percent and grow to five percent over time.

At the last Commission meeting, Peter mentioned the Medicare spending per beneficiary concept as an alternative way to think about bundling, and we've included a short description of this in the paper. In brief, the MSPB establishes a spending target for groups of conditions, such as a major diagnostic group. The bundle spans 30 days and includes hospital, PAC, the physician services, and readmissions. The MSPB is a measure of hospital efficiency and would hold the hospitals responsible for total spending. Eventually, the plan is to use this value-based purchasing with hospitals at risk for spending above the targets and sharing in savings if they are below it.

The big difference between this and the bundling approach we've been talking about is at the MSPB, the
hospital is fully responsible for spending during the
episode. In the bundling approach, all providers share in
the risk and reward for keeping spending below the targets
or benchmarks, and in this sense, all of the providers'
incentives are aligned. But you may want to discuss this
alternative approach we've outlined.

Other items you may wish to discuss are preferred
ways to establish the episode benchmarks and the withholds;
ways to influence beneficiaries' selection of providers and
settings while preserving choice; the need for a transition
and possible approaches; and, once we've agreed on an
approach to bundling, we can conduct impact analysis to
begin to model the alternative ways to establish benchmarks
and withholds.

And with that, we look forward to your discussion.

MR. HACKBARTH: Thank you very much, Carol and
Evan.

Who looks ready? Mary.

DR. NAYLOR: Just because I wasn't ready the last
time. So thank you. Just a couple of questions.

First, this was framed as bundling post-acute, but
it's bundling the entire acute care episode, is that -- I
mean, meaning it's inpatient, post-acute, et cetera.  

DR. CARTER: And readmissions, right.  

DR. NAYLOR: And readmission.  

DR. CARTER: Right.  

DR. NAYLOR: And so I'm wondering how you would frame it as different from Model 2, which includes and allows for up to 90 days. This one, I think, says all condition readmissions, and Model 2, I think, has only related. Is that the distinguishing characteristic? I'm talking about the demo --  

DR. CARTER: I think you're right in terms of related readmissions being included in the bundle, and I'd have to double-check on that. My understanding of Model 2 is that providers could propose length of their bundle --  

DR. NAYLOR: Right.  

DR. CARTER: -- and so there's some variation there. Providers also were given choices about conditions that they could bundle. They were actually given many choices to include in their proposal to CMS, and now that CMS has approved a set number of conveners and participants and providers, they're working out those arrangements, including things like gain sharing arrangements and what
risk adjustment model and what quality measures to include and things like that. And our understanding is that, you know, at this point, those haven't been locked down and the providers that are in the mix may not end up in the end actually moving forward, so --

DR. NAYLOR: And one last question. Is there any thought that having this approach could actually increase referrals to post-acute care among those that might have just benefitted from community services? So is there a sense that one of the things you would have to watch for is maybe increased referrals for people that may not need those services?

DR. CARTER: I mean, it's true that the benchmark will reflect sort of the average mix in utilization. So to the extent that you use post-acute care more, you may exceed the benchmark. But it is something -- you know, in our proposal, we've tried to balance the incentive for stinting with trying to encourage the right setting to be used. But we appreciate that concern, and we're also concerned that it might generate bundles, and so we've tried to put proposed policies to counter that, as well.

MR. CHRISTMAN: I guess I would just add that it
may increase the frequency of post-acute referral for some
patients, but I think in that, one would hope there might be
a drop in readmission. So you might see what -- when you're
monitoring performance against a benchmark, you may see the
post-acute dollars rise, but hopefully, you'd see the
readmission dollars drop, and so --

    DR. NAYLOR: But you could also see hospital
lengths of stay drop as people get moved more quickly to a
different setting.

    DR. CHERNEW: I'm sorry. I have a clarifying
question on your clarifying question. So the original
admission is included. So, for example, if somebody has a
stroke, that first admission is included, and then all of
the subsequent post-acute admissions and all that other
stuff is also included. And so if you decided just to send
someone to the community, that first admission would avoid --
-- would get their whole withhold back. So you wouldn't have
the --

    DR. NAYLOR: That is -- I misunderstood --

    DR. CARTER: Well, they'd only get the -- they'd
get the withhold associated with the hospital spending,
right, because there is no full up-front bundled payment.
DR. CHERNEW: [Off microphone.] Their proportion of the withhold -- so they wouldn't have an incentive to send someone to post-acute, because the extent to which that ramped-up spending, it would reduce the likelihood that that original hospital for the original admission would get its portion of the withhold -- the withhold on its payment -- back. That's what I think you said.

DR. CARTER: Right, because we're not fronting the whole bundled amount.

DR. CHERNEW: Right.

DR. CARTER: Right.

DR. COOMBS: Before I put anything in my mouth, Table 3. I had a question about these with any PAC versus without any PAC, and I remember that during the LTCH presentation, we had an average cost of $17,000 per admission or something like that. This doesn't seem like a -- I mean, it's a savings, but it's not like a tremendous savings. So I'm wondering if this is additive or synergistic or just in terms of additional savings when you bundle it.

MR. HACKBARTH: Say again, Alice, where you are --

DR. COOMBS: So when you bundle -- the bundle with
PAC on Table 3 --

MR. HACKBARTH: This is in the paper.

DR. COOMBS: It's in the paper, page 16. The average cost per episode spending is $30,000. So are you proposing that with the bundle, you're going to go much less than that?

DR. CARTER: We didn't propose any specific amount, but so that right now is the average spending.

DR. COOMBS: Right. So you would propose potentially that if you were going to use the services here, it would be much less, because there's no difference between the separated fee-for-service that exists right now.

DR. CARTER: I'm sorry, I --

DR. MARK MILLER: No, go ahead.

DR. CARTER: No, I'm actually just not understanding your question.

DR. COOMBS: Okay. Go ahead.

DR. MARK MILLER: All right. Table 3 talks about average spending for selected diagnoses with and without the post-acute care services, so it's just reporting that. In the presentation, if you're tracking on the $43,000 number, that was just an illustration of one, you know, episode, and
it was completely illustrative.

DR. COOMBS: Okay.

DR. CARTER: Oh, yeah. That doesn't tie to any of these conditions.

DR. MARK MILLER: And it wouldn't tie to any of this here. So maybe I don't understand your question.

DR. COOMBS: So if you go to that slide, which it was the difference between the two costs, one was $41,000 and the other was $47,000 --

DR. MARK MILLER: [Off microphone.] It's just an illustration.

DR. COOMBS: Yeah. So for the illustration, for costs, the withhold of four percent still results in the same services being rendered and there's a gradient between the two. One goes over the benchmark, gets four percent withheld, but still, at the bottom line, still gets $45,000 versus the $41,000. So the four percent doesn't seem to be enough to make that much of a difference for the --

DR. MARK MILLER: [Off microphone.] And I think I now see what you're saying. You're saying, in that instance, even though actor number two on the far right ran over the benchmark and didn't get their withhold back,
because that row is zero, they still got paid more.

DR. COOMBS: Exactly. So --

DR. CHERNEW: [Off microphone.] Their costs were higher.

DR. MARK MILLER: And it's absolutely correct. I mean, this is an attempt to illustrate how the policy would work and you have raised a good point because maybe that isn't strong enough incentive and you would have to think about a larger withhold. But, of course, you'd also have to think about whether you're giving enough money to get the care done and all that, as well.

DR. COOMBS: Right. So what I was doing is actually looking at the chart that shows a stroke plus VACU [phonetic] care at 30 grand, and looking at the data that we had before and just comparing basically a higher benchmark -- the same benchmark but higher billing in terms of the bottom line, what you get from the four percent withhold with both cases.

MR. HACKBARTH: You know, this, too, is an illustration, but you put your finger on a key design issue. How strong do you want this incentive to be to be efficient without making it so strong that it encourages stinting on
needed care. So there's a balancing to be done.

MR. KUHN: Another question kind of on the
benchmarks but maybe from a little bit different angle -- so
we've talked a lot around this table in the past about the
different assessment tools that are used for post-acute care
and the development now of the care tool, which is step in
the direction towards kind of a site-neutral payment system
which, to a degree, bundling takes us towards more of a
site-neutral, hopefully, system as we move forward.

So, if the care tool was fully deployed, would
that have any impact in terms of benchmark calculation, or
is the benchmark total devoid of kind of the assessment
tools and kind of what goes on in the post-acute care area.

MS. CARTER: Well, I think it would help in terms
of setting a risk-adjusted benchmark because right now we
don't have assessment data for folks who use long-term care
and, maybe more importantly, we don't really know the
functional status and cognitive status of patients at
discharge from the hospital. If we had all of that
information, I think you'd have a better way of establishing
accurate -- more accurate -- benchmarks.

MR. KUHN: Thank you.
MR. HACKBARTH: In the absence of a really good tool like this, this sort of accepts the world as it is with its imperfections and says, well, how can we create some incentive at the margin to try to improve it, whereas the care tool takes sort of a fundamental reform approach. That's the way I think of it.

MR. KUHN: I think that's a fair way, and that's kind of what I was trying to think about. Is it an either/or, or is there a blend of the two as we go forward?

MS. UCCELLO: I'm afraid this might be a blend, but I'm going to go for it now. For slide 13, I'm just trying to understand the incentives between the different providers.

So, if you have a hospital and you have the PAC providers, and now -- so the hospital sends somebody to a SNF.

Now the SNF could say, well, I don't care. I'm going to be paid fee-for-service. I'm going to just bill high. And so what? The hospital doesn't get its withhold back? I don't care.

MS. CARTER: These would be withheld 4 percent from every provider.
MS. UCCELLO: From everybody.

MS. CARTER: Right.

MS. UCCELLO: But looking at the right-hand column, in a sense, they're paid more.

But my question then is, does this still provide incentives for the quasi-partnerships?

Can the hospitals say, well, no, I'm not going to send somebody there anymore because I see that they're just acting totally in their interest rather than kind of across -- I mean, is that what we hope is kind of going on here to prevent one of the actors from saying, well, I don't really care about this thing on the whole; I'm going to maximize what I can get?

MR. HACKBARTH: Although your initial point is one of the basic design issues with withhold-based systems, at the first level of analysis, every individual player's incentive is still to maximize their fee-for-service payment and do that enough so that the loss that we share collectively doesn't hurt too bad. And so, withhold arrangements by themselves do not create really strong incentives for joint action.

Now it may well be, though, that if the SNF in
your example behaves that way the hospital and/or other participants say I'm not going to send anymore patients to them. So you exclude them, and that's the punishment for inappropriate behavior -- is exclusion from the referral network.

MR. ARMSTRONG: So just building on that for a moment, we've looked at various ways of constructing bundled payments for post-acute and for other kinds of services in the past. This whole idea of withhold as a mechanism for bundling payments -- have we ever tried an alternative that's sort of a sub-cap kind of a payment for a set of services, which would create a totally different dynamic but also some infrastructure issues too, I suppose?

MR. HACKBARTH: Yeah. Well, I think the tradeoff. MR. ARMSTRONG: Have we ever examined that other alternative? Is that work we've done?

MR. HACKBARTH: Carol?

MS. CARTER: We have not, no.

MR. HACKBARTH: So, to me, all other things being equal, setting aside all the organizational issues, which is a big set-aside --
MR. ARMSTRONG: It is, yeah.

MR. HACKBARTH: -- moving to a true capitated payment is preferable to this sort of withhold mechanism with fee-for-service payment for two reasons. One, the incentives are much stronger, both on total cost and for collaborative behavior, and second, because by getting out of fee-for-service payment you allow a free flow of dollars within the system to where they can do the most good for patients.

The problem is that it requires fundamental change in provider organization and relationships. That's the tradeoff.

MR. ARMSTRONG: So that was what I was thinking about, and I think this is a round one question.

So on the one end we have fee-for-service, and I know how that works, and you're paying on a real micro level for services.

And on the other hand you have Medicare Advantage, and that's 100 percent prepaid. So we're in this middle space.

And when you look at the total spend, we're carving out what we're calling post-acute care services,
And I'm wondering, first of all, if we have a sense for of the total spend how much are we trying to package into this bundling idea?

And then, second, is it possible that we could actually reduce payments to post-acute services through our proposal but, in fact, increase the overall PMPM that we're spending because costs end up going somewhere else?

MR. CHRISTMAN: Well, I think there's a few pieces to your question, and so to just give you a frame of reference, if I recall correctly, just the post-acute dollars in fee-for-service are about $50 billion a year. Also, remember we've also included acute care in our bundle. So it's a pretty big piece of the fee-for-service spending.

And, if I follow your second concern, you know, one of the things that we have talked about as a problem is that providers would have an -- if you pay them based on a bundle, they have an incentive to generate more bundles.

I don't think -- you know, we've talked about it a little bit in this paper, that the volume of bundles is something you would have to watch if you were to implement this.
But in terms of what you would do in the next step if you started to see some different trends that raise concerns, I suppose Nancy and Sara have been looking at potentially preventable admissions and potentially preventable visits. And I think -- and I'm not that familiar with that project, but I think you start to go down that alley to sort of address the concern you're raising.

MS. CARTER: Do you remember the chart that Jeff showed this morning where he had fee-for-service on one side and then ACOs and then MA?

MR. ARMSTRONG: Yeah.

MS. CARTER: Well, this is kind of to the left of ACOs, right?

MR. ARMSTRONG: Yeah.

MS. CARTER: Okay.

MR. ARMSTRONG: I've got ACOs in my little chart here, too.

MS. CARTER: Yeah.

MR. ARMSTRONG: This probably is taking my second round question, but if you actually combine acute care and post-acute care spend, you're bundling a huge percentage then of our overall spend into this proposal. And it just
might be worthwhile as we're going forward, kind of putting it into the context of that overall spend and how we're in that middle territory where we're trying to do something in between Medicare Advantage and fee-for-service by bunching big chunks of the spend.

Anyway, that's kind of clicking up a couple file folders, but it would be good for us to look at that.

DR. NERENZ: Yeah, a couple of related questions, and this may end up being sort of a sharper version of Cori's question.

Let me preface, I'm a fan of bundled payments.

MS. UCCELLO: Are you saying I'm not sharp?

DR. NERENZ: No, no, this is -- I'm going to be --

DR. MARK MILLER: I'm pretty sure that's what I heard.

DR. MARK MILLER: That's what I heard.

DR. NERENZ: No, no, no.

[Laughter.]

DR. NERENZ: No, that has to do with the tone of the question coming. You're fine.

And I preface, I'm a fan of bundled payment, but I'm a little worried about some of this.
It occurs to me in looking at this slide in particular that I see no positive financial incentives for any individual providers or any collection of providers relative to just doing nothing; status quo. If this were a voluntary demonstration project, I don't know who would step forward to participate.

So, I guess, first, am I missing something?

MS. CARTER: We're not talking about something voluntary.

DR. NERENZ: Okay. That was going to be part of the --

MS. CARTER: And we're talking about some kind of benchmark that's lower than fee-for-service, and we're talking about some withhold that you would not get back. If you don't pay attention and do nothing, you may not get your withhold back.

So that just depends on -- those are the moving parts, and depending on how you perform relative to the benchmark that would be what's at risk.

DR. NERENZ: Okay. I just wanted to make sure I understood.

MS. CARTER: Yeah.
DR. NERENZ: Heavy stick, little carrot, I think it looks to me.

Okay. Now just when I look at the column down the middle, when I compare that, for example, to the ACO shared savings model, that kind of approach gives the organizations at least some option to recover the difference between 41 and 43, but I see that you haven't illustrated that here. Is there a reason why that's not built in here?

MS. CARTER: Well, they've covered -- the payments covered the services that they billed for. That 41 was what they billed out, and that's what they got paid for.

DR. NERENZ: Right, but just let's make sure. I mean that there is no shared savings element here that is providing some of the current attraction in the ACO model.

MS. CARTER: I see what you're saying.

DR. NERENZ: In the ACO shared savings, you get some money back for having gone from 43 to 41. Here, you don't. Okay.

MR. HACKBARTH: So why do it that way, Carol?

MS. CARTER: I'm sorry?

MR. HACKBARTH: Why do it with an approach where there's no positive shared savings; there's only a stick?
MS. CARTER: I guess we were thinking just if you build out those services, would the payments cover that, and the answer was yes.

So are you saying, so then we should pay them more than their payments that they billed as sort of a reward for having --

DR. NERENZ: Yes, actually, because it costs you money to go from 43 to 41. You have to do medication reconciliation. In fact, you listed some of the things. You have to incur costs to do things differently, to go from 43 to 1.

In a shared savings model, you recoup some of those costs.

And in some of the illustrations, it's even debatable on the ACo side how long it takes you to get there. We looked this morning. You have to achieve a substantial target savings just to recoup the incurred costs of doing the work. And just here, there's none of that.

DR. MARK MILLER: What I would say is that if you -- we're trying to start off with key -- what we've moved away from -- and this was some of Scott's questions and some of the things that Bill Gradison was saying earlier this
morning.

How much weight could a hospital carry if you were
to just give them a dollar amount, say, for example, and
then let them manage everything from there? That becomes
probably a difficult proposition.

So this stays in the fee-for-service world, and so
the change isn't as dramatic.

So, if you set all of this at averages -- you
know, average episode spending -- and engaged in the
behavior that you're talking about, you essentially end up
spending money in all likelihood.

Now, if you wanted to pursue your approach and say
I want a shared savings approach for this, one thing you
could consider here is to set the episode bar below the
average and then discuss sharing savings off of that lower
average.

So my only caution in the exchange there would be
this could be a different conversation depending on where
you wanted to set the bar.

DR. NERENZ: Right. And this guy really was
trying to stay consistent with this round one. I was just
trying to clarify the thinking that led to this layout.
That was all.

DR. MARK MILLER: I think it's Cori you're going to have to deal with after the meeting.

[Laughter.]

DR. NERENZ: I'm just going to ask a meaner question. That was it.

DR. HOADLEY: [Off microphone.] I have nothing.

MR. GRADISON: I'm still trying to understand going into this, it's my understanding that the post-acute care settings -- the very settings. They would bill separately as they do today, right? Okay.

I assume to make this work -- I think it's in here -- the payment would be for a particular condition, risk-adjusted and so forth, but not based upon the site of care. So we got that.

So we develop a benchmark -- I'm looking at table 13 -- of $43,000. Now you've shown what happens if the spending is at 41 and 47. What if you build 43, do you get 43?

MS. CARTER: Oh, I'm sorry. If you -- yeah.

MR. GRADISON: You get 43. So why would you build 41?
If you know the benchmark is 43, you build 43, right?
You don't build 43?
I'm having a lot of trouble with this. And I'll come to some related questions in a minute, but I've got to understand, though.
You've given the 41 and 47 examples. I'm just asking, what about 43, which is what you say is the benchmark?

MR. HACKBARTH: I think the answer to Bill's question is, yeah, you get back your withhold --

MS. CARTER: You get the withhold back.

MR. HACKBARTH: -- and you pay 43. If that's not right, somebody needs to explain to me why it is right.

MS. CARTER: At or below the benchmark.

MR. GRADISON: Okay. If you build a benchmark and -- okay.

Now what --

MR. CHRISTMAN: I guess one thing I would just add, though, is that we're talking about setting that benchmark at less than the national average for the rate now. So in some sense, if the provider was significantly
below the average, perhaps they could go up and still be at that 43. But I think by setting the benchmark below the average many providers would still have to change their behavior to get there.

MR. GRADISON: Now to do this wouldn't you just have to -- for a given condition, regardless of site of service -- set whether it's called a DRG or a RUG or something, that this is the benchmark for a particular type of post-acute care, item by item?

I presume you'd want to do it a few at a time. So you'd pick some particular conditions.

DR. MARK MILLER: No.

MR. GRADISON: No?

DR. MARK MILLER: Bill, let me pick up there. So what's going on here is that the underlying payment systems largely remain unchanged. Okay.

So, if you use a service, Medicare fees -- you know, Medicare payment rates as they exist stay in place.

The episode benchmark was more conceptual in the sense of saying, okay, for a 90-day episode that's triggered by a hospital for these particular services -- and this is just again, for the public, just an example. In this
particular instance, it's 43.

So the providers engage in their behavior, and that dollar figure, whether it comes out at 47 or 41, is a function of both what Medicare is paying and how many services are used. And then whether they hit that 43 or not, above it or below it, is a function of whether they used more or less services and how each of those services was priced in the regular fee-for-service system.

MR. GRADISON: Now I'm really confused. I understood from the discussion a few minutes ago that the hospital was not at risk if the post-acute care setting turns out to be more expensive than we would like it to be.

DR. MARK MILLER: Everybody -- hospital, post-acute care provider. They're both at risk.

MR. GRADISON: Then I have to circle back to my fundamental question here. How is that going to work in a system where under current law the choice of where you go if you have to go to a nursing home, to a SNF, is not the hospitals?

And, in fact, they've got to be very careful what they say or what they do because the choice under statute, as I understand it, has to be preserved.
And it may well be that the patient or the physician, for reasons that the hospital doesn't even agree to, wants the nursing home to be a mile from the home of the family rather than the better one 10 miles from the home of the family.

I don't quite understand how this system can really work the way we want to and still maintain the current rules of choice. But that's, I guess, a part two comment. I didn't mean it to be, but I didn't understand.

The hospital then is at risk. It may not be at risk for $50 billion, but it's at risk for a significant amount.

And just to go a little step further from what I was saying earlier in the day, that may be the way we want to go, ultimately, but to do it really is saying we're going to turn the world over to the insurers because they're the ones who are going to have the capital, the experience and the wherewithal to make this work.

It can't possibly work with the hospital because they're not sufficient as -- because they -- it has no reflection upon their capabilities as providing health care, but in terms of providing capital and accepting risk, $50
billion may just be a little high.

MR. HACKBARTH: So I think you put your finger on what's a really important dilemma for Medicare that pops up in various places. I'm not sure I would agree with all of the last part of your statement.

We do have this issue where traditional Medicare is a free-choice-of-provider system. Indeed, it is in the second section of the Medicare law that Medicare shall not infringe on the patient's free choice of provider. That design feature, which is at the core of traditional Medicare, is always a potential hurdle when it comes to establishing accountability for total cost of care.

This is an issue with ACOs. The design is no infringement of free choice but accountability for total costs over a period of time for a defined population. So this is an issue that we're always tugging at.

Now here it pops up in a much narrower form than on ACOs. The only infringement on free choice is the potential use of different post-acute providers. That's not to diminish its significance, but in some ways the ACO problem is bigger than this one, at least when you have downside risk --
DR. CHERNEW: Yeah.

MR. HACKBARTH: -- on the ACOs.

Now having said all of that, one of the reasons I thought you could still maybe have ACOs work is free choice is influenced heavily. The patient's choice is heavily influenced by provider advice. And so it may be that in fact you can hold somebody accountable -- a provider or group of providers responsible -- still given the beneficiary free choice, and providers will use their relationships to influence where the beneficiary goes.

But all of that is not to deny for a second that there is some friction between establishing accountability and a free choice system. The two at some level are at odds with one another.

DR. MARK MILLER: And the only thing I would add -- and I think this made its way into the paper, Carol, but I'm forgetting now.

There was some discussion, at least among ourselves and in some of our other meetings, of whether you start to think about changing those rules so that if a provider decides, like Cori's example, that there’s a SNF that is really a bad actor and makes referrals, that you
allow those rules to be somewhat relaxed. It's a decision, but I thought there was some discussion of that in the paper.

The other thing I'd like to do is just maybe offline talk to you a little bit about the hospital risk because we specifically -- and this is to some of your comments from previous meetings. We specifically think that this mitigates a lot of the risk for a hospital.

Ultimately, the hospital is at risk for its withhold, whereas if you go a full blown bundle and hand them the dollars, they're at risk for the entire post-acute care episode, however defined. So, in some ways, we felt like we were dealing with some of your concerns about the hospitals being put in the cross-hairs.

MR. GRADISON: Well, let's talk about it separately.

My understanding is in addition to hospitals you're talking about physicians here. The physician's bill might exceed the hospital's bill for very complex procedures, and that raises a whole series of other questions about what role they play, what influence they can have other than a wink and a nod, which is kind of what you
were saying. It might influence them a little, but they still have free choice.

We'll talk about it separately. I don't want to take an undue amount of time, but I see some things that seem to be in conflict.

And I kind of wonder whether we wouldn't be better off long-term, as an interim step, to get away from this differential in payment for identical conditions based upon the site of service and take that step first, but I appreciate that's pretty modest.

MR. HACKBARTH: I guess what we're -- as I hear the discussion around the room, we're not necessarily using this as a cost containment method, I think. Aren't we saying what we're trying to do is improve the overall quality of health care for our Medicare recipients? That's an important distinction.

DR. MARK MILLER: And again, I think that would depend on how deep or shallow you wanted to go on a benchmark and the withhold. I think our first and most important objective is to try and create some incentive to coordinate.

So perhaps Cori's point ends up being that there's
an actor who says I'm going to maximize my own revenue, the
good with everyone else, but at least under a system like
this, you would start to want to reach out to your community
to figure out whether there is a way to stay underneath the
benchmark.

MR. HACKBARTH: Right. So I guess you can't
always control for the extreme exception, but it seems to me
that no physician works in a vacuum now. You may be an
independent entrepreneur, but you have to depend on certain
systems, use facilities that are out there, whether it's a
hospital or a nursing home, and they have their own quality
standards, which most human beings would say are meritorious
if they're set up the right way.

So I think basically what this is, is an attempt
to gradually move as many other initiatives we're taking, to
point out that the fee-for-service system may not be viable
for a long period of time in the modern health care system.

MR. GRADISON: I agree with you.

MR. HACKBARTH: And, to me, that's -- and I think
maybe they can't be giant steps, but I think bundling is not
a bad place to dip our feet in the waters here.

MR. BUTLER: [Off microphone.] Where are we?
MR. GRADISON: This is round one.

MR. BUTLER: Come on, don't blame me. I didn't say anything yet.

MR. HACKBARTH: [Off microphone.] Look at it this way; you had the last word in round two.

MR. BUTLER: Okay. Okay, so I just have one round one question.

These are examples in the text. You have actual kind of bundles with and without post-acute care. Do those adjust for -- to do this thing right, you have to pull out things like the add-on payments. You've got to adjust for wages. You've got to adjust for all kinds of things that basically make it so that you're looking at utilization differences as opposed to a pricing and add-on payments difference.

And that, technically, either you've done or you feel pretty confident can be done because when I look into our own medical spending per beneficiary that's not a simple thing, but that's what you're trying to do.

MS. CARTER: Right, and these are standardized payments. So we took all of the add-ons and the outlier payments out.
MR. BUTLER: Okay.

MS. CARTER: So it's to exactly get at that.

We're trying to show utilization differences.

MR. BUTLER: I'm not sure your outliers belong out, but, okay.

MR. HACKBARTH: So let me begin round two with a question that I invite people to react to. If Medicare were to go down a path like this, one of the questions that would arise is how this relates to some other ongoing activities. In fact, I think we alluded to this in an earlier discussion.

Does it make sense to do this bundling around an admission if you want to move to ACOs, if that's the comprehensive model is your long-term objective?

How does this fit?

Does it make sense to do this as, as some people have said, a halfway house that allows people who aren't quite ready for the full ACO thing to sort of do it on a smaller scale, and it's a way to move into the accountability world in a small way?

So that's a question.

Another activity that we have in current law now
is the readmission penalty. How would this fit with the readmission penalty?

Do you do the readmission penalty in this, or does this supplant the readmission penalty?

And then the third question is in the paper Evan and Carol describe the ongoing CMS bundling demos, which take still different approaches to trying to establish accountability for total cost and quality around admissions and post-acute care. How would this fit with those?

Are we saying stop the demos; do this? Or, what's the division there?

So it would be easy for us to focus on all of the details of how this might work, and that is an important conversation to have at some point. But maybe the first conversation is, if we want to do anything like this, how does it fit with the other initiatives that we've talked about that are now underway?

So I invite comments on that in round two.

DR. NAYLOR: So I, conceptually, think this is an area we should pursue because it is unique and different from ongoing initiatives and adds a very important perspective.
I do think that -- to answer your three questions -- one is that we would carefully, as Evan has suggested, need to monitor hospital admissions to make sure that the opportunities and availability of bundles, especially these kinds of bundles, don't create incentives for the index hospitalizations to grow.

I think in terms of the readmission policies the opportunity here is to look longer-term, the 90-day look, whereas the readmission program is looking at 30 days. It's a really important one because it forces the building of collaborations and partnerships between hospitals and post-acute providers.

I think the focus on all condition readmission for the Medicare beneficiary is exceedingly important and is not the focal point of the CMS demos. They focus on hospital-related.

The thing that I really do want to ask is a very fundamental question in design. When I read this a couple of times, I missed it.

So is this a bundled -- I'm Mr. Smith. I come in for an acute episode of heart failure. Is this a bundled payment for heart failure admission and whatever happens in
90 days, or is it a combined heart failure plus home health
or skilled nursing or LTCH or whatever?

In other words, fundamentally is this -- I thought
the design issue here was hospital plus post-acute rather
than just hospital and whatever happens in the 90 days.

That gets back to your question.

MS. CARTER:  So this is a bundle that spans 90
days, and the 90 days starts at hospital discharge. But the
bundle episode benchmark -- so let's say in this example the
43 -- includes the initial hospitalization, what you term
the trigger hospitalization. It would include any post-
acute care.

DR. NAYLOR:  But it doesn't require post-acute
care. That is what --

MS. CARTER:  Well, because it's a fee-for-service-
based model, the post-acute care providers get paid if
they're used, but --

DR. NAYLOR:  Honestly, I kept reading it as a
combined post-acute plus, which I thought also distinguished
it. Okay.

[Off microphone.]  So, it doesn't require it,

okay.
DR. BAICKER: I think this is a very promising direction to go, in part because a lot of the big-picture things that we are talking about are phase in slowly, have very low powered incentives involved and are a step towards a broader system reform, whereas the counterbalance to that is doing what you can in the system you have now. And this has, I think, a greater potential to have higher powered incentives in the short run even though it's still within this architecture that we're trying to move away from in the long run.

I wouldn't want to throw out reforms like this because they don't move us as far away from that infrastructure because they may be more effective in the short to medium term and don't run counter to those other things we're trying to do.

MR. HACKBARTH: So, if I understand you correctly, you're saying that you think it's appropriate to do this and ACOs, that this can be a useful sort of interim step.

What about this versus readmission penalties? How do you see those relating to one another?

DR. BAICKER: I think that there's a downside to having too many different policy levers trying to be
deployed at the same time, that the incentives may be not orthogonal but not exactly parallel.

And I think the more different -- slightly different -- pulls there are, that can undermine the effectiveness of each, but I don't feel well enough informed yet to say this versus that.

So I've a strong sense that they should be harmonized, but I'm not clear on the space of how well they might actually work in conjunction, together.

DR. CHERNEW: I think that the word, bundle, is a little confusing in this discussion because bundle has this notion that there's a fixed amount of money that someone is going to get no matter what happens, and that's not really what's happening here. This is basically a withhold program.

So, if I understand correctly -- I'm still in my first round one question -- say the initial index admission was $20,000. The hospital will get paid that minus 4 percent of that. If nothing else happens, they get that 4 percent back, all said and done.

If they send someone to a post-acute setting, that begins to move up towards this budget. And as soon as it
exceeds -- as soon as all the post-acute stuff, any
readmissions, exceed what that original budget is, then all
the organizations that have provided that care -- the
original hospitalization, all the other post-acute -- they
begin to note get their full fee. They get their full fee
less, basically, 4 percent.

And there's this weird range before you get to the
sort of max withhold reduction where they get a portion of
it but not the full thing.

That's how I think that this is set up, just
mathematically.

Then the question is, is that design good or bad?
And the question, of course, for any good and bad
is, relative to what?
I think if we have nothing else running around I
think it's better than the status quo.
Relative to readmissions policies, I actually am
not a big fan of the readmission penalty as a general rule
versus things that I've learned relatively recently, in part
because a lot of concern that there are issues related to
socioeconomic factors. And we've had a lot of discussion
about that. So I would have to look at the exact version of
this compared to the exact version of that and the magnitudes and a bunch of things.

I prefer broader things like ACO, personally, ACO-type models, but I agree it's not clear how quickly we are going to get to those types of models.

This is an area where I think there are such clear problems in the use of post-acute, that anything we can move in this direction probably gets me over the hurdle to support it, but I am admittedly worried about how it fits in both with all the other procedures and, frankly, the political lift and intellectual distraction of trying to sort -- even if I didn't worry about it, just if we spent all of our time trying to figure out how to perfect this version for all of the legitimate things that Bill talked about with this, I think that might distract us from moving in a direction, just emotionally.

So, in the end, I guess it remains to be seen.

The concern, of course, is that the incentives for the hospital is not to do post-acute care. Everyone, incrementally, is responding to these incentives, and I haven't mapped out how that choice is being affected at each point in the choice phase.
So I think it's worth us exploring a little bit more, but I think we have a way to do, to figure out how to answer Glenn's questions.

DR. BAICKER: Just to make sure that I understand the relationship between this bucket of policies and the readmissions penalty, I'm sort of thinking of that as nested in this, if we think about the withhold flexibly in terms of functional form. Really, that's a form of bundling where you're getting a clawback that's just not one for one.

And so, the question is, is that what's — then the question reduces to, what's the right clawback and what's the window over which it should be implemented?

And if you think of that framework, then the —

DR. CHERNEW: [Off microphone.] And who pays it.

DR. BAICKER: Right. Then the readmission thing would be part of that whole question. It's not a separate thing. It just has to be harmonized in terms of the parameters.

DR. MARK MILLER: And this may be way too simplistic, but the way I was thinking about it is if you had -- you know, we've been talking about the readmissions penalty to move to a potentially-avoidable-but-
all condition.

So then let's say somebody began to say, you know, I think we're ready to move forward on this. Somebody. And then they started off with five DRGs. So, for those five DRGs, they're no longer in the penalty because readmissions now have been dealt with here for those DRGs.

MR. HACKBARTH: So you see this as supplanting --

DR. MARK MILLER: I see you could do it that way.

DR. CHERNEW: This is going to put a lot of burden on the actuaries. Who's facing the incentives under this and how much incentives they're facing is very different than the readmission policy, which is coming -- basically, the way we have it now, it's coming out of the hospital but not the post-acute setting, and the magnitude there is a different percentage relative to this magnitude, but it's off of a different base.

MR. HACKBARTH: [Off microphone.] Let's continue around.

DR. COOMBS: So I agree with Mike.

My issue is one of the notion of readmission for any cause. Say you have a hip, and you come back for something else -- pneumonia. And that 90-day period is
extraordinarily long.

And just on first blush, looking at the slide here in consideration with some of the other factors, it would be a real disincentive to do a CABG on a diabetic who has a high incidence of a wound infection and has to come back and have multiple interventions, may go to an intermediate care facility and bounce back on multiple occasions for which the cardiac surgeon will be responsible for that patient.

Why would you consider this risky patient where there's so much time investment? You'd have to be a missionary.

So my concern really is this 90-day window where you're really on the hook for people who -- you may be having a region of the country where you have these patients that are just sick. You know, they're just very, very sick.

You can't be responsible for something you cannot predict. I mean, you just can't be responsible for that.

It's not like you planned that they were going to have these other comorbid conditions for which there are exacerbations.

And so, for me, I'm looking on that side of it.

And I think it's a good idea to do something where it forces coordination with the people in the village, but
you have to watch what you do because the unanticipated negative effects will be that it will steer people away from this table 3.

I'm just going down through the table 3 and looking at some of the diagnoses: Septicemia with ventilator, 96 plus hours and the cost of that, and the patient bounces to a place that's really good with ventilators, and all of a sudden you have another problem. You know.

The whole notion of bowel resections -- some patients actually go to these facilities with wound vacs in, and if they have some problem with the wound vac and they bounce back for problems -- mechanical problems -- with the wound vac or, say for instance, they develop some kind of super infection -- I know it's one of those things that should never, ever happen, but it does happen.

And so, I'm not sure that this 90-day period is one of those things that makes people want to run toward these patients in table 3. That would be one of my concerns.

I'm going to sit down and think a little bit more about this. It gives me warning signs. The hairs on the
back of my neck just kind of stand up because if I was
trying to manipulate the system or gain the system I clearly
see there's a way in which I could do that.

And I think just to put a form out there to say we
force coordination -- there's no cost-sharing. There are a
lot of things that are really missing from this puzzle.

I would favor the ACO plan more so than just
something that just kind of makes us kind of come together
in terms of coordination between providers. I like the
idea, but I'm not sure this is -- I like the idea of
bringing us together, but I'm not sure this is ready for
primetime.

MR. KUHN: Well, for the last subject on a long
day -- and Carol and Evan, you've given us plenty to think
about -- it stimulated some interesting conversation.

Glenn, kind of responding a little bit to your
questions, how they relate to one another -- and I'm glad
you framed it that way because to a degree, when I read the
paper and as I listened to the earlier conversation, I kept
thinking in those ways. So kind of three tiers come up in
my mind.

One, if we're really thinking about proper post-
acute care placement, is that already in the works in terms of the care tool or better assessment?

So is that work already ongoing as we move forward versus is this really looking at readmission?

And right now we know we have a 30-day policy.

This looks at -- to a degree, one way you can think about it is this is kind of a 90-day readmission policy for all -- you know, one way to kind of look at this.

But there already is a readmission policy that's just kind of getting up and running. It just started last October.

Versus a third thing is the issue of care coordination, whether it's ACO -- also readmission policy gets into care coordination as well.

So what I was thinking as I kept looking at all of this -- are we really layering on?

I think Mark's point made a good observation -- is that, well, do you just carve out those certain areas as part of that? You know.

So, again, I think there are a lot of things going on in all these spaces. How do they kind of all interrelate with another so you don't have the layering-on effect?
Bottom line for me is I think there's been a lot of good questions raised. I think this is something worthy for further conversation. I'm not sure which way I want to go with it right now, but I think we ought to at least continue the conversation and look at additional policy options here.

DR. DEAN: In general, I find the bundling idea appealing although, as Mike points out, this isn't exactly bundling in the way we've talked about it before.

I guess my concern would be we need to stop and think, what are the incentives for any individual provider within this structure, and I fear that they're not the same as what we're trying to get to overall.

And it even has -- some of the aspects of it make me think of the SGR and the fact that any of us can be perfectly responsible and yet still be penalized because of somebody else's actions. I think we really need to be careful about that.

DR. SAMITT: So I'll go directly to the questions that you asked because I think it frames the opportunity well.

Yes, I think it makes sense to do this. Even with
everything else going on with ACOS, I think it's complementary because I think it appeals to a different provider population that may not be in ACOs today but is yet another means to promote a value-based care delivery model. And now, again, we're getting at another sector that needs to think in this direction.

So I think it's complementary.

I think it will help in transition, which was one of the discussion questions, by focusing on a select set of conditions, and I think this is what Mark alluded to.

I think when it's done that way it supplants the readmission penalty. I would agree that that's what we do, that we don't double-count that way for those conditions, that it's inclusive of those conditions for readmission, but the readmission penalty methodology still applies for the conditions that are not part of this global post-acute bundle.

So I think that, too, is potentially complementary.

I'm not sure what to say about the demos. In the paper it talked about the fact that the demo phase is a no-risk phase right now. So it just feels like it will take
too long to see if this will work, and I'd rather see some potential results sooner. So maybe they can still happen in concert.

And then I'd rethink the methodology because while we don't have to do traditional bundling I don't see much incentive to change behavior in this. I mean, the way that I envisioned it would happen is that if you're below the benchmark, you're trued up to the benchmark; if you're above the benchmark, you're trued up down to the benchmark.

It's really more of a methodology that you don't have to subcapitate. You can still do a shadow pricing methodology like this, but I think you've got to create an incentive for the right stuff to happen and a disincentive for the wrong stuff to happen.

And then one other comment, the alternative bundling strategy that was referenced -- you know, that's intriguing to me because it seems to include physicians as well, and then it's not just the hospitals that are on the hook for the total bundle, but it's the doctors that will potentially influence some of those decisions as well.

So I don't quite know how that would work, but I kind of like that alternative strategy, and I'd be
interested in learning more about it.

MS. UCCELLO: So, despite the questions and the downward spiral they caused in the first round, I am supportive of further consideration of this. And I think if we look back to the first session and that continuum of fee-for-service to MA plan, this moves us to the right of fee-for-service.

And, if we think about making sure we do it in a way that -- this may or may not be the perfect way to do it, but does it help start to -- help create incentives for the coordination and discussion across providers, and I think this does have the potential to do that. The details matter, but I think this is worth pursuing.

DR. REDBERG: So I am certainly supportive of the concept of bundling and how it could help ensure care coordination and not paying for the same services at different places differently.

But I have to say maybe it's the hour, but I'm a little confused now on how this actually will work in terms of the bundle because when I look at that I thought, well, the people that are spending too much are still going to get more. So it's not really an incentive to do less. They
just will lose the 4 percent withhold, but overall they're
coming out still ahead.

And plus, I guess, you could talk about what the
benchmark should be.

And then there's always -- you know, just because
-- and we started talking about, well, this would fit sort
of between ACO, and I feel like it's already so complicated.
I guess it's just hard working within our system, and I can
see if we want to do something more quickly or shorter-term,
then that's what we have to do, but my sort of ideal scheme
of things gets simpler instead of more complicated.

And then we would always have to watch for is it
post-bundle expenditures shifting to outside bundles, and
that would take a little while to actually determine if this
would actually work or just shift.

And then the last sort of thing that now I'm
confused about is how the bundle would work in terms of
where you chose your site of service because we know that
some post-acute care is less expensive than others although
what I got from the demo was that the outcomes seem the
same. Presumably, the benchmark would be different, or
those more expensive sites of post-acute care would still be
getting paid more because it's still a fee-for-service system.

So how would that change then the use of more expensive post-acute care when less expensive would give you the same outcomes? How would this address that?

MS. CARTER: Well, you would be more likely to reach the benchmark if you used a more expensive mix of services.

DR. REDBERG: Less likely to reach the benchmark -

MR. HACKBARTH: People doing the referring would have a reason to say, does this patient really need to go to an LTCH versus a nursing home?

DR. REDBERG: Well, I guess it depends if the benchmark was set according to the IRFs or the SNFs or whatever.

MS. CARTER: Right. Presumably, it would represent some mix.

DR. REDBERG: Overall, I'm supportive.

MR. ARMSTRONG: So, despite the fact we're kind of at the end of a mind-numbing day, I actually think this is one of the best discussions this group has had in a while.
I really love this proposal that you put together. It's what we asked for, but it's a level of specificity. So it really describes how it might work, and it gives us something to react to and ask, I think, really productive questions around.

I think as it is it's worthy of, and needs more, discussion and so forth, but I think it's an excellent, really concrete idea that's consistent with the things we've been asking for.

And then to kind of move from the concreteness and specificity of the proposal to this conversation more broadly about, wow, how does this fit within all the other things we're trying to do -- and I really like -- you know, we do -- I don't know if this is the right way of framing it, but my hope is this is part of our agenda at the retreat.

We've got all this work going on in fee-for-service. We want to get the payment right. We want to -- you know, and whatever.

And then we've got MA, and we want to make sure that's doing what we expect of it and how hospice fits or doesn't, or whatever.
And then you've got all this stuff in the middle that we're working on, and we're trying to make sure that the different initiatives that we're pushing forward actually kind of hold together and make sense and don't conflict with one another or build on one another.

And I think with some time we could get clear about the criteria we use to judge those things too:

Are they trying to save a cost problem that's an obvious problem?

Are they trying to deal with margins that are inappropriate?

Are we trying to do something that improves quality and coordination because we know those are things we are really concerned about?

Or, are we investing in a pilot or a policy change or payment change that we think will help advance industry's reform to a future that we think would be different?

I think those are different criteria, different outcomes. Right now, we're kind of laying them all out. I think we could be a little bit more structured about how we evaluate that, and I think that would be really great work for us to do.
DR. NERENZ: I agree with Scott. Thank you very much for putting something with this level of specificity in front of us so we could really discuss it and sink our teeth into it. It's a really nice job.

Within this particular framework, just a couple of things -- I would encourage thinking a little bit more about adding some carrot elements, including possibly a shared savings component because of issues people have raised about problems with incentives.

I'd also encourage considering more about some of the regulations and rules embedded in fee-for-service that perhaps could be relaxed or eliminated in this model to make it easier to do some coordination of things like steering people to good and efficient rather than other places. I understand the difficulty, but I think we look at it.

Even with that, I share Tom's concern about there being some SGR dynamics in this. It looks a lot like that. With that in mind then, the discussion might be extended to say, what about a true, real bundled alternative?

We're clearly looking at a fee-for-service billed system here as a way to transition to that perhaps with the idea that as many current providers as possible could at
least be players in a system like this, built on fee-for-service. But maybe that's not the best and most effective way to transition.

Maybe what you want to do is put forward a true bundled system that only a few organizations currently can step up to. But if it works and if it's attractive, then other organizations will create the ability in the future to step up and do it. So I wouldn't totally ignore that option as well. I'd like to see that in the discussion.

DR. HOADLEY: So I agree with Scott, that this really took something we always talk about in sort of vague, warm and fuzzy terms and tried to make it concrete, and that gave us things to react to. Sometimes we don't like what we see, and so that's where we've gotten to.

I guess some of the things that make me think about that I haven't heard anybody specifically articulate — because the underlying payment systems that we're bundling together are prospective payment systems with their own bundles, the dollars that go in to make up the payments, to make up the 41 or the 47, come in these big lumps.

So the hospital is getting one big DRG, and yeah, maybe there's worry about what we do about outliers or other
things like that. And many of our other post-acute systems come in big lumps. And so you might jump from 38 for the hospital to you can either add 6 or 10,000 or whatever, based on which post-acute.

You're tempted to think about it as if these are continuously variables, like every day of the nursing home is another $200 or whatever, the way the older systems were. I think it just gets harder to think about it with the payments all coming in those lumps as well as the sort of lumpiness of the different options for the post-acute care. And there are such big differences between home health and SNF and, especially, LTCH that, again, it makes it hard to kind of think about. So, as soon as you're in an LTCH, you've guaranteed you've lost the 4 percent. So it's like an on-off switch.

Or, if you don't go anything, like several people have said, and you only do the hospital stay, I assume the single hospital stay would almost always, or always, be below the benchmark. So then that's an on-off switch that's on. You get the withhold back.

So, instead of having a little more of a dial possibility, there's a lot of lumpiness.
Where that goes to sort of -- that leaves me kind of unsure of how to answer Glenn's questions.

I kind of like the conversation that Kate initiated, that maybe this is just a special case of the -- and Mark added to it. You know, the special case of the readmission. If we actually work this through, we wouldn't need the readmission and wouldn't need to be on top of the readmission, at least for whatever part of the system.

This versus ACO -- I just don't feel I'm smart about either of them yet to sort of think about the choice.

And the only other thing that was on the original set of discussions was the beneficiary incentive issue, which we haven't as much talked about. I may have some philosophical concerns about how that's set up, but from a practical point of view I really have trouble thinking about how you would turn to a beneficiary and say these differential -- some kind of differential co-pay built on a system that already has a lot of very different co-pay rules in it. Even if you ignore the Medigap issues and just pretend that those weren't there -- how they would try to think about this and potentially pretty gameable parts of that system.
So I've got my doubts about that piece of it although, obviously, the other aspects of trying to get the beneficiary invested in why they might weigh one choice over another, and figuring out a mechanism to get there is something we need to think about.

MR. GRADISON: I'm sorry if I came through as being dogmatic on this -- I really am -- because I just want to say the thing that I want to be very comfortable with that I'm not at this stage is that at the end of the day the punishment fits the crime. That is to say that whoever is getting dinged on this is getting dinged for something they can influence.

And I look at the current hospital readmission process and look at who's being penalized, and I wonder about the soundness of the system. There seem to be large categories of hospitals that I think are going to have a very difficult time because of the socioeconomic circumstances of where they are and who their patients are. They can't control that, and I pick that as a very specific example of why I'm concerned.

I've told you this story maybe once before. I was talking to the head of a large hospital who was very
concerned and used this as an example about readmissions. He talked about one young man who -- a teenaged African American who got caught between two gangs in a shootout. He was not involved in either of the gangs and left a paraplegic. He was treated and discharged and readmitted and discharged and readmitted.

And when they looked further, they found out when he was discharged he went back to home, which was a crack house. The hospital ultimately, although they said they couldn't do this very often, rented an apartment for this young man, large enough that the young man's father could be there, and so there was some support system to try to keep him on his meds and keep him off drugs.

Maybe that should be the responsibility of the hospital, but I'm not sure. And you can say, well, that's an extreme example, and I recognize it, but I think it makes the point.

Let's make sure that -- if we're going to hold somebody responsible, financially responsible, let's be sure as we can that it's something they can do something about. That's really -- that's my nagging concern.

MR. HACKBARTH: Bill, your nagging concern is a
really important one.

Here, I think, is the policy challenge. The absolutely worst facet of the free choice, fee-for-service system that has been the staple of Medicare in U.S. health care in my book is not the fact that it creates incentives to do more. Surely, that's a problem. The worst part of it is that it utterly fragments accountability.

And so the policy challenge that we face is, how do we move from a system where nobody is accountable beyond their narrow, little silo to one where we do have people accountable for patterns of care that span multiple, different types of providers?

If your mind set is nobody can be held accountable for anything that's not within their four walls, you're locked in place. And so you have to start figuring out how to move and create incentives for people to say, oh, I am responsible beyond my walls but do it, as you say, in a way that's measured and doesn't put people -- you know, the institution -- at risk for things that are utterly outside their control.

It's inevitably going to be a little bit of a challenge, and some stops and starts, and difficult patches
along the way. But if you use as your rule of thumb, nobody should be held accountable for anything that's not in their current silo, you'll never get anywhere. And so, we're trying to strike a balance.

MR. GRADISON: I hope it's clear I wasn't saying that. Perhaps we have to reexamine this choice question because if the hospital, to take that example, has something to say about which institution is chosen, it's not within their four walls. But they would then, by making that recommendation, be taking some responsibility as to why they selected it.

I just have to say I'm not thinking in terms of four walls. I think that's a different matter. It isn't that at all.

But the choice thing -- I think we need to confront it. If we're gradually going to move away from the very undesirable system we have now, with the silos and the fee-for-service, and if that is an impediment ultimately, then I think we ought to at least have some strategy how we're going to move away from that.

We do it when people voluntarily go into an MA plan, which is a perfect example of having the
responsibility for the whole thing. It's an ideal thing. And here, we're trying to figure out some
intermediate step. I understand that, but whether that's workable with the current limitations on choice -- I'd like to hear more conversation about that.

DR. HALL: I agree with Scott, that I think this has been a really stimulating discussion.

In terms of what you mentioned, Glenn, about the whole issue of responsibility for good outcomes, we all recognize that the whole here is not greater than the sum of the parts.

But remember, this payment system hasn't changed since the 60s when Medicare came into play. There weren't even intensive care units then. When I was a medical student, there was still an iron lung around somewhere that they used to take us to look at that was operative. There were no means of communication. There was no way to hold everybody responsible. But the world has changed, and it's changing very rapidly right now.

Our discussion doesn't make us ready to vote on something that's ready for primetime yet, but I think this is exactly the sort of discussion we have to have to be
ahead of the curve and be able to give good advice to
Congress and others who are going to have to make some very
difficult choices. But we can't ignore it.

MR. BUTLER: What comes after the caboose?

[Laughter.]

MR. BUTLER: If you felt like the caboose, I don't
know what I feel like.

So, thank you not just for the specificity of the
proposal, Evan and Carol, but you responded not only to my
issues but a number of other ones.

And you know I enjoy this data and this issue. I
started, myself, wanting to go down this path, as you know,
because I saw this Medicare spending for beneficiary index
and said that's going to get plugged into value-based
purchasing.

So, in a sense, in a small way, these incentives
are going to built in there. Why not give an option to have
somebody even more boldly participate, particularly, I think
as Craig pointed out, those that may not have a big,
widespread primary care base but were getting these
illnesses in the door and felt, boy, I can make a difference
in managing this care?
And I like the virtual solution in terms of paying claims as it is. I think the -- but I envisioned this more as a mini ACO for those that weren't doing the full-blown one. So I viewed it more as a shared savings versus a fixed payment.

And I definitely didn't view it as a withhold. I mean, why not withhold the 5 percent on the AAPCC that we were looking for a long time ago?

I think that's a -- so I would prefer, as Mark pointed out earlier, then just set a lower threshold under which you could get some benefit.

And I don't think, contrary to some maybe, that we ought to take something out of each of the providers. I think you need somebody in charge, frankly.

I think you could create criteria for the receiving organization that says, okay, you have to create incentives among each other, or something. But to dictate a certain slice out of everybody will not get the collective behavior.

So I think I would view this as something that would be an option. It would be voluntary. If you did it, then you would not be subject to readmission rates and some
of the other things that the -- you know, some of the other
utilization tools that are being applied to reduce spending.
So that's my comments.
MR. HACKBARTH: This is a very good discussion, Evan and Carol, and thanks for your work on it. Clearly, we'll be back to it again.
So let me now have the brief public comment period. Could I see the hands of anybody who's headed that way?
Anybody going to the microphone?
Going once. Going twice. Sold.
Okay, we are done. We reconvene tomorrow at 8:30.
[Whereupon, at 5:48 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, April 5, 2013.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 5, 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
THOMAS M. DEAN, 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

Improving Medicare payment for chronically critically ill patients in hospital settings
- Dana Kelley, Julian Pettengill 3

Medicare’s coverage of services provided by advance-practice nurses and physician assistants
- Kevin Hayes, Kate Bloniarz, and Katelyn Smalley 85

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MR. HACKBARTH: Okay. It's time to get started.

Our first session this morning is "Improving payment for chronically critically ill patients."

MS. KELLEY: Good morning. Julian and I are here to discuss improving payments for the medically complex patients we call the "chronically critically ill," or CCI. Medicare's payments for the services furnished to CCI patients in long-term-care hospitals are generally much higher than payments for CCI patients in acute-care hospitals. But a decade of research has failed to provide a compelling reason why this should be the case.

Today I will review the history of how we got to different payments for these similar patients, depending on the type of hospital they receive care in, and the consequences this has had for both the Medicare program and for patient care delivery in some areas of the country. I will talk about an analysis we've done that attempts to define and describe CCI cases and where they are cared for. And then Julian will describe some approaches we're developing to make payments for CCI cases site-neutral and more patient-centered.
And before I go on, I just want to acknowledge Lauren Metayer's assistance with this work.

Let's first discuss why Medicare pays differently for hospital services in acute-care hospitals and LTCHs. Remember that back in 1983, 84 hospitals with very long average lengths of stay were excluded from the Prospective Payment System for acute-care hospitals. These hospitals predominantly had begun as tuberculosis and chronic disease hospitals. Until 2003, Medicare continued to make cost-based payments to hospitals with a Medicare average length of stay of more than 25 days. The cost-based payment method was inherently inflationary and led to growth in the supply and use of LTCHs and, of course, to growth in Medicare spending for these services as well.

When the LTCH PPS was implemented in 2003, its rates were based on these inflated costs, resulting in overly generous payments that provided few incentives for efficiency.

In addition, the LTCH payment system includes policies such as the 25-day average length of stay requirement and the short-stay outlier policy that likely distort the delivery of care and the use of resources in
these facilities. So let me review our evidence for these conclusions.

This slide shows growth in the number of LTCHS and LTCH spending over the last 20 years. The green line, showing the number of LTCHs, suggests an attractive reimbursement environment. The number of LTCHs has increased more than five-fold during this period and continued to grow following the implementation of the PPS.

The blue line shows that in the last years of cost-based payment, Medicare spending for LTCH services was growing at an average annual rate of about 18 percent. In the first years of the PPS, that rate accelerated to 27 percent per year.

You've seen this slide before, which shows LTCHs per case payments and costs. Here you can see that Medicare spending for LTCH care has increased not just because of growth in the number of cases, but because of growth in payments per case. And you can see that LTCHs appear to be responsive to changes in payment, adjusting their costs per case when payment per case changed.

When the PPS was implemented, the aggregate LTCH margin was about zero, as you would expect with a cost-based
payment reimbursement. After PPS, margins climbed to a high of 11.9 percent in 2005. In 2011, the aggregate margin was 6.9 percent.

And this slides shows us how the payment system itself can distort the delivery of care and the use of resources in LTCHs. This slide shows the length of stay along the X-axis. The lines show the number of discharges at each day of stay for the two month common LTCH diagnoses. Remember that under the LTCH PPS, payments are generally reduced for cases that fall below the short-stay outlier threshold for the DRG. The big spike of discharges in the period immediately following the short-stay outlier threshold suggests that LTCHs' discharge decisions are strongly influenced by financial incentives. The 25-day average length of stay requirement has a similar although less striking impact.

The Commission has expressed concerns about LTCHs for many years. Those concerns can broadly be described as you see here. First, there are almost no established criteria for admission to an LTCH. That means acute-care hospitals in areas with LTCHs can unbundle care by transferring costly patients. And LTCHs can admit any
patient needing hospital-level care as long as they maintain an average length of stay of greater than 25 days. Without criteria for admission, it's not clear whether or which patients treated in LTCHs require that level of care.

Second, some parts of the country have many LTCHs while others have none. The oversupply of LTCH beds in some markets may result in the admission of less complex cases that could be cared for in other less costly settings. This, of course, is not difficult to do because, as we've established, there are almost no criteria for admission.

At the same time, the fact that there are areas of the country with very few or no LTCHs means that many Medicare beneficiaries receive similar services in other settings.

So does the use of LTCHs cost Medicare more? Generally, the answer is yes. Studies of episodes of care for medically complex patients have consistently shown that Medicare payments are considerably higher for most episodes that include LTCH stays. However, for the most medically complex patients, Medicare payments for an episode of care may be lower when the episode includes an LTCH stay. The research findings are not consistent on this point.
Do LTCHs help beneficiaries achieve better outcomes? Here the answer is possibly. Some studies have shown improved outcomes but, again, generally only for the most medically complex patients. As we've discussed before, CMS' CARE demonstration did find that on a risk-adjusted basis LTCHs had lower acute-care hospital readmissions rates within 30 days compared with other post-acute-care settings, although they performed no better on other outcomes. The better readmissions rates may be due to LTCHs' ability to provide hospital-level care.

It must also be noted that additional analyses of CARE demonstration data found that readmissions rates after 30 days may be worse for LTCH patients compared with patients who used other post-acute-care providers.

If LTCH care provides relative benefits only for the most medically complex patients, the obvious question to ask is: Are the patients who use LTCHs the most medically complex? CMS contracted RTI International and Kennell & Associates to conduct a number of analyses of LTCHs and the types of cases they care for, as well as the overlap in the types of patients and levels of acuity across acute-care hospitals, LTCHs, and some specialized SNFs. This work
identified two extremes of the LTCH care spectrum. The first are the high-acuity or chronically critically ill patients who are described as overlapping with hospital ICU patients and account for about one-third to one-half of LTCH Medicare admissions.

The second group is the subacute patients who overlap more with SNF patients and who account for about 15 percent of LTCH Medicare admissions, although for a much greater share in some LTCHs. The remaining cases are not identifiably CCI but have more complex conditions than the subacute group. The high-acuity CCI LTCH cases were found to be heavy users of ICU services in their previous acute-care hospital stays. We used this work as a springboard for our own work on identifying CCI cases and paying accurately for them.

For this analysis, we examined Medicare claims for IPPS and LTCH services in 2011. We identified direct CCI cases as those discharges with eight or more days in an ICU or CCU. We also identified claims for hospital stays that did not include eight or more days in an ICU, but which could be linked to another immediately preceding hospital claim that did include charges for eight or more days in an
ICU. We call these "indirect CCI discharges."

While we found only a small number of indirect CCI discharges in acute-care hospitals, the distinction was especially important in identifying LTCH cases who were heavy users of ICU services during an immediately preceding acute-care hospital stay.

What we found is that 6 percent of all IPPS cases are chronically critically ill, as we've defined it. They include eight or more days in an ICU. Of the CCI cases in acute-care hospitals, about half go on to use at least one institutional post-acute-care provider -- a SNF, an IRF, or an LTCH. We did not look at the use of home health care for this population. Only 9 percent of CCI cases in IPPS hospitals go on to use an LTCH.

We also found that, by our definition, most LTCH cases are not CCI. About 5 percent of LTCH cases spent eight or more days in an LTCH ICU, and an additional 35 percent spent eight or more days in an ICU during an immediately preceding acute-care hospital stay.

So, to summarize, we have four major points of concern about the way Medicare pays for chronically critically ill patients.
First, the program makes very different payments for these similar patients, depending on where the care is provided.

Second, Medicare's payments don't match the resource needs of these patients. Julian will show how this is true for CCI patients in acute-care hospitals. There is reason to believe that this is true in LTCHs as well, given the inflated costs that were originally used to set LTCH payments and the distorting effects of LTCH payment policies that I mentioned earlier.

Third, the financial incentives of the two payment systems are very misaligned. There's a push-pull effect that results in increased costs to the program. Acute-care hospitals face incentives to reduce lengths of stay. LTCHs are able to provide hospital-level care, so where they exist, they offer an opportunity for acute-care hospitals to unbundle care by discharging patients early and thereby reducing their costs.

Finally, I talked a lot about how the status quo is costly to the Medicare program. As they are currently designed, Medicare's payments for the most medically complex patients encourage unnecessary transitions between care
settings. We're very mindful that these incentives may not encourage optimum care for beneficiaries.

MR. PETTENGILL: So, as Dana mentioned, our policy objective is to realign payment incentives by making payment rates site-neutral and patient-centered. To accomplish this objective, we would pay for all ACH and LTCH cases using IPPS rates, and we would modify the IPPS to better align payments and costs for CCI patients. If we can do this well, then payments would reflect patients' characteristics rather than the setting for inpatient care. In addition, payment rates would also more accurately reflect patients' resource needs.

LTCHs could continue to treat clinically complex patients, but they would be paid under the same rates and the same policies that apply for ACHs treating similar patients. At the same time, restrictive features unique to the LTCH PPS, such as the 25-day average length of stay requirement, would disappear. Perhaps the resulting realignment of incentives would enable LTCHs to develop more effective practice patterns while lowering their costs.

In January, we talked a little about what might be done. In one approach, we would make changes within the
IPPS to include payments for cases now paid under the LTCH PPS. And we would also improve payment accuracy for CCI patients.

There are two ways to improve payment accuracy.

Option 1 would increase outlier payments for the most clinically complex patients, the CCI cases. We would expand the pool of funds available to make outlier payments, and then we would ensure that these added funds are focused on the high-cost CCI cases by setting a separate outlier policy just for them.

Under Option 1, current IPPS payment rates and the outlier threshold for non-CCI cases would not change. The outlier threshold for CCI cases would be lower than under current policy, and hospitals would be paid 90 cents on the dollar for costs above that threshold.

The second way to increase payment accuracy is to carve out CCI cases into new CCI DRGs and reset the relative weights for all DRS. We would also expand the outlier pool in this option, but we would not make the outlier policy more generous for CCI cases. Under Option 2, payment rates for CCI cases would rise while rates for non-CCI cases would fall somewhat. The added money in the outlier pool would
tend to lower the outlier threshold for non-CCI cases. It's hard to say in advance, however, how the outlier threshold for CCI cases would change, and I'll explain that in a minute.

There's also the possibility of bundling expected costs for institutional PAC services in LTCHs and SNFs into the IPPS payment rates for cases in the new CCI MS-DRGs. This would be Option 3. At this point we've done quite a bit of work on Options 1 and 2, but less on the bundling option. Rather than give you piecemeal results, we will wait until we have all of the work done in the early fall.

Today we want to talk about Options 1 and 2 and give you an idea of how they would work and how they would likely play out.

So both Options 1 and 2 would expand the IPPS outlier pool. This slide shows where the money would come from and how it would be used. We would combine current IPPS outlier payments with all LTCH spending for a projected total of about $10.4 billion. But not all of this money would be available to make outlier payments. As shown on the far right, because current LTCH spending is thought to be too high, some portion of it might be held back as
savings to the Part A trust fund. The box at the lower
right-hand corner indicates that if all LTCH cases were paid
under the IPPS, money would have to be allocated to cover
their base IPPS payment rates and any other teaching DSH or
other IPPS payments that they would get.

The remaining funds would be allocated to the two
boxes on the lower left. The amounts in each would vary,
depending on how we split the funds between CCI and non-CCI
outlier payments. Now let's turn to how these options would
work.

To understand what each option would do, we first
need to talk about what current policy does. To illustrate
what happens under current policy and what would happen
under each option, I'm going to use the cost distribution
and payment data for IPPS cases in a single MS-DRG. The
horizontal scale here is in $2,000 intervals that run from
less than $2,000 to greater than $48,000. Each bar shows
the share of all cases in the DRG that had costs in the
particular interval. So for example, about 14 percent of
all cases had costs between $8,000 and $10,000.

The IPPS payment rate, shown as the solid yellow
line, is roughly $9,000 here. As you can see, some cases

have costs below the rate. The hospital keeps the difference and makes some money. Other cases have costs above the payment rate, and the hospital loses some money. On average, for an efficient hospital, these gains and losses are intended to roughly balance out, with the hospital perhaps making a small surplus.

But some cases have extraordinarily high costs and very large losses. Here the high-cost outlier policy kicks in. If the cost of the case exceeds the outlier threshold for the DRG -- and that's the dashed line in yellow on the right -- the hospital receives an outlier payment that is equal to 80 percent of the costs above the threshold. This 80 percent figure is called the "marginal costs factor," and the outlier threshold is set by adding a national fixed-loss amount -- currently about $22,000 -- to the payment rate for the DRG.

You can think of this as an insurance policy where the loss deductible is $22,000 and the coinsurance rate is 2 percent, because we're paying 80 percent of the costs above the deductible.

When we look inside this DRG, however, what we see is that non-CCI and CCI cases have very different cost
distributions. The bars for the non-CCI cases are shown in light gray, while the bars for the CCI cases are shown in green. This slide --let's go to the next one. Go ahead. All right. This slide shows the two underlying cost distributions, the current payment rate still the solid yellow line, and the current outlier threshold now in light gray that you just saw earlier.

It's clear that most non-CCI cases have costs below the payment rate, so the hospital makes money, while most CCI cases have costs above the payment rate, and the hospital loses money. And CCI cases are much more likely than non-CCI cases to get outlier payments under current policy. But that only mitigates their most extreme losses. Option 1 would simply add money to the outlier pool and spend that extra money on additional outlier payments for CCI cases. The current IPPS payment rate and the DRG would continue to apply for both non-CCI cases and CCI cases. And the current outlier threshold would stay in force for non-CCI cases. So payments for non-CCI cases would be essentially the same as they are now. For CCI cases, the marginal cost factor would be increased to pay 90 cents on the dollar above the CCI
outlier threshold, which is the dashed green line. Given the extra money and the 90 percent marginal cost factor, we would set a new CCI outlier threshold at a level that would exhaust the extra money added to the outlier pool.

As shown on the slide, the new CCI outlier threshold would be much lower than the outlier threshold currently. While regular DRG payments would not change for CCI cases, they would get a lot more in outlier payments, and those extra payments would help to reduce existing discrepancies between payments and costs and modestly improve payment accuracy for CCI cases.

To illustrate what Option 2 would do, let's reset back to the two cost distributions for non-CCI and CCI cases, as you see here.

In this option, the first thing we would do is break out CCI cases into new CCI MS-DRGs. After we do that, the only cases left in this DRG would be the light gray non-CCI cases with lower costs.

Next, we would reset the relative weights for all MS-DRGs. The weights for the original MS-DRGs would fall a bit because they now contain only lower-cost cases, while the weights for the CCI DRGs would rise. We would also
expand the outlier pool, but in this instance, we would use the same 80 percent marginal cost factor and a single fixed-loss amount applied for both non-CCI and CCI cases; that is, in Option 2, the outlier policy would not be more generous for CCI cases than it is for other cases, but it would be more generous than under current policy because we're adding money to the outlier pool so we can spend more.

Okay. Next slide. So what happens -- so carving out the CCI cases into new CCI MS-DRGs and resetting the weights would realign payments and costs for both types of cases. As you can see, the payment rate for non-CCI cases, in solid gray, would be a bit lower than the current rate, while the payment rate for CCI cases would be much higher than the current rate.

Even though we would set a single fixed-loss amount, the outlier thresholds would change for both non-CCI and CCI cases because their payment rates change. As shown here, the outlier threshold for non-CCI cases, in dashed gray, would be much lower than under current policy because the payment rate dropped and also because the fixed-loss amount is smaller.

In contrast, what would happen to the outlier
threshold for CCI cases, in dashed green, is uncertain. The rise in the payment rate would tend to push the threshold up, but that would be offset to some degree, maybe totally, by the decline in the fixed-loss amount.

To summarize, under Option 1, payments would increase for ACHs that have a disproportionate share of CCI cases. This would include primarily large hospitals in urban market areas and major and other teaching hospitals. ACHs that serve few CCI patients would see little change in their payments.

As we showed in the mailing material, LTCH cases generally have higher costs than IPPS cases in the same MS-DRG. Paying them at IPPS rates would substantially reduce their regular DRG payments, but their outlier thresholds also would be lower for both non-CCI and especially for CCI cases. Consequently, they would receive much higher outlier payments than they get under the current LTCH PPS.

For Option 2, redefining the MS-DRGs and resetting the relative weights would have much bigger effects because they would redistribute payments across DRGs and hospitals. The net result would depend on each hospital's case mix, but generally we expect that ACHs that have a disproportionate
share of CCI cases would likely see higher payments. Payments likely would decline for ACHs that have few CCI cases, but the decline would be partially offset by increased outlier payments. For LTCHs, regular payments would decline generally, but the decline would be smaller for those that serve lots of CCI patients.

We also want to note some other issues to think about. Both options would significantly reduce payments for non-CCI cases treated in LTCHs. This may be appropriate given the research findings Dana mentioned earlier that suggest that low-severity patients can be treated at lower cost with comparable quality in ACHs. However, there are some trade-offs between Option 1 and Option 2.

Option 2 would yield a larger improvement in payment accuracy but also has a higher risk of gaming than Option 1. The gain payment accuracy is due to creating new DRGs and higher payment rates for patients who receive prolonged care in a critical care unit. Historically, these patients have been more costly, and ideally they should have higher DRG payment rates.

However, if we offer higher rates for CCI cases, hospitals would face an incentive at the margin to increase
critical care use and to get the higher payment. There is no new DRG in Option 1 and no great incentive to game the system. As we move forward with our work, we want to spend some time to see if we can develop strategies that might be used to mitigate the risk of gaming in Option 2.

So for our next steps, we have refinements to make in our models and in our estimates for Options 1 and 2. We want to complete the development of our model and estimates for the bundling option. And then we want to do, as I said, more work on trying to figure out strategies to mitigate or discourage gaming. Then in the early fall, we plan to return with impact estimates and other results from the analysis.

That concludes our presentation, and we'd be happy to take your questions and comments.

MR. HACKBARTH: Thank you, Dana and Julian. Good work.

Let's see. We'll start with round one clarifying questions. Any on this side? Scott and then Herb. Scott.

MR. ARMSTRONG: Are there any other post-acute facilities where CCI patients may be cared for, or by definition, is it only acute-care hospitals and then these
long-term care hospitals?

MR. PETTENGILL: Yeah, go ahead.

MS. KELLEY: Yes. We do think that -- we know that some also go on to use SNFs, although I think we've documented a declining number of SNFs that care for the most medically complex patients since the SNF PPS was implemented. I think that has improved in the most recent year since some payment changes were made in the SNF PPS. But, in general, a small number of -- well, let me restate that. Most of them go on to use SNF care, of CCI cases. The question is, where in their length of stay they go to the SNF, and I think there are a small number of SNFs that can care for them at that real high level of care that an LTCH might provide.

MR. ARMSTRONG: So it's conceivable that if we're building a payment policy that is geared to pay regardless of the setting, a comparable -- under a similar set of policies for a population of patients, it could go beyond just the long-term care hospitals. It could potentially extend into skilled nursing facilities, as well?

MS. KELLEY: Possibly, yes. But I think what we're focusing -- what we've been focusing on is the fact
that both the LTCH and the hospital provide hospital-level care, which is not necessarily what's provided, or not typically what's provided in a SNF. So we've been thinking of that as a lower level of care.

MR. HACKBARTH: So let me just pursue Scott's questions. So as we've often noted, there are many areas of the country where there are not LTCHs. So are you suggesting, Dana, that in those areas, it's not SNFs picking up the CCI patients. They're just staying in acute-care hospitals as outliers?

MS. KELLEY: That is what I'm suggesting, yes.

MR. HACKBARTH: Okay. Then a second related question. You noted that SNF care for medically complex patients is declining, but -- go ahead.

MS. KELLEY: Yeah. Perhaps I misspoke. So I think there are two things here. We have what we're considering to be the critically -- the CCI patients who we've defined as patients who use eight or more ICU days.

MR. HACKBARTH: Mm-hmm.

MS. KELLEY: And we do know, of those patients, the six percent of IPPS patients -- cases -- half of them go on to use some form of institutional post-acute care and the
plurality of them do use a SNF. But I think the separate question is, at what condition --

MR. HACKBARTH: What stage --

MS. KELLEY: -- they are when they enter the SNF.

MR. HACKBARTH: Yeah.

MS. KELLEY: And what we know is that, beginning when the SNF PPS was implemented, we saw a decline in the number of SNFs that were admitting patients that fell into the medically complex SNF patient groups, RUGs.

MR. HACKBARTH: And I understand that. Thanks for the clarification. What I'm trying to get at, though, is that in talking about SNF payment policy, I think we've observed that part of the change in the pattern of care in SNFs may be attributable to flaws in that payment system.

MS. KELLEY: Absolutely. Yes.

MR. HACKBARTH: And so -- and we've made specific proposals on how to change SNF payment policy so that, financially, they may be more willing to take on more complicated patients.

MS. KELLEY: That's true, and I think --

MR. HACKBARTH: And I'm trying to understand how these two pieces fit together.
MS. KELLEY: And Carol, I think, reported earlier in the year that she had seen some growth in the number of SNFs willing to take, or admitting, patients in medically complex RUGs, beginning with some changes to payments that were made.

MR. PETTENGILL: Still, our hypothesis would be that --

MR. HACKBARTH: That would be --

MR. PETTENGILL: -- in areas lacking LTCHs, the acute-care hospital keeps the patient longer, giving them the step-down hospital-level care that they need and then may transfer them onto a SNF.

MR. HACKBARTH: Okay. I think, Herb, you were next.

MR. KUHN: Two questions, and one of them was kind of answered a little bit in the first round here from what Glenn and Scott, and that is where there are LTCHs in communities, do we see the IPPS hospitals or the acute-care hospitals having less outlier payments? Is that an assumption we're making or does the data actually show that, that there's fewer outliers?

MR. PETTENGILL: That's -- I don't know the answer
to that, but as we continue to do work on this project, one of the things we're going to do is make comparisons between areas that have a lot of LTCHs and areas that don't. And we've actually broken the markets up, U.S. care markets up into three groups: Those that have no -- pardon?

DR. MARK MILLER: I thought we did look at this a couple of years back. I thought we saw shorter lengths of stay in those markets.

MS. KELLEY: That was an analysis we did back in 2004, and we have not repeated that analysis since then.

DR. MARK MILLER: But that's what we found at that time --

MS. KELLEY: But that is what we found then, and RTI has found --

DR. MARK MILLER: [Off microphone.] That is also what I thought --

MS. KELLEY: Well, I don't recall if RTI looked at hospitals that have LTCHs in their areas versus hospitals that don't. They did find that -- I think we've repeatedly -- it's been repeatedly established that patients who use LTCHs have shorter hospital lengths of stay than patients who don't.
MR. KUHN: Got it.

MR. PETTENGILL: So all I was trying to do is indicate that this is one of the things that we can look at, and we plan to look at comparisons between these types of areas to see what's different, because we have hypotheses about that, too.

MR. KUHN: Got it. And the second question was on Slide 4. And, Dana, when you were walking through this one, you said the growth was both the number of cases as well as the payment per case. Can you explain a little bit more the reason behind the growth in payment per case?

MS. KELLEY: Well, some of this was, as I said, related to the fact that payments likely under the PPS, when the PPS was established, were too generous, and over time, CMS has attempted to kind of take back some of that money. Some of that has been through changes in the short-stay outlier payment policy. I think it's generally accepted that payments for short-stay outliers were far too high at the beginning of the payment system. We've also had some case mix creep, and so there have been changes for documentation and coding improvements.

MR. KUHN: And then, also, if I remember right,
isn't it true, for LTCHs, they're the only PPS system that doesn't have locked into statute a market basket update each year? That's total discretion of CMS, is that correct?

MS. KELLEY: That's true. The update is at the discretion of CMS.

MR. KUHN: Thank you.

MR. HACKBARTH: Round one clarifying questions?

Alice, Mike, Mary, and then Peter and --

DR. NAYLOR: Slide 11, please. So I just wanted to understand the differences in findings between Dalton and this refined analysis that you did, building on their work in terms of percentage of cases that are CCI versus non-CCI. So is this the added criterion of length of stay, eight days, ICU, CCU, versus not? Is that how you arrived at these findings?

MS. KELLEY: Yes. This was looking at our claims for all hospital care and looking to see the share of cases that had eight or more days billed to ICU or CCU.

DR. NAYLOR: And can you just remind me of the rationale for that threshold?

MS. KELLEY: Sure. That was based on work that CMS sponsored that RTI and Kennell and Associates did, and
it -- they found that looking sort of more broadly at clinical characteristics of cases, they found that the kind of highest level acuity patients in LTCHs generally had heavy use of ICU services in their previous acute-care hospital stay. Eight is a number that we chose based on the work that they had done. That's a number that obviously could be changed. It could be higher or lower, depending on one's preferences. But that was a number that they arrived at as a reasonable cutoff.

MR. BUTLER: One thing that was new to me -- by the way, I think the graphs, in particular, really help tell the story in this and that's really good. As in yesterday, the very specific proposals are very helpful to respond to, which I'll do in round two.

But the ICU days in LTCHs was a new -- that was something new to me. My experience directly with LTCHs has been mostly around complex critical patients and ventilator patients, which I also assume were -- I mean, they were beds, but they weren't necessarily designated in ICU beds.

Are ventilator patients in LTCHs sometimes not in ICU beds?

MS. KELLEY: Yes, but I don't know how that would -- I don't know offhand how that would break out. Not all
LTCHs have ICUs, and I think, to some extent, it's a designated unit that an LTCH may be providing an ICU level of care but may not have designated a unit as such. So they may sort of swing their capability as they need to. But a ventilator patient in an LTCH may not be in an LTCH ICU.

MR. HACKBARTH: If they were in an ICU in the acute-care hospital, they still qualify as a patient covered. So you can qualify for the payment either as a direct or an indirect CCI patient.

MS. KELLEY: Yes.

MR. BUTLER: It was more of a question of -- it seemed like a new concept. I thought that they treated a certain kind of patient at a certain kind of level. They didn't worry about whether it was an ICU bed or not. But, anyway, just a technical question.

MS. KELLEY: RTI and Kennell and Associates conducted a number of interviews with LTCHs and found that I think virtually all of the LTCHs that they spoke with either had an ICU or were planning to establish an ICU. So I can't say why they've been moving -- why they didn't have them before and they think they want them now and why they're moving in that direction, but that is a trend that they
MR. BUTLER: So my other question relates to patient engagement, and obviously a lot of these patients are not in a position, given their health, to engage too directly, but their families are, and I've never seen any patient satisfaction HCAHPs kind of data, or for that matter, have a sense of preference, because these are often big moves where the facilities may not be close to where the patient or family lives. And you hear all kinds of stories about hospice or other kinds of post-acute kind of care options, but I don't have a sense of the patient themselves and they say, this is great, we need more of it, or neutral, or what.

MS. KELLEY: I have not seen patient satisfaction data for LTCH users or for families of LTCHs. That's something I can look further into. I know that there are clinicians who are concerned that patients who have moved to LTCHs don't understand necessarily the difference between an acute-care hospital and a long-term care hospital, what that transition between the two might signify. And we also have been told by -- when we had our quality panel on LTCH quality a few years back, we were told by many participants
that many of the patients that they admit arrive not
realizing that they may not be able to be weaned from the
ventilator, for example, or that they are nearing the end of
their life and that some decisions may need to be made for
their future care.

So I think there is good reason to be concerned
that patients and families don't get full information before
these transitions take place. Whether or not they would
make different decisions if they had that information, you
know, I don't think we can know.

MR. BUTLER: It just strikes me as one of those
areas where shared decision making probably could be a lot
better and end up in the appropriate placement.

MS. KELLEY: And we included a discussion on this
in our March report.

MR. HACKBARTH: Bill Hall, did you have your hand
up?

DR. HALL: [Off microphone.] No.


MR. GRADISON: It's been some years since I've
taken a look at the way the outlier pools work and I want to
make sure that I understand it today.
My understanding is that an estimate is made of the anticipated amount of payments that may be required, appropriate, in the upcoming year for the outlier pool, or pools, and that that amount is actually a reduction -- is used to -- is funded through a reduction in the base payment amounts. And so we then have a pool. Now, this is where my question comes in, and there's two different situations.

The first situation is that the amount in the outlier pool is insufficient to meet the outlier qualification -- outlier appropriate claims. And the second is, what happens to the balance in the pool if the outlier claims are less than the amount in the pool. And there's some roll-forward or something, but I don't remember how it works.

MR. PETTENGILL: Okay. Under the law, the outlier payments must be between -- this is IPPS operating payments we're talking about here.

MR. GRADISON: Yes.

MR. PETTENGILL: Under the law, CMS is required to set the outlier threshold such that outlier payments will be between five and six percent of DRG payments, which includes both base DRG payments and outlier payments. So what that
really means is that what CMS has done, their longstanding policy has been to set the pool at 5.1 percent, okay. But what that really means is it's just about 5.4 percent of base DRG payments, okay.

So you have a fixed amount of money determined prospectively based on projected spending using the latest claims. If it turns out that CMS ends up spending more money for outlier cases, then they spent more money. It's still a claim on the trust fund and it gets paid. If they spend less on the outlier pool, then they spend less and the Treasury ends up saving some money. It's a prospective determination. The rule is set in place and it operates.

MR. HACKBARTH: So, Julian, have people looked at -- have we looked at -- how that averages out over time?

MR. PETTENGILL: Yes, we have, and during the 1990s, the Medicare program was regularly paying out more than 5.1 percent in outlier payments. And during the recent -- since about 2005, we've been paying out less than 5.1 percent. And, you know, there are lots of reasons for that. Making the projection is incredibly difficult and CMS has refined its methods, but it's just really difficult to get it right.
MR. GRADISON: Well, in this instance, it's a new pool, so no historic -- well, there's limited historical experience, especially since we can't be sure what behavioral effects there may be --

MR. PETTENGILL: Right.

MR. GRADISON: -- of the change in the -- you know, I think the case was a client I was working with who felt that they had been shortchanged -- a very large hospital chain, not-for-profit hospital chain -- which felt they were, in a sense, being shortchanged because the amount in the pool was not being used, as I recall, but it wasn't restored back into the base of the --

MR. PETTENGILL: Yeah, there --

MR. GRADISON: -- of the payments going forward.

And that's why I wanted to make certain --

MR. PETTENGILL: Their usual argument is that CMS has set the fixed loss amount too high and it should have been lower and we would have spent out more money had it been lower. But, you know, we've looked at CMS's methods for making the forecast and it's just a tough job.

MR. GRADISON: Of course. Thank you.

DR. HOADLEY: Yeah, a couple quick things. On
Slide 11, when you have the nine percent of CCI cases that use LTCH, that's national, right?

MS. KELLEY: [Off microphone.] Yes.

DR. HOADLEY: And you have or will do that within these geographic groups, of whether there's an LTCH in the region in the region or not?

MS. KELLEY: Yes.

DR. HOADLEY: Okay. Good.

On 14, on your methodology, I just want to be clear. A non-CCI patient that's being seen in an LTCH, they would, under this idea, they would go into regular IPPS, so whatever their DRG is, and so when you're doing things like impact analysis, you'll be thinking about the effect of that part of the change, as well.

MR. PETTENGILL: Yeah. All cases would be paid under the IPPS, under either option one or option two.

DR. HOADLEY: Right. Okay.

MR. PETTENGILL: Okay. So I don't know if -- I'm not sure we had planned to try to make separate impact estimates for non-CCI and CCI cases, but it's a thought.

DR. HOADLEY: Yeah. I mean, it just seems to make sure there isn't something else going on in that side of the
story that we'd be missing when we get to that.

MR. PETTENGILL: Mm-hmm.

DR. HOADLEY: And then just one refresher question. In the DRG system, the actual DRG categories, that's assigned at the discharge point when everything is known about what happened to that patient in the --

MR. PETTENGILL: Right. It's based on the principal diagnosis, which is the diagnosis determined after study that caused the patient to be admitted to the hospital for care.

DR. HOADLEY: And so under these CCI things, you would then know --

MR. PETTENGILL: Yes.

DR. HOADLEY: -- what the thing is. There is no prediction involved.

MR. PETTENGILL: Right.

DR. NERENZ: Actually, if I can just follow up on that, for a patient who then ends up in an LTCH, I'm looking at your table that had the most common DRGs with septicemia at the top. Septicemia, would that have been present on admission to the initial hospital, or is this a new DRG assignment based on now what's happened since?
MS. KELLEY: It's a new DRG assignment --

DR. NERENZ: Okay.

MS. KELLEY: -- and, in fact, the majority of LTCH patients get a different DRG assignment in the LTCH than they had in the acute-care hospital.

DR. NERENZ: Yeah, because a number of those, with septicemia as an example, looked like complications of care from the initial acute stay.

Okay. Also, if we go to Slide 16, it's just a schematic. I'm curious, what do we know, since LTCHs are typically post-acute care as opposed to a place where someone is directly admitted, where along this line is a person typically transferred from the acute-care hospital to the LTCH? Is there a pattern to that that's worth knowing about? Like, for example, do people get well out into the outlier tail and then move, or do they move sooner? What do we know about that?

MS. KELLEY: It really varies, but that's something we can bring back to show you.

DR. NERENZ: Okay, because there'd be a question about if somehow a payment change caused fewer of these transfers, would you then create bottlenecks and backlogs in
the ICU setting or elsewhere in the acute care, which might depend a little bit just on where in this they're coming.

Okay. But that's --

MR. PETTENGILL: Yeah, although if IPPS hospitals are transferring patients who've had prolonged ICU care, it may well be that it's after they've gone to a step-down unit --

DR. NERENZ: A step-down --

MR. PETTENGILL: -- in the IPPS hospital, which wouldn't cause a backlog.

DR. NERENZ: And that was sort of my question.

When in this long tail-

MR. PETTENGILL: Right, and we don't know the answer, but we can look.

DR. NERENZ: Okay. Good.

And then my last thing. Just on Slide 5, with these interesting 21- and 28-day peaks, does that clock start on the day of LTCH admission or the day of initial acute care admission?

MS. KELLEY: The threshold clock, you mean?

DR. NERENZ: Well, just whatever is day one on the graph.
MS. KELLEY: Oh, this is admission to the LTCH.

DR. NERENZ: To the LTCH. Okay. Thank you.

MR. HACKBARTH: Okay. Let me --

DR. MARK MILLER: Rita has her hand up.

MR. HACKBARTH: Oh, I'm sorry, Rita. Go ahead.

DR. REDBERG: These are obviously very ill patients. Can you just remind me what the mortality data is for the LTCHs and if you have for the areas that don't have LTCHs and the similar patients that are cared for in acute-care hospitals, how that compares.

MS. KELLEY: We have not looked yet at mortality rates for patients who use LTCHs in areas where they have LTCHs versus areas where they don't. That's -- the question of mortality rates for these patients, though, has come up in other studies and in, of course, the work that we just sort of generally do looking at LTCH claims.

Mortality rates vary very greatly in LTCHs. Some DRGs have mortality rates both in facility and within 30 days of discharge of the LTCH combined of close to 50 percent for some of the most severe DRGs. Mortality rates for other cases -- multiple or severe pressure sores, for example -- are very low. So it does vary quite widely
depending on diagnosis in the LTCH.

DR. REDBERG: You were talking about hospital mortality?

MS. KELLEY: I'm sorry. I'm talking about LTCH mortality.

DR. REDBERG: But, I mean, that's 50 percent don't leave the LTCH or die before leaving the LTCH?

MS. KELLEY: Fifty percent die within -- either in the LTCH or within 30 days of discharge from the LTCH for certain DRGs. I think the average in facility mortality is about 15 percent in an LTCH.

DR. REDBERG: I'm trying to understand the value added of the LTCH, what they're offering that the other hospitals don't have.

MS. KELLEY: There's been -- other researchers have looked quite -- or tried to look closely at this question of whether mortality and other outcomes measures are better for patients who use LTCHs, and as I said before, the data on that -- the findings on that have been pretty inconsistent.

MR. HACKBARTH: So let me kick off Round 2, and I'd like to go back to Peter's question about ICUs and CCUs
in LTCHs and the fact that that's not common but apparently growing. I'm trying to begin to think about the relative merits of Option 1 and Option 2.

Julian I think mentioned that Option 2 potentially was subject to gaming, and I would think that part of that gaming risk is that you would spawn a rapid increase in ICUs/CCUs within LTCHs. Is that right, that there would be a strong incentive to start classifying patients that way?

MR. PETTENGILL: Well, that would be one risk. Another would be that at the margin a patient who is an ICU in an IPPS hospital for six days could be kept an additional day or two to qualify, because, in effect, what you have is kind of a payment notch here where, if you go over eight days, all of a sudden the payment bumps up a whole lot.

MR. HACKBARTH: Yeah, and so on both sides, in both the acute-care hospital and the LTCH --

MR. BUTLER: Could I ask a quick clarifying -- I thought the Option 1 and 2 applied just to hospital payments, not to LTCHs.

MR. PETTENGILL: Say that again?

DR. MARK MILLER: The way I would answer that is this is now the payment system for both of those actors, and
so in Option 1, you get a PPS payment whether you're an LTCH or an acute-care hospital, and then you would have the commensurate outlier, depending on whether it was CCI or non-CCI. And the thing I wanted to say in this exchange, that notch effect on the payment applies to Option 2 because it bumps you into a higher DRG.

MR. PETTENGILL: Right

DR. MARK MILLER: If you keep them two extra days in the ICU on Option 1, you have to incur some cost and then move into the outlier pool. I'm sorry. Did you get dealt with? This is now -- there's no separate LTCH system.

DR. CHERNEW: We save a meeting session.

[Laughter.]

DR. MARK MILLER: Dana, it's not that they don't want to.

MR. HACKBARTH: So that's a potential liability of Option 2, this gaming due to the notch effect.

Now, Option 1, you don't have that, but with a lower outlier threshold in a higher payment after outliers, you in effect have more patients being paid for under sort of a cost reimbursement structure.

MR. PETTENGILL: Yes, that's true. Now, how much
of a risk that is, I don't -- I don't think that's a big risk because right now they're getting 80 cents on the dollar over the threshold. But the big thing is that they have to take a big loss before they get any additional money, and there's no notch there.

MR. HACKBARTH: Yeah, because of the fixed-dollar loss requirement to get in -- the deductible, as you put it earlier, to get into the system.

MR. PETTENGILL: Right.

MR. HACKBARTH: Last question, and then I'll turn it over to you, Scott. So for the non-CCI patients, LTCHs would be paid under the IPPS system. What are the financial implications of that for LTCHs. Is there any way to tease that out? You know, the patients qualifying for the higher payment would be taken out, and they'd be paid under a new system. But now they'd have this remaining group of patients paid at a dramatically lower rate. Help me think about what that means.

MR. PETTENGILL: Well, I mean, I think you've hit the nail on the head. They would be paid at a much lower rate. I don't know exactly what the difference is on average between the LTCH payment rate and the current IPPS
payment rate for the same MS-DRG. But in the one that I've
been using here, the payment rate is four times as high in
the LTCH for a non-CCI case as it in the IPPS. Now, that's
probably a bigger difference than you would find in many
DRGs.

DR. MARK MILLER: And the next step in the
analysis is to come back and have quantified distributional
impacts. Since this is fairly complicated, there was one
step of here's the idea and then notionally the impacts at
the end of the presentation. Then we come back and do the
distributional impacts.

It is a reduction in payments for LTCHs, but it
kind of goes back to but how many of those that are
currently in LTCHs, you know, really qualify as the most
complex cases, and that's the --

MS. KELLEY: And I think it's also important to
remember that we're concerned that the costs in LTCHs are
distorted by the payment system itself. So if we were to
implement one of these policies, new options, and the LTCH
payment system went away, so would the requirement that an
LTCH have an average length of stay of 25 days or that they
keep their patients to this short-stay outlier threshold in
order to get a full payment.

So the entire cost structure within an LTCH could change as well to the extent that it is influenced by payment policy as opposed to clinical indicators.

DR. MARK MILLER: And that was sort of the point on Slide 4, that the payments change, the costs, you know, seem to follow them, which is not unusual in the post-acute care setting.

MR. ARMSTRONG: Thank you. You guys have done an excellent job of taking a very complicated issue and -- and I think Peter said this -- boiling it down to graphs that help us at least understand directionally the work you're doing. I just want to say I strongly encourage us to move forward as you've described. I think you've demonstrated that there are different payments across settings and incentives that really don't help, in fact harm the Medicare program. And this is also entirely consistent with very clear policy directions that we've taken in other areas to pay equally for comparable services, regardless of the setting that this is in. And, frankly, I -- well, no, I'll stop there.

So I just really strongly encourage the direction
that you're going in.

DR. REDBERG: Thank you for going through the options and the history. I guess I'm still struck by these started as TB hospitals, it seemed like, and, you know, for patients that probably were in iron lungs or things like that, things that we're not dealing with anymore, but even though that has gone away, you know, on Slide 4, clearly the number of LTCH hospitals has gone up a lot. And so I'm still trying to understand what their role is and what their value-added is in the system. And I think perhaps when we think about, you know, besides the principle of certainly paying the same no matter the site of setting, of incorporating, as Peter mentioned, shared decisionmaking, because it does trouble me that patients may not have chosen to be -- you know, we know there's a high mortality, these are very sick patients, but we know that most people prefer to die at home, not in a hospital, and that perhaps patients are entering these facilities really against their will if they had known that they would likely die in this facility and that there could have been alternatives, including home care, that might have been preferable.

So I think that we should try to incorporate, you
know, some evidence that they understood all the
alternatives, or their family, and chose to be in this
facility before making any further changes.

DR. MARK MILLER: Back when we first started
looking at this, some of us went out and, you know, visited
facilities and talked to various medical directors. And
this was not an uncommon -- it wasn't against their will,
but the medical directors definitely said there's people
here where there really should be a conversation with the
family, but either there's no one who's willing to do that;
or if the conversation occurred, the family was very clear
that they didn't want to take the alternative. But,
decidedly, even the medical directors in the LTCHs were
saying this is a dilemma. There are people here that
probably shouldn't be here and should be thinking about the
next stage.

MS. UCCELLO: I think this is excellent work, and
I think you've done a really great job creating some -- or
establishing some order out of chaos. We always have some
trouble with LTCH issues, and I think this is just helping
us get some more direction.

Just initially, or at least in theory, I prefer
the Option 2 because of the increased payment accuracy. But I am concerned about the gaming issues, so just providing more information about the ability for both the acute-care and the LTCHs to game this would be helpful.

What might also be helpful is some sensitivity analysis surrounding the eight-day definition, if that were changed either way, how much that would affect things.

And just one more minor comment. When we're talking about, you know, what does this do to the LTCH payments compared to what they are now and they would go down a lot, they're going to go down even more for the non-CCI folks under Option 2. So just something else to think about with those changes. But great work, I look forward to the additional analysis.

DR. SAMITT: The analysis was incredibly clear. Thank you very much. It's actually very helpful to see the financial projections and compare them between the options, so thank you for that.

I'm most curious about the gaming analysis, and I do have great reservations about Option 2 just because I think the gaming potential is likely.

I'm also worried, though, about gaming potential
in Option 1 given that there is -- as you look at the bell
curves of CCI versus non-CCI, I guess the question is: Is
there potential gaming in Option 1 for acute facilities to
transfer CCI patients to an LTCH as opposed to retaining
them and essentially focusing purely on non-CCI in the acute
setting, essentially deferring responsibility for CCI to
other facilities? And so in some respects, you even begin
to wonder whether Option 1 needs to be associated with some
kind of bundling or accountability for downstream decisions
should transfers occur elsewhere. And I don't know whether
that risk is a patient in Option 1, but the question is: Is
there gaming in either scenario?

DR. BAICKER: Can I just jump in? I had a similar
question about gaming in Option 1, that I would have thought
if you have different DRGs for CCI versus non-CCI patients
even though there isn't the same notch effect, there's still
an incremental effect, I would think, to move people into
that CCI DRG versus the non-CCI DRG that would be a little
smoother than Option 2 but would still be there.

DR. SAMITT: Yeah, which then raises the question:

Why not Option 3? And --

DR. MARK MILLER: Did you have the same reaction
[off microphone]?

MR. PETTENGILL: I did, yeah. So, remember, Option 1, we're not changing the DRG definitions. Only Option 2 changes the DRG definition.

DR. BAICKER: So not a separate [off microphone]?

MR. PETTENGILL: Right, right. So -- and as to the gaming potential in Option 1, what we're doing is we're moving the outlier threshold to the left for CCI patients. But the incentive to discharge a patient to an LTCH is the world we live in right now. So I'm not --

MR. HACKBARTH: Stronger, currently --

MR. PETTENGILL: Yes.

MR. HACKBARTH: -- than it would be under Option 1.

MR. PETTENGILL: Right. So I think actually the incentive to do gaming in Option 1 is lower --

DR. SAMITT: Is minimal.

MR. PETTENGILL: -- than it is in the current world. So -- but I don't know. That's just my initial thought about it.

DR. SAMITT: So if the incentive is still potentially the same to refer to LTCH, is it worth expanding
the analysis to include what Option 3 would look like and
whether a bundling -- you know, going back to the discussion
we had yesterday about upstream accountability, do we want
upstream accountability here as well in Option 1 so that
we're not seeing multiple admissions occur and that the
acute facility does take some accountability for what
happens to the patient after that first admission?

MR. PETTENGILL: Well, we do plan to model a
bundling option here, so we will come back with that.

MR. KUHN: I, too, want to join everyone else,
Dana and Julian, this is really terrific work. Thank you.
Well written and great presentation. I have two
observations for me.

One, I think it is worth continuing in this
effort, but one on the Option 1. What I worry a little bit
or would like to know as you continue to do your analysis is
the administrative complexity of this issue. We're talking
now a second outlier threshold. And you had the
conversation with Bill about CMS' ability to estimate at
least one threshold, their ability to estimate a second one
and how accurate can they be in that environment and the
administrative complexity of the agency to manage that on a
I don't know if you have any thoughts now, but as part of the analysis, that would be helpful to know.

MR. PETTENGILL: It's actually -- I don't think it makes the situation any worse than it is right now in terms of ability to be accurate in calculating a fixed-loss amount. You just have a larger pool to work with. You fix the one where it is and estimate the other. And I don't see that as a huge deal, but it's worth thinking about.

MR. KUHN: Okay. Just if I were still at CMS, that would be my first reaction, okay, can we even implement something like this as it goes forward.

And then my second just comment as you continue to do your analysis, when we look at Option 2, I guess one question: How many additional CCI MS-DRGs do you think would be created through this process?

MR. PETTENGILL: I forget what the number is. It's probably around 100.

MR. KUHN: So we'd go from maybe 745 now, or thereabouts, to about 845?

MS. KELLEY: It was not more than 150.

MR. PETTENGILL: Yeah, not more than 150 is
probably a good answer.

MR. KUHN: Thank you. So I guess what I would be interested in the analysis is that if folks remember when we migrated from the old DRGs to the MS-DRG system -- and you kind of mentioned this in your presentation -- it did change the weights and moved more towards surgical procedures versus medical procedures. And as a result of that, we saw a shift more from rural hospitals and those that did more medical type procedures in to more tertiary kind of facilities. So as we continued to lay out this analysis -- now, obviously, we're talking $5.5 billion and $140 billion I think in total Part A hospital spend here. But it would be interesting to know when you do the analysis the types of hospitals which kind of do that analysis and how the movement of dollars, and would we see further dollars flowing out of rural areas into urban areas as a result of this change as we go forward.

MR. PETTENGILL: We plan to do that.

MR. KUHN: Okay. Thank you.

DR. MARK MILLER: Which I think would be mostly peculiar to Option 2.

MR. KUHN: Exactly.
MR. PETTENGILL: Yes.

DR. MARK MILLER: Whereas, Option 1, I think --

MR. KUHN: It wouldn't be Option 1, but Option 2, I think you would see that it would be movement of dollars and redistributional, and it would be interesting to see what that looks like.

DR. MARK MILLER: Right, because I think in Option 1 mostly acute-care hospitals either benefit or are held relatively harmless.

MR. PETTENGILL: Yeah, that's right, because the only thing that's going to happen is that they're going to get more outlier payments. The basic payment rate isn't going to go down, so they would be okay.

MR. KUHN: Thank you.

DR. MARK MILLER: And as to the LTCH impacts, which would be present in either options, LTCHs are not heavily in rural areas.

MR. PETTENGILL: Right. That's right.

DR. COOMBS: Thank you very much. This actually teases out a lot of the issues that we had earlier, and I think we're on to the right course in terms of matching the resources with patients' needs.
Just for a clinical lens on this, Peter, you asked a question about ICU critical care beds, and there are some institutions where they have a stepdown unit or even the vented patient is actually on the floor. And so when they transfer from that institution, they go from a floor now to an LTCH that is considered to be a critical care -- a CCI. And I'm wondering if there's a way to reconcile that because they're not critical care like the critical care patients that are, say, on the sixth floor in the sense that they're stable enough to be on a floor situation or even in a stepdown unit in the acute-care facility, and then when they go to the LTCH, they've been bumped up in terms of acuity for that institution, which is right, but there needs to be a way to reconcile that piece of it. And what I'm trying to say is all critical care is not all the same in that sense. So that would be an issue that I would have some concern about.

And then the eight-day cutoff, I know you said it was arbitrary, if we could noodle around that to see what the type of cases are requiring that eight days, and then maybe you could work backwards to say there are some different type of criteria that you could choose within the
framework of that eight days. And I think that's a place to go. That gives you a better defined limit. Because I know that the threshold for some ICUs, eight days is just -- it's the difference between nursing care on the floor versus nursing care in the ICU. My sister had surgery and had to go to the ICU because they don't do epidurals and narcotic infusions -- epidural infusions at the same time, so she went to an ICU. And it's a very different criteria based on what the regional resources are within hospitals. So I think that's really important.

I think I like the fact that you've included Option 3. I don't know how we can get there. I do think that practicing ICU medicine, there's this whole notion of a level of accountability in terms of 24-hour coverage, I mean meeting Leapfrog criteria. There's all these criteria that are met in the acute-care setting that are nowhere analogous to some of the LTCHs' coverage for the same critical care DRG.

So I'm still trying to work with that in terms of the differences in the levels of acuity in terms of multi-system organ failure and how you manage that. So I'd be interested going forward in looking at what's in that
interval of eight days in terms of working around diagnosis specifically and the co-morbid conditions that may be more prevalent there versus a blanket DRG that's just in the acute-care setting is exactly in the LTCH setting where the resources in the acute setting are much more labor intensive.

DR. CHERNEW: So I like this a lot. In fact, I think the entire yesterday and today have been good because we've been working in ways to, I think, clear out the underbrush of a system that views it as a bunch of separate providers towards a system that views it as a bunch of patients with different needs. And I think this moves us in that direction, which I think, generally speaking, is good. As I've said before, I tend to think of payment systems based on the incentives that they create as opposed to how they move money around. That doesn't mean how they move money around is not important. But the incentives they create for me tends to be more important, and, of course, gaming fits into that, although we talk a lot about accuracy, and payment accuracy matters. Of course, incentives to game will push you away from accuracy in some particular way, even if ideally in a non-gameable world,
they would be perfectly accurate. And I worry -- very much
like what Cori said, I worry about the gaming.
So my loose and somewhat weak preference right now
is for something that's closer to Option 3 if we are
comfortable that we can get the quality measurement right
and the case mix adjustment right and deal with some of the
other things in them, I think broadening the way we think
about the patient across, you know, their entire spectrum of
care strikes me as better within that.
I do worry most about the gaming for Option 2, so
I think you've laid out quite well the issues and where the
work has to go, and I look forward to doing it. And I think
in many areas we're moving in the right direction, so thank
you.
MR. HACKBARTH: So would you just talk a for a
minute about gaming potential in Option 3?
MR. PETTENGILL: Well, okay. First of all, I'd
have to define Option 3 a lot more concretely.
[Off-microphone comments.]
MR. PETTENGILL: Yeah, and given the discussion
yesterday, I'm not sure that my initial definition of Option
3 is the same one that I would create tomorrow. But the
option that we've been talking about would bundle in a portion of the expected costs of LTCH and SNF care associated with CCI patients into the rates for the CCI DRGs. And because it does that, I think it raises questions about gameability of ICU stays in ICHs. Okay? Because, again, you're dependent on the CCI definition.

And then the other thing it would do is it would say the hospital's responsible for paying for -- the hospital's responsible for the make or buy decision on post-acute care. If they decide to buy care from an LTCH, that care would not be paid for in the IPPS. The hospital would pay for it out of the funds in the bundle. And then a portion of what they pay would be eligible for outlier payments in the IPPS. So we wouldn't put very much of the expected cost of the post-acute care into the bundle. We would make them claim it through the outlier policy. Okay?

You know, I haven't really thought very hard about the gaming potential here, but it strikes me that the biggest piece of that is not the outlier part of it, it's the ICU part of it, to get into the CCI DRG in the first place.

DR. MARK MILLER: I see it as kind of like Option
2 except it's a bigger pot of money now.

MR. PETTENGILL: It's a bigger pot of money, and you've changed the responsibility for, you know --

DR. MITCHELL: Once you get [off microphone] --

MR. PETTENGILL: Right.

MR. HACKBARTH: You don't have the gaming potential in the LTCH for them to characterize patients as CCI patients.

MR. PETTENGILL: Right.

MR. HACKBARTH: You just have the acute-care hospital.

DR. CHERNEW: I had a different vision of the way the bundles might be defined, but I think the key point is it hasn't been defined in detail, so we have some work to do. And I think thinking about defining 3 or 2, or 1 for that matter, in a way to mitigate any gaming potential around pushing people to longer or shorter ICU stays is a fundamental component of all of these options.

MR. PETTENGILL: Well, if you have thoughts about that, we'd love to hear them.

DR. BAICKER: So, Mark helped clear up my vocabulary issues in thinking about the gaming, that there's
still some gaming in option one in terms of pushing people into CCIs to get the extra outlier payment, although, of course, that would involve incurring the cost of the extra ICU day. And I'm very much in favor of this direction of harmonizing these payments and stopping having these separate site-specific what look like big overpayments. And the gaming seems fundamentally built on the fact that the definition is based on use of care, and we see that in DRGs. You know, DRGs were originally not supposed to be about use of care and then use of care gets built in to try to define really sick people versus less sick people.

And I know there's been a lot of background work on the ICU-based definition of CCIs, but in some ways, you solve a lot of the gaming problems if you change the definition of CCI to be based on something less easily gamed. You have to worry much less about these threshold effects. And I don't know whether it's possible, either practically or even with a lot of work, based on the data available, to find conditions that map pretty cleanly to that use of intensive resources, because if these definitions of CCI patients were based on a set -- either utilization from a year ago or diagnoses that are already
coded up, then we would -- then that opens up a lot more possibilities of things that we can do to try to match the payments to the real resource costs.

And I don't know whether that's just not feasible or whether we don't have the analysis but it's feasible if somebody would do a new study based on those definitions instead and --

MR. PETTENGILL: Well --

DR. CHERNEW: Can I just say one thing? We have to get it right on average. We don't have to worry about getting it right for everyone all the time.

MR. PETTENGILL: Yeah. I think -- you know, I hear you. I would absolutely love to do that, but, and here's the kicker, two things, actually. One, I'm not a clinician. And two, the real problem here is the diagnoses by themselves don't do it. They take you just so far and then they stop, because I can get a principal diagnosis or a secondary of somebody who has congestive heart failure, but it doesn't tell me anything about the level of severity of that, the congestive heart failure. I might know which valve is the problem, but I don't know how sick that patient is and that's what I have to know.
DR. MARK MILLER: And the other thing I would add to this is, so several years ago, we went through this process as a Commission of saying what you really don't want to do is pay on the basis of the silo. You want to pay on the base on the characteristics of the patient. And we did lots of consultations with different clinicians and different associations and societies and so forth and we're now years later and there is no consensus out there on this is a patient who needs this level of care. And a lot of the policy debate is beginning to devolve to lower common denominators than even this.

But your point, you know, conceptually, is correct. It's just the ability to say, this patient, yes, this patient, no, even on average still leaves a lot of play for people to game.

DR. BAICKER: Well, and so, then, going back to Mike's point, the question would be, if you use the granted cruder measures that are based only on data up to 60 days ago but nothing in the most recent window, how good a -- you know, what's the predictive value of that on average? Would you be roughly aligning payments and reducing gaming, or is it still so noisy at that point that it's not very helpful
in terms of flagging the patients we want to flag, you just have to live with the gaming?

MR. PETTENGILL: Yeah, that's an interesting idea, and maybe we can get somebody working on a parallel project on that.

DR. MARK MILLER: [Off microphone.]

MR. PETTENGILL: No, I mean, if I have to deliver something in September, an analysis, there's no way I can do that between now and then.

DR. MARK MILLER: [Off microphone.] We'll talk about that. But I do now capture better your idea. Your idea is if you could capture some set of coding or characteristics that precede what happens far enough that the actual actor wouldn't have had a chance to --

DR. COOMBS: Well, I was saying earlier -- that was my specific point, is not all critical care is all critical care is the same, and that was my point, and that a lot of times, and I see a doctor, I'll go down and triage someone and say, no, this one doesn't need to go to the ICU, whereas the benchmark for admission to a critical care will vary depending on the resources. So a lot of times, it's bed-dependent. What is the percentage of critical care beds
in an area? And so that translates to the post-acute care
course, as well.

So I think that there's some pieces of the puzzle.
Congestive heart failure is one. COPD with exacerbation.
There's a lot of clinical conditions for which the range and
the severity of illness is like this and it doesn't lend
itself to a purely scientific economic analysis like we
would like to be in a model.

DR. BAICKER: And this is a related point,
although I think somewhat different, in that you're saying
these conditions don't very accurately differentiate between
people who are truly critically complex, expensive, and
people who aren't, that they're too broad bucket. I'm
making a related point that by any definition, regardless of
how specific and sensitive it is in identifying the correct
payments, if it's endogenously determined based on whether I
deliver a specific item of care today or not, I have an
incentive to deliver that item of care. So I'm willing to
give up a little bit of sensitivity and specificity if I
eliminate a lot of gaming potential, and the question is,
how big is each of those things to trade off. See, it all
comes back to economics.
MR. PETTENGILL: But there's another point here that also needs to be remembered. Yes, if you add ICU days, you're going to get a higher payment, but you're also going to pay the costs for that added care. So you have to consider both.

DR. BAICKER: So you want to weigh the net incentives to game, based on both the costs incurred and the potential increases in payment against the failure of adequately flagging the patients you're trying to flag.

MR. HACKBARTH: This is a really important discussion and we're running a little bit behind, so we need to keep moving ahead and make sure everybody gets a chance on this.

Mary.

DR. NAYLOR: So I'm not going to talk about endogeneity.

[Laughter.]

DR. NAYLOR: I honestly think the conversation thus far really just highlights the -- first of all, great report -- the critical need for clarity on the definition of CCI versus non-CCI and how that is a continuous struggle.
So I love the idea of some sensitivity analyses around whatever, either resource use or diagnoses. I think the principles that are moving this agenda forward around paying for comparable services to a comparable population regardless of setting are critically important. I also think the issues around -- that we talked about a lot -- of continuity of care are critically important, and to the extent that the policies can help to align these are big things.

I do think the issue around -- focused on accountability, as Craig mentioned, for decision making as early or as downstream as possible. So we're talking and engaging people in the kind of shared decision making conversations that would say, do you really want to go to the ICU or CCU given what we see as your trajectory.

And the last point I'd make is in addition to all the complexities that Alice and Kate talked about, you know, people transition pretty quickly from non-CCI to CCI, and so it -- even within an episode. And so accounting for this based on days of service, et cetera, is really challenging, as you're describing. I wish the complexity of care needs were that simple. So I do think we have to account for
transitions within groups who are high risk who move from one level of care to another right within one setting at a point in time.

MR. BUTLER: So, first, I have to say I'm sensitive about our discussions of gaming. If I were a caregiver in an LTCH or an ICU in a hospital listening to this, it sounds pretty crass. I don't know. These are people that are very dedicated to these things and we're sitting fairly distant, talking about, oh, well, we'll give this more day or that more day. I just had to say that.

Now, the option one, I think, just doesn't go far enough to change behaviors or payments to me. I like option two the best. And there's a history of us refining and creating new DRGs when you can create enough of a homogeneous definition of who those patients are. And I know hospitals start to focus on the protocols associated with those DRGs in a different way than if you just expand an outlier payment. Certainly, tracheostomy is an example of that, for example, which was a new DRG a while ago.

I think what trouble we're having is that, as Kate points out, the lever for service, when it's just another day of ICU care, it's a very different kind of thing than an
actual intervention where you're kind of doing something specific to a patient, and that's what's -- and I do understand the gaming issue relative to that, so it is an important one. But if we had a different way to get at that, that would be key.

Finally, I would say, let's remember where, from my perspective, where this was at. The typical maybe big urban hospital might have a 20-bed ICU and they might have on a given day five of these patients that are staying a heck of a long time and are viewed as they're here forever. They could be here for months. And, therefore, you really only have a 15-bed ICU, not a 20-bed ICU, and you cannot give the focused kind of care that those wound care or ventilator patients need, and if they could be in another place, everybody would be better off.

And so that's where I still lead, and option three is difficult, but you're trying to create win-win collaborative relationships between the LTCHs that really do a good job at this with the ICUs. And so the only -- my downside of two is it's still a little bit of a silo, let's take from one to give to the other because it's fair and it's better than where we're at, but it still doesn't quite
get at kind of having the LTCHs and the ICUs and the hospitals work directly together.

MR. HACKBARTH: Could you just go back to option one. You said you didn't feel like option one went far enough. It seems to me option one is still a pretty dramatic change from current law.

MR. BUTLER: It is. It's better than doing nothing. I'm just not sure what the behaviors -- how behaviors -- again, it's about the patient and putting them in the right place at the right time for the right treatment, and I'm not sure that having that extra outlier payment is going to create that change in behavior or that thought process, where I was thinking in option two, you really -- okay, who are these patients? What's their protocol? Let's move them along. I mean, I have to think about it a little bit more.

DR. HALL: Did you mention anything about mean or average length of stay in LTCHs?

MS. KELLEY: I don't think I did during the presentation. The average length of stay currently --

DR. HALL: Not length, occupancy rate, I meant to say.
MS. KELLEY: Oh. I'll -- I don't want to misspeak. I would have to get back to you on that.

DR. HALL: Well, it might be worth looking at that.

MS. KELLEY: Yeah. Sure.

DR. HALL: We've seen this steady growth in LTCHs --

MS. KELLEY: I have that number.

DR. HALL: Now, if that steady growth is associated with, say, 50 percent occupancy, we might say that there's a much more greater potential for gaming. And I sort of agree with Peter that we probably should be a little careful about how much we attribute to gaming. But if there's been this incredible growth over 15 years in LTCHs and they're all running at 100 percent occupancy, then I think I would look more for another kind of discriminator, whether we use option one or two.

And one that I think, if it's possible to do, that I would just suggest this from my own experience, having had some experience in LTCHs and also in non-LTCHs, is that in Table 3 of the materials we were presented, virtually all those patients had some kind of a respiratory issue. And I
would bet that the major clinical discriminator here is the requirement for one-to-one attention to somebody, not necessarily all people with trachs or on ventilators, but just in terms of pulmonary hygiene that becomes so very important in an emaciated person.

And if there was some way to add that as another indicator or discriminator, I think we would see a little more insight into this. I'm just not sure that it's possible going just from the MS-DRGs to get to that point, but I think it might be worth looking at.

MR. GRADISON: A quick comment about the outliers. I'm not trying to stir up an issue about the current policy with regard to outliers for hospitals, but since this would be new and there are a lot of variables and uncertainties, we might want to suggest with regard to the new outlier pool that it be trued up in the subsequent years so you don't get into the question of whether money is being diverted from one group to the other. It would, over a period of a couple of years, average out. We could talk more about that if you have -- I don't think it's a big deal, but I did want to mention it.

The specific thing I should have asked before, to
make either of these options work, would it be necessary to change the payment rates for some of the high-intensity SNF categories to get equal -- to level off the payments, which I thought was one of our objectives?

MS. KELLEY: That's not been part of this work. I think all things -- I think our concern about the payment rates in SNFs has not necessarily been the level of payment but rather the relative profitability of certain RUG groups versus others, which I think is a -- so I think the issue of leveling up is not so much level of payment, but rather getting the weights correct so that payments are directed so that we don't have some RUGs that are so much more profitable than others. Have I characterized that --

DR. MARK MILLER: It's actually both. I mean, we do have concerns about the payment levels, but you guys are talking about the distributional equity within the payment system, and to that end, what you're saying is correct.

MR. GRADISON: Yeah. I mean, I just thought that that was one of the objectives here, where the treatment could be as a case, apparently -- no, it could be either in a SNF or it's properly equipped, or a long-term care hospital.
MR. HACKBARTH: Bill, just go back to the first part. I didn't quite follow. So what's your concern about how this relates to SNF payments?

MR. GRADISON: I just wondered if any of the SNF payment rates need to be modified to keep them in line with these new payment levels that we're --

MR. PETTENGILL: I think that there's a fundamental problem here with -- first, our hypothesis, I think, is that when SNFs are used, they're not the same as an acute-care hospital stay or an LTCH stay for these patients. They're being used for the sub-acute care or the recovery care that follows a long stay.

And, second, the SNF payment system is a per diem system, so the payment is not really comparable to the way we pay on a per case basis in the acute-care hospital or the LTCH. So there's not that truing kind of problem here, I don't think.

MR. GRADISON: Okay. That's very helpful. I want to join in complimenting you on an excellent analysis of a very complex issue.

With regard to the gaming, yes, there are those risks. I'm sure we're all going to collectively try to
minimize them. But in no way do I think that should be considered a deal-breaker because if the experience turns out to be adverse, it's possible to come back later and try to fix it.

DR. HOADLEY: So, again, I add my compliments. This is just really great analysis and really has helped to structure what's obviously been a good discussion.

You know, it almost goes just to what Bill is just saying. The one thing I guess I keep trying to think about is the history of getting into this category of payment was that there were hospitals that, back in the 1980s when this whole system was developed, that, well, they might not quite work. And they were just defined, as I understand it, on the number of days of the average length of stay.

And now we talk about it much more as post-acute, and at that point, it might not have even necessarily been that some of these things were doing post-acute cases as opposed to initial admissions.

And so the question I have is, when we think about these two options, for the more common case now, where they are really dealing with a second stay, they've been in the acute hospital and now they're going into this, and yet
they'd be thrown into sort of a comparable DRG category with the person when they were in the original hospital and now they're in a second hospital at some different stage of their care. Is there some way to exploit that difference short of the bundling approach, some in-between place, I mean, so that it's almost like when they get to the LTCH, they're not really on day one now. They're on day 17 or whatever of their overall stay.

So I don't know quite where to go with that, but it seems like if you have two patients and one of whom is starting in the acute-care hospital and has a particular length stay and another one is starting in the LTCH after they've been in an acute-care hospital, and yet we're sort of paying them the same payment --

MR. PETTENGILL: Right. Well, it's a combined episode illness, but it's not the same stay --

DR. HOADLEY: Right.

MR. PETTENGILL: -- because the DRG they get into in the LTCH is different.

DR. HOADLEY: It could be different --

MR. PETTENGILL: Almost always.

DR. HOADLEY: Okay. Almost always different. So
that helps.

MR. PETTENGIll: Yeah. So it's an intriguing idea. I see where you're trying to go, but --

DR. HOADLEY: I'm trying to think about what the parallels are and whether there's anything that can be exploited about the fact that might even differentiate. I don't know if there's any cases that sort of go straight to an LTCH that are in this CCI kind of situation. There may not be. But those could look different, and maybe that's all picked up in the way you would code them into a particular DRG.

MR. PETTENGIll: Yeah. Well, one thing we know is that the indirect CCI patients are less expensive than the direct --

DR. HOADLEY: Okay.

MR. PETTENGIll: -- which suggests that there's something there.

DR. HOADLEY: Mm-hmm.

MR. PETTENGIll: But --

DR. HOADLEY: And with the indirect patient, once they're in the LTCH, are they getting paid the same way that the direct --
MR. PETTENGILL: That was our original design, yes.

DR. HOADLEY: And whether that's an issue that should be thought about --

MR. PETTENGILL: Right. I mean, the problem is that the direct are here. The indirect are here. And the non-CCI are down here.

DR. HOADLEY: Yeah.

MR. PETTENGILL: And, actually, the ones that overlap, that are both direct and indirect because they go from -- they had a prior stay with eight-plus days and then they went to the LTCH and they had --

DR. HOADLEY: Another eight-plus.

MR. PETTENGILL: -- and they stayed in an ICU for eight or more days, those are even less expensive than the indirect. So I don't know what to make of that.

DR. HOADLEY: But, anyway, it's clearly going in some -- and I, like a number of people, my gut was sort of saying option two made more sense, but with all these other issues, that could either push us to the gaming fixes or to seeing some of the merits of option one, and I await hearing more.
And the only other thing I wanted to add goes back to the exchange between Rita and Mark about the decision making kind of side, and the conversation I remember from some years ago was almost the mirror image, the complement to the example Mark did, which was a doctor in an area that did not have LTCHs saying, yeah, because we don't have it, we think we do end up with those conversations sooner and we have a better conversation with a patient because there isn't this sort of easy option, and so I just wanted to throw that back into that part of the conversation.

MR. PETTENGILL: Interesting.

MR. HACKBARTH: Okay, David, last word.

DR. NERENZ: Okay. Well, I apologize for what may appear to be a round one question, but if we could go to the bottom of Slide 11. Just as this discussion has gone on, I'm feeling less settled about the focus on CCI as opposed to the broader spectrum of LTCH patients. So I observe here on the bottom, non-CCI patients represent about 60 percent of the total LTCH population.

Then we move to Slide 12 and then the focus from this point forward is about alternative payment models for the CCI population. And I apologize if I just missed it,
but I'm not completely clear why the rest of the patient has been left out of the subsequent discussion. Now, I understand the distributions are different. The outlier cutoffs could be different. I mean, I understand the rest of what was said.

But it does seem, then, to lead to a potential gaming problem when the key distinction between CCI and non-CCI is this eight-day stay, and others have brought that up, that if you create a different set of payment rules that have some attractive features to them for a CCI group only, then you create these incentives to put people into that group by virtue of decisions about eight-day versus six-day stay.

So I feel like maybe I missed something between Slide 11 and 12 about why the strict CCI focus.

MR. PETTENGILL: Well, the non-CCI patients in an ACH under option one, they're treated exactly the way they are, okay. Their payment rate doesn't change. Their outlier threshold doesn't change.

In an LTCH, they go from being paid under the LTCH payment system to being paid under the IPPS, which has much lower rates, okay. So they're definitely being -- they're
going to definitely experience a policy change, okay.

DR. NERENZ: [Off microphone.] Yes.

MR. PETTENGILL: I'm not sure what else to say.

DR. NERENZ: No, that's okay. I didn't have any great further direction to go except just to -- I want to make sure I clearly understand where some of these gaming --

MR. PETTENGILL: Under option two --

DR. NERENZ: -- because just to follow on just what you said, then, that would seem to just clarify the incentives to have an eight-day stay that would put someone perhaps into a higher-paid CCI category, other characteristics being essentially the same.

MR. PETTENGILL: Right.

DR. NERENZ: Okay.

DR. MARK MILLER: But you understand the distinctions between one and two, where in two, there's a strong incentive to do that because it moves you into a higher payment category. In option one, you can do that, but you run some loss before you hit the --

DR. NERENZ: Yes. Right. No, no, understood. Understood. And the net is complicated.

MR. PETTENGILL: Right. Very.
DR. BAICKER: So, would it be fair to say that the goal that we're talking about, rolling LTCH payments back into normal acute care payments, but we're worried about a group of people who might be very expensive that we want to protect facilities against and how do we flag those patients to provide some financial protection for the extra care they're going to need, CCI is the word we're using for that. The definition of it is what we're trying to figure out. But that's for the group of people that we're protecting from this rollover whole cost. Everybody else is just going to get paid under the standard acute care bundle.

MR. HACKBARTH: And we want to protect them regardless of whether they're in an acute-care hospital --

DR. MARK MILLER: Yes.

MR. HACKBARTH: -- or in LTCH.

DR. MARK MILLER: Yeah.

MR. HACKBARTH: Okay. Obviously, you have generated lots of interest and we look forward to future discussions.

Okay. Our last session is on Medicare's coverage for services provided by advanced practice nurses and physician assistants.
MR. HACKBARTH: Okay. Who's leading? Let's go for it.

MS. SMALLEY: Good morning. Today we will discuss Medicare's coverage of services provided by advanced practice nurses and physician assistants. Most of this presentation will be an overview of scope of practice for these non-physician providers in general and a discussion of how Medicare pays for the services they provide. Today's presentation is not meant to be comprehensive but, rather, to act as a starting point for the discussion of these issues. We look forward to hearing your thoughts on where to take this research in the future.

First, we will define the terms "advanced practice nurse" and "physician assistant" and discuss the state, provider, and payer policies that affect which services APNs and PAs can deliver and under which circumstances.

Next, we will turn to Medicare's policies regarding APNs and PAs, including covered services, payment methodology, and a breakdown of services these clinicians provide to Medicare beneficiaries.

Finally, we will outline some issues for you to
Both of these types of clinicians must by definition meet certain education and certification requirements. APNs, a category that includes nurse practitioners and clinical nurse specialists, must first be registered nurses. They must complete additional training, often a master's degree with some clinical experience, and be certified by a national certifying body. They then must be licensed to practice in their state.

Note that certified registered nurse anesthetists and certified nurse midwives are also considered APNs. However, for the purposes of this preliminary discussion, when we use the term "APN," we refer only to NPs and clinical nurse specialists.

PAs must also graduate from a PA program that includes clinical rotations. They also undergo a national certifying process. They then must be licensed by the state in which they plan to practice and establish a relationship with a supervising physician.

States regulate the practice of APNs and PAs in two ways: licensure and scope of practice. Licensure determines who is and is not a certain type of clinician.
State boards of nursing -- or in the case of PAs, boards of medicine or other PA specific groups -- decide who receives a license based on the completion of education requirements and a national certification process. Licenses issued in one state generally are not valid in other states. However, there is some discussion around the creation of multistate licenses.

Scope of practice, on the other hand, dictates what having that license enables the APN or the PA to do. Often, this means the extent to which these clinicians can do certain activities, like prescribe medications, without the supervision or collaboration of a physician. Each state has developed a nuanced interpretation of what these terms mean. For instance, in some states, collaboration implies a written agreement that the APN will refer patients to the collaborating physician in the event that the case exceeds the APN's knowledge and experience. In others, the physician must be physically present for at least some portion of the time the APN practices.

Because working closely with a physician is integral to the training of PAs, their scope of practice does not vary as widely across states. They do not practice
purely independently, but it is often up to the discretion of the supervising physician how much the PA can do without being physically supervised.

Provider and payer policies may further influence the scope of practice. For instance, facilities such as hospitals and SNFs can decide whether they will allow APNs or PAs to be a part of the medical staff or to have admitting privileges. They can also determine the extent to which these clinicians must work under supervision.

Payers can restrict both activities that these clinicians perform and the roles they can play, such as being a primary care provider, and can also determine the billing processes they must ascribe to, including how much they will be reimbursed relative to physicians.

These policies are in addition to state scope of practice laws and cannot contradict state scope of practice. Therefore, in a state that does not allow admitting privileges for PAs, a hospital could not decide that they can do so within the walls of the facility.

As I mentioned earlier, scope of practice laws for APNs can vary widely by state. As an example, let's take a look at two neighboring states with very different scope of
practice laws. This table is a list of some of the most common activities performed by APNs, such as prescribing medications independently, referring patients to physical therapy, and acting as a primary care provider. As you can see, APNs in Arizona can practice much more independently than in Nevada. The variation in scope of practice laws does not follow regional patterns as much as one might expect. States tend to be quite individualized in setting these rules.

Now Kate will discuss Medicare specific policies regarding APNs and PAs.

MS. BLONIARZ: So turning to what Medicare covers, generally the Medicare program covers all medically necessary services provided by APNs and PAs permitted under state law. Medicare requires that the services be provided by a state-licensed advanced practice nurse or PA with national certification, and APNs must be registered nurses. But that is also consistent with the requirements in nearly all states.

There are a few exceptions to this general rule of Medicare coverage. For example, APNs and PAs cannot authorize home health or hospice services. Only a physician
can do so. And some of the conditions of participation for institutional settings described in regulation specify activities that only a physician may perform. But these issues are complex, and we're only giving you a sense of them. So if you want us to do more in this area, we can.

I want to recap what Katelyn and I have just covered. Generally, Medicare's coverage of medically necessary services follows what state law allow them to do. There aren't many areas in Medicare policy where there are significant additional restrictions imposed by the Medicare program.

So, in other words, the variation that we see in whether APNs and PAs can practice independently is resulting from state scope of practice law along with provider policies. And then payer policies, such as whether insurers will cover and pay APNs directly, is another factor.

Medicare pays for advanced practice nurse services in two ways.

The first, down the left-hand side of the screen, is the APN or PA billing directly for the services they provide. There's a nuance with physician assistant billing that I can cover on question. Under this method, they bill
under their own provider number and are paid at 85 percent of the applicable fee schedule amount for the service.

The second way, down the right-hand side, is when the physician bills for the services that an APN or PA provides under their direct physician supervision, and this is called incident-to billing. A physician can bill for any services provided by an APN or PA as long as they meet the incident-to requirements. In this case, the physician is paid at 100 percent of the applicable fee schedule amount.

We can't tell how much incident-to billing is occurring because only the physician's ID is submitted on the Medicare claim. In other words, Medicare can't tell whether a physician or other clinician working under their direct supervision provided the service.

We did a claims analysis of APNs and PAs billing Medicare directly. And, remember, this is only one of the two ways that they can receive payment under Medicare.

APNs and PAs billing independently accounted for about 4 percent of the spending in the Medicare fee schedule in 2011. It's about between $2 and $3 billion. And these services are paid at 85 percent of the applicable fee schedule amount.
Looking at the services that nurse practitioners, clinical nurse specialists, and physician assistants bill for, we also see there's variation in the type of service they provide, depending on which specific clinician type we are talking about. About two-thirds of the services nurse practitioners provide are primary care services; clinical nurse specialists are about one-third; and physician assistants are about 40 percent. Primary care physicians, the right-hand bar, furnish about half their services within primary care. So although APNs and PAs provide primary care services at about the same rate overall as primary care physicians, it varies by APN or PA specialty.

So I'll turn it over to Kevin to continue with this line of inquiry.

DR. HAYES: Looking further at claims data, we see that APNs and PAs tend to bill for office visits that are of a lower level of complexity than the visits billed by primary care physicians and by other physicians.

To see this in the chart, note that the billing codes for office visits are defined according to a visit's complexity, with Level 5 visits being the most complex.

Thirty-six percent of the office visits billed by
APNs and PAs are at the upper end of the scale, at Levels 4 and 5. But 46 percent of the office visits billed by primary care physicians are the higher level 5 visits. And 42 percent of the office visits billed by physicians other than primary care physicians are Level 4 or Level 5.

Nurse practitioners, clinical nurse specialists, and physician assistants often furnish services in the office setting, but not exclusively. The percentages of their fee schedule services with place of service equal to office are as follows: nurse practitioners, 46 percent; clinical nurse specialists, 40 percent; and physician assistants, 54 percent.

Other sites of care are important depending on the health professional considered. Nurse practitioners and clinical nurse specialists furnish about one-quarter of their services in nursing facilities. Physician assistants furnish about a fifth of their services in either the hospital outpatient department or the emergency room.

So, with that, we have completed the overview portion of the presentation. Our goal, of course, has not been to be exhaustive but, instead, to give you some perspective on the kinds of issues we could pursue further.
We would now like to move on to setting up your discussion of how you see the policy environment and the Commission's further work in this area.

Recall first that the Commission has expressed certain goals for advancing value in the Medicare program. One is to ensure equity through design of payment systems that do not systematically favor some providers or patients with certain conditions over others.

Another goal is to improve care coordination by encouraging providers to coordinate care across sectors.

And a third goal is to move payment and care delivery from fee-for-service to coordinated care models with more global payments.

As to the current policy environment, the Institute of Medicine, in a 2010 report, made a number of recommendations about the future of nursing such as removing scope-of-practice barriers and allowing advanced practice nurses to practice to the full extent of their education and training.

Specific to Medicare, IOM made recommendations such as changing Medicare coverage rules and authorizing APNs to certify patients for home health and hospice. Such
proposals have been in the environment for some time but have not moved forward. Utilization of services has not been a concern. In addition, there may be budget scoring considerations.

In the policy environment, there are also concerns about access. You might consider whether to focus your conversations at future meetings on those issues. Recall that at last month's meeting, we had a session on the payment adjustment for services furnished in HPSAs. A question that arises from our presentation today is whether there is a role for APNs and PAs in addressing concerns about access.

What role might APNs and PAs play? Some policies, either current or proposed, apply to fee-for-service and include APNs and PAs at different levels of involvement. For example, there are two new billing codes for transitional care management, billable starting this past January. The codes are defined to include services for patients transitioning from, for example, an inpatient hospital setting to the community setting.

The definitions of these codes include non-face-to-face services such as communication with patients or
caregivers within two days of discharge and assurance in scheduling follow-up services.

The definitions also include a face-to-face visit. Physicians but also APNs and PAs can bill for these services.

Also in fee-for-service, there's the hospital readmission reduction program you heard about at last month's meeting and the more general focus on reducing readmissions. And recall that the June 2012 report had a chapter on care coordination in Medicare fee-for-service. The chapter models of care coordination such as embedded care managers, external care managers, and transitions models.

Other options in the policy environment might be characterized more as delivery system reform. For example, CMS has programs and demonstrations underway that recognize primary care and care coordination as critical components of better care for beneficiaries.

Examples include the Multi-payer Advanced Primary Care Practice Demonstration and the FQHC Advanced Primary Care Practice demonstration. Both call on participating organizations to conduct what the Commission described in
its June 2008 report as essential activities of a medical
home.

Then there are community health teams. PPACA
included authority, but alas no funding, for
interdisciplinary community health teams of nurses,
pharmacists, social workers, and others to support patient-
centered medical homes. These and other delivery system
reforms, if proven effective, could be adopted by ACOs and
MA plans.

To conclude, we list here three topics you may
wish to consider during your discussion:

What is the role of APNs, PAs, and other
clinicians in delivery system reform?
What is Medicare's role in this area relative to
others, including the states?
And what are the scoring implications of any
changes in current policy?

We look forward to your questions.

MR. HACKBARTH: Okay. Thank you. Good job.

I know, Mary, I asked you to lead yesterday, at
least once, but it seems like I really --

DR. NAYLOR: I have been waiting for this day.
[Laughter.]

MR. HACKBARTH: Yeah, right. So I'll give you first crack at clarifying questions.

DR. NAYLOR: Thank you. Thank you for the opportunity I think to really take a look at, as we use the phrase, "physicians and other health professionals" to kind of bring to life the other health professionals. Great introductory chapter. And so I would love to go to Slide 9, and I just have a couple clarifying questions.

Can you remind all of us the rationale for deciding in terms of independent advanced practice nurse billing an 85 percent reimbursement rate relative to comparable services by physicians at 100 percent?

DR. HAYES: If we look back at the record, the best discussion I've found of this was in a PPRC, Physician Payment Review Commission, report along about 1991, and they talked about a couple of things. One had to do with the fact that while the codes are often the same used for billing purposes -- and we saw that in one of the slides -- the mix of patients that can be seen just looking at one individual code could be somewhat different.

There was also discussion there about differences
in training, duration of training in particular, and so the
view of -- and that was focused, you know, pretty much on
the issue of the payments in the fee schedule for work. If
you want, we can talk about practice expense. That's a
separate issue but related thoughts.

Anyway, based on those considerations, the
Commission recommended continuation of some differential in
payment for APNs and PAs relative to physicians.

MR. HACKBARTH: "The Commission" in that sentence
being the Physician Payment Review Commission.

DR. HAYES: Exactly. Exactly.

DR. NAYLOR: Can I just do a follow-up on that?

Now that we have this history of understanding the
complexity and the coding that's going on, does that help to
clarify, you know, who is providing what services?

DR. HAYES: It does. It would take some further --
-- because we can see -- let me see if I can find the slide
here. So, for example, here we would see, you know, some
illustration of how the coding varies and what it would
take. But this is pretty crude. This is just, you know,
five levels of codes. There could be some diversity within
this. It would take some further work to kind of tease out
what the particulars are within an individual code.

DR. NAYLOR: Two last questions. In an earlier report, we heard that about 15 percent of Medicare beneficiaries use other health professionals exclusively for primary care and about a third, at least based on your report. So do the data that we have now, many years later, help us to understand the growing importance of other health professionals in providing access to Medicare beneficiaries?

MS. BLONIARZ: Sure. So I think the numbers we'd had from the survey was that about 15 percent of Medicare beneficiaries responded that they used advanced practice nurses or physician assistants for their regular and routine primary care. When I showed the pie chart of 2011 -- yeah, 2011 billing in Medicare, so APN and PA billing is about 4 percent, and this is double what it was five years ago.

DR. NAYLOR: And it's 15 percent of providers accounting --

MS. BLONIARZ: 15 percent of providers, about -- yeah, and 4 percent of billing.

DR. NAYLOR: And one last one. The rationale for APNs and PAs not being able to certify for home health or recertify and for hospice, can you provide some basis for
that?

MR. CHRISTMAN: The very short answer would be no in the sense that I'm familiar more with the home health side of it, that, you know, the physician certification for home health was created very early at the beginning of the program, and the law specified that a doctor needed to be able to certify this. And, you know, I guess the -- you know, I couldn't guess what their thinking was at the time.

DR. NAYLOR: Thank you.

MR. HACKBARTH: On that point, is there -- in our discussions of home health, we've been concerned that the bar for certification is pretty low, at least in some parts of the country, and there are a lot of episodes created as a result due to a lack of supervision. And, you know, at one level you might think if we add a new group of people able to certify, it could increase costs. But if, in fact, there are clinicians who will actually spend more time checking with the patients and what their status is, it could be a more effective control on certification of home health. Has there been any analysis of that or thinking about that?

MR. CHRISTMAN: No. I mean, I think that there is some concern that, you know, there are -- the home health
benefit expects that the physician who certifies care is going to be sort of helping or supervising the episode in a loose sense, and there is a concern, you know, that that interaction isn't always very strong. If NPs were more likely to engage in that type of work, it could be beneficial.

You know, I think the thing that I kind of come back to is at least in home health, we have yet to see anywhere that there's sort of a systematic access problem, you know, to the benefit, and so, you know, I guess what I've struggled to see is, you know, who is the pocket of beneficiaries who would sort of benefit from this change. That's sort of a separate issue from whether, you know, NPs have the training and qualifications to do it. It's just sort of, you know, what access bump would I get from it, and we haven't really identified a patient population.

MR. HACKBARTH: Okay. And then I just want to go back to Mary's first questions about why the 85 percent. Kevin, my recollection is that one of the premises of the RBRVS is that level of training really ought not be a factor in payment; it ought to be the nature of the service, so we don't pay different amounts for the same service based on
specialty training. It's the service that matters. This seems to be a departure from one of the core principles of RBRVS in that regard. There is a question mark actually at the end of that.

DR. HAYES: Yes, when you first talked about a training difference, I was going to point out that, well, no, it's actually an issue of specialty. But then you closed with the point about specialty, and so if in looking at what the PPRC said on this, they, too, you know, made the point about no specialty differential, but they made a distinction between a training difference between physicians and other professionals, and that was the difference that they focused on, not the within-specialty kind of difference.

MR. GRADISON: Thank you. There are two statements in here which I really have read over and over, and I can't figure out whether they are consistent with each other.

On page 4, it says, "Medicare requires that physician assistants must have graduated from an accredited physician assistants educational program or pass a national certification examination and be licensed by a state," and
so forth. And then on page 15, it says, "All states require that PAs graduate from an accredited PA program."

Does Medicare use -- and what is it? Does Medicare, as indicated on page 4, have this option that the PA can pass a national certification examination and that somehow is different from the state requirement that they -- do they all have to have a degree?

MS. BLONIARZ: Yes. And basically what Medicare is saying is -- there was this option, you know, one path or another. All states require a degree and certification.

MR. GRADISON: Yes.

MS. BLONIARZ: So it's kind of a moot point. Medicare doesn't -- Medicare is defaulting to what the States have done.

MR. GRADISON: So this national certification requirement is not an element. The key element is graduation. It's the second line from the bottom on page 4. I just -- it's a minor matter, but I frankly think these sort of -- I didn't find it clear. Let me put it that way. More substantively, have you taken a look at the implications of this to some of the efforts to expand the
use telemedicine in the Medicare program?

MS. BLONIARZ: We haven't. My understanding is telemedicine, APNs and PAs can serve as telemedicine -- the provider at the originating site. One way in which there can be -- that state policies can affect it is whether there is a direct supervision requirement for the APN or PA. So let's say it's a rural area and an APN or a PA is practicing out in this rural area. Some states have requirements for the percentage of time that a physician must supervise, and so it may impose kind of geographic restrictions on how far away an APN or PA may practice from their supervising or collaborating physician. So that has an implication, but not directly for telemedicine.

MR. GRADISON: I have been spending some time on this telemedicine issue. Generally speaking, state laws control. As far as I know, the only major exception that Congress has made so far has to do with VA hospitals, the VA system. Some of us have been noodling the idea that maybe Medicare should be considered a national program, like the VA is a national program, and have its own rules with regard to this. And it's possible there may be some legislation introduced along these lines, and that's why I was asking,
because I'm trying to figure out how this would work if a state -- let's take the extreme -- is one of those states that does not permit advanced practice nurses or PAs to do very much except under direct supervision, does that mean that somebody from the outside who's being consulted has to be part of that same rule? In other words, could somebody -- could an advanced practice -- if an advanced practice nurse from outside the primary state communicates electronically into the secondary state, how does that work? Or are they prohibited from doing so? And then that's the kind of question I'm sort of grappling with.

Okay. We can talk more about that. If anything comes of this, I'll let you know.

DR. HOADLEY: Yeah. On the same point that Bill was making on the degree, you said the advanced-practice nurses, typically a Master's degree. Is the PA -- what's the PA degree typically?

MS. BLONIARZ: It can vary, actually. It can be post-associate's or -- so, like, kind of a B.A. equivalent or a Master's degree.

DR. HOADLEY: Okay.

MS. BLONIARZ: And there's -- the format of that
education and training is a little different because there is also clinical rotations that are part of the education requirement.

DR. HOADLEY: And on the pie chart on 10, which I guess you already have up, the calculation -- this is based on Medicare spending. So the calculation of four percent already incorporates that 85 percent differential. So in terms of sort of amount of services, it would be a tick higher.

And the "incident to," I think you said that can't be included in this.

MS. BLONIARZ: Yeah. We -- Medicare has no way of telling what the level of "incident to" billing is because the claim is just submitted with a physician identifier on it and so you have no idea whether the service was directly provided by the physician or provided by another clinician under the "incident to" requirements.

DR. HOADLEY: And is there any kind of guess about -- I mean, are we talking about it might be as much again, or just a tiny bit more, or do we have any sense?

MS. BLONIARZ: So, the one piece of data -- it doesn't directly answer your question -- that I have is the
Inspector General decided to pull a sample of claims where a physician had billed for more than 24 hours of services in a day --

DR. HOADLEY: Uh-huh.

MS. BLONIARZ: -- and they did chart review based on that, and for that very small group, half of the services were provided by a clinician other than the physician.

DR. HOADLEY: But you'd really have to go to some kind of chart review to probably do that.

MS. BLONIARZ: That's right.

DR. HOADLEY: Yeah.

MS. BLONIARZ: That's right.

MR. HACKBARTH: And so remind me, Kate. The "incident to" physician requirement is simply they be in the building, right?

MS. BLONIARZ: It's that they have to be in the same suite. The physician has to be in the same suite of offices and that the clinician is providing care that was under a plan of care established by the physician. And so it kind of has to be in the middle of a continuing plan of care that the physician has laid out.

MR. HACKBARTH: So in an organization like
Craig's, you know, a big group practice where there's a physician that has an ongoing relationship as the primary care physician for Mrs. Jones, and that physician has an advanced-practice nurse working with him or her, it's pretty easy to qualify for the "incident to" billing.

DR. SAMITT: But I think it's when the -- the question is, is interpretation on the word "suite." So is "suite" sort of in the facility, and if the facilities are large, that there is the opportunity to have relative direct contact with APs in a broader geography, if that's what you're getting at.

MR. HACKBARTH: Yeah. I can't imagine that anybody is really looking very closely at the configuration of office space and what's a suite and what isn't. Sort of "on site," I would think, is probably better.

DR. HOADLEY: And I had one other on this same thing. What would the percentage of APN and PA be if you did it out of only primary care? Have you ever done that calculation? I mean, the next graph does the flip side of it, what percentage of the PA services -- it would just be interesting, because it would be more apples-to-apples because they mostly do primary care. What percentage of
primary care is delivered by these providers?

MR. ARMSTRONG: I think you just asked the question I was going to ask, but let me try it again to make sure. So I'm working with a presumption that care delivery is going to evolve and rely much more heavily on these providers. Are we concerned about whether there are enough being trained to meet the demand in the future, much as we're concerned about the number of primary care providers that will be available to us?

DR. HAYES: We did look at the -- the only evidence that I have on that is the -- and I don't think I'm going to have the numbers, but we did look at -- for the March report, we did look at the growth in the number of physicians and other health professionals billing Medicare, and we found that the ratio of physicians to the beneficiary population, I believe, was pretty constant, looking 2009 to 2011, but that there had been some increases, you know, in the numbers of APNs and PAs billing Medicare relative to the beneficiary population. So that suggests that there, at least from that standpoint, from the standpoint of who's billing Medicare, there's been more growth relative to the beneficiary population, the APN and PA care. But it would
take a closer look at just what the output of the educational institutions is like to kind of go and address your question directly.

MR. HACKBARTH: Just let Kate jump the queue here. She had a follow-up question about "incident to" billing.

DR. BAICKER: So, I understand that from the claims themselves, you can't differentiate the "incident to," and you gave an example of when you could get more data. I wondered if there were other back-of-the-envelope calculations just based on the total number of people there are and the number of hours they provide and the share of Medicare beneficiaries they serve to give us a sense -- I don't have a sense of just how big the scope of the "incident to" services is in terms of order of magnitude. Is there a back-of-the-envelope you have in mind?

MS. BLONIARZ: We could think about it. The one other thing I would say is that it also includes a number of other clinicians, like therapists, occupational therapists who may work out of a physician's office. So it's not solely advanced-practice nurses and PAs, but --

DR. HAYES: The only other thing I would say, add to that, would be that in some circumstances, we might be
able to look at -- or let's put it this way, that it would be possible to estimate the amount of time that physicians or other health professionals spend furnishing services, but you need data from all payers to really get a comprehensive look at what their workload is over the course of a day, week, whatever it would be.

DR. REDBERG: Thanks for a really helpful report. I have a few questions that are mostly related to understanding better the educational and licensing requirements.

So for advanced-practice nurses, I think most, you said, have a Master's degree, but do you have any idea how many, what that "most" is that have a Master's degree?

MS. BLONIARZ: We can get back to you, because I know it's in some of the -- I know the educational associations keep things like that, so we can get back to you.

DR. REDBERG: For the ones that don't have a Master's degree, what do they have? Sorry.

DR. NAYLOR: I was going to say, now it's a requirement to have a minimum of a Master's degree.

DR. REDBERG: Oh, okay.
DR. NAYLOR: So the only ones remaining in the workforce that don't -- as a matter of fact, there is great movement to move toward DNP, Doctorate of Nursing Practice, to prepare. But the only ones that don't are grandfathered in.

DR. REDBERG: Okay.

DR. NAYLOR: So the requirement for much of the workforce right now is all have a Master's and may have more.

DR. REDBERG: That's fair. Then you don't have to get back to me, because it sounds like it would be a moot point.

And then if I understood your answer to Jack's question, you can be a PA by having just a two-year Associate degree. So after high school, two more years of school and that's it --

MS. BLONIARZ: No. I'm sorry. I should have said it looks like there's people who have about four years of training after graduation or --

DR. REDBERG: After graduation from --

MS. BLONIARZ: After --

DR. REDBERG: -- high school or college?
MS. BLONIARZ: High school.

DR. REDBERG: High school.

MS. BLONIARZ: Yeah. So kind of the equivalent to a Bachelor's or a Master's. And I think that about half have either -- half the PA population have either. But I can confirm all of that.

DR. REDBERG: And also, I was trying to understand the numbers. I saw 124,000 are either APNs or PAs, but do you know how that breaks down?

MS. BLONIARZ: So that's billing Medicare --

DR. REDBERG: Right.

MS. BLONIARZ: -- and we can get back to you on how many are nurse practitioners versus clinical nurse specialists. But overall, about two-thirds of the nurse practitioner -- or the advanced-practice nurse workforce is nurse practitioners.

DR. HAYES: If we look at this slide and the three categories shown here, nurse practitioner, clinical nurse specialist, and physician assistants, the clinical nurse specialists are a small proportion of the total. If we combine them with nurse practitioners, they represent about 56 percent of that total of those three categories.
represented here, and physician assistants being the other 44 percent.

DR. REDBERG: And then -- thank you. In terms of -- my other question related to the "incident to." Do you have a feeling, for most advanced-practice nurses, would they be in both categories, sometimes billing on their own at 85 percent and sometimes billing as "incident to," because that would give us an idea of how many more APNs there were that weren't captured in the billing.

DR. HAYES: We have that barrier of not being able to identify the "incident to" in any definitive way, so --

DR. REDBERG: Unless the nursing profession keeps numbers on how many have graduated. But they could be doing non-nursing things, as well, I guess.

DR. NAYLOR: So I can get back to you on that, right?

DR. REDBERG: I was just trying -- you know, it's kind of related to Scott's question of what workforce we're talking about and are there --

DR. NAYLOR: So there are a couple hundred thousand, 220,000 advanced-practice nurses in the four categories, 124,000 that bill Medicare. There's a huge
effort, including a Graduate Nurse Education demonstration, that is trying to double the workforce of advanced-practice nurses to prepare primary care. So there's a lot of dynamic, but, yes, the nurse associations do keep data in terms of who's in primary care even beyond the Medicare program and so on. So we can get that.

DR. REDBERG: My last question for this round is I'm a little interested, also, in the geographic distribution of particularly nurse practitioners. I'm not as familiar with what the PAs are doing in the primary care. And in particular, I'm wondering if it is related to the State regulations, because I would imagine some nurse practitioners would prefer to practice where they can practice independently and open their own clinics, and I don't know how the salary compares to ones that are employed in places like Craig's or where we have nurse practitioners that work within our primary care practices. But I'm just wondering how the distribution is and whether there's any relationship between that. Like, are they more concentrated in States that have more independence for nurse practitioners or not? Thanks.

DR. SAMITT: So, the chapter references Medicare
Advantage, but I won't ask my question about that because you can expect what I would ask in comparing the numbers. So I will ask a question about Slide 14, if I may. I guess the presentation in the chapter is extremely well done, but it really begs the question, what problem are we trying to solve, which isn't clear to me. I wonder whether we've interviewed any physicians or APs or systems to understand where payment policy interferes with any of these things, because, again, you could say, well, are we under-employing or under-engaging advanced practitioners because of the 85 percent differential, and my guess is the answer is no because there is the "incident to" pathway. So it's not clear to me what the problem is, and I guess I'll leave it at that. It sort of helps for round two if I could get a sense of that.

MR. HACKBARTH: Okay. So, let me just put out a couple hypotheses, and I guess these would relate most to the first bullet on access. So, some people have said we have a looming primary care access problem, not just for Medicare beneficiaries but more generally. The pipeline for training new physicians, even if we can persuade more medical students to pursue careers in primary care, is a
long one. Can expanded practice opportunities for advanced-practice nurses help deal with that looming problem, and if so, what would be policy levers that Medicare and others might pull in order to enhance the possibility that they can fill some of the void?

A related set of questions, and this relates to our conversations last time about HPSAs. You know, we have areas of the country where those problems with access to care may be greater. The ability to attract physicians to those areas by jiggering the payment rate may be limited. Would advanced-practice nurses be more responsive to bonuses and opportunities for expanded practice in those underserved areas if we paid them differently or we paid them more? So questions like that, I think.

Tom.

DR. DEAN: In response to a couple of questions, I think, Bill, my understanding is that the national PA exam is required, I think, everywhere. So it's a national certifying exam that PAs do have to take. So I don't think it's quite as confusing, maybe, as it seemed to --

DR. HAYES: [Off microphone.]

DR. DEAN: Yeah. And, Rita, you asked about
background for PAs. I think it's mixed, in my experience, because the PA program grew out of medics returning mostly from Vietnam, I think, and there was a primary care shortage and the view was that here are some very experienced people who have a lot of skills and we're not taking advantage of them. And so I think we were talking about that last night, that Duke, particularly, started, and it's obviously expanded widely.

So I think, now, the programs probably primarily do grant a Master's degree, but there's a whole mix of -- for quite a long time, anybody with some kind of health care experience, whether it's EMTs or various things, could enroll in PA programs regardless of what their actual formal degree was prior to that. Now, I think it's probably more rigid now. I don't know. I haven't really kept up on that. But there is a big mix in terms of the group that's out there, how they came to that role, and so -- but I think they do all -- at this point, everybody has to pass that national certifying exam.

Does that fit with what you --

MS. BLONIARZ: It does, and it's helpful. A lot of the PA materials that we look through did talk about the
education programs are trying to attract people with substantial prior experience in medical care of some kind --

DR. DEAN: Yeah.

MS. BLONIARZ: -- and so that's helpful to know.

DR. DEAN: In fact, a lot of the PAs in our area are nurses that, for one reason or another -- partly because I think the PA program was more available -- and wanted to expand their role, and so actually went into the PA program. I'm still a little confused, and I should know this because I worked with these people a lot, this "attendant to" thing. You said that they have to be following a plan of care. Does that mean that the physician has to have been involved with that particular patient and establish the plan of care, because I doubt if most places are quite that precise. But I wonder if, technically, is that the requirement --

MS. BLONIARZ: Technically --

DR. DEAN: -- that the physician sees the patient, sets up a plan, and they just follow up? Is that the way it was originally set out?

MS. BLONIARZ: The way that the Medicare manual presents it, it's that it's a plan of care established by
the physician for that patient.

DR. DEAN: So it's much more demanding than just having the physician in the, quote-unquote, suite, right?

MS. BLONIARZ: Right.

DR. DEAN: Okay.

MS. BLONIARZ: Yeah.

MR. HACKBARTH: So, does the manual characterize what a plan of care is? It does? You don't need to go through it right now. If there's something, I'd actually be curious about what that says.

DR. SAMITT: But my understanding is the plan of care is not with each visit.

MR. HACKBARTH: Right.

DR. SAMITT: The plan of care is for the patient, and so it's in the record as the plan of care for multiple visits.

MR. HACKBARTH: Yeah.

DR. SAMITT: And if the advanced practitioner is supporting that plan of care, it doesn't have to be unit by unit or visit by visit.

MR. HACKBARTH: Yeah. So if, in my earlier example, if one of your colleagues who's the primary care
physician for a patient -- let's assume it's a patient that
has no serious ongoing problems -- the plan of care is that
they periodically come in for acute illness, I would assume
that it's okay for the nurse practitioner to see the patient
and bill "incident to."

DR. DEAN: I mean, that's the issue. If you
really enforce that precisely, it's very restrictive. And I
don't think that's the way it's usually applied. I mean, if
every new problem required a --

DR. NAYLOR: So "incident to" is billing and it's
different than scope of practice. So that, I think, will be
really important to clarify, because there are many, many
people that are working in very large suites or in very
different sites delivering services consistent with their
education, scope of practice, et cetera. So one's a billing
issue and the other a scope of practice and they're not the
same.

MR. KUHN: If I could go to Slide 10, please, just
a question on the four percent, which I think in response to
a question from Mary, you said has grown about 50 percent
over the last five years. So has that growth largely been
changes in State licensure laws, like urgent care centers
and just more opportunities for delivering care, or do we know -- obviously, it's a small number, but I'm just curious about the reasons for the growth.

DR. HAYES: Sure. This would be spending, so it would be influenced by a number of factors. We could probably try and disentangle what contribution each factor makes to this, but part of it would be just the increases in fees. We've seen increases in RVUs for the services frequently billed by these practitioners, so that would be one thing.

In response to Rita's question, I mentioned that there's been an increase. There's been growth in the number of these practitioners, the APNs and PAs, billing Medicare relative to the beneficiary population -- more growth than what we've seen in the physician population, so that would be a consideration.

And then -- what else -- no, those would be, to me, would be the key drivers.

DR. COOMBS: So with the resident reduction in hours, one of the things I was interested in is the academic institutions, if there's a predilection for a concentration of PAs and nurse practitioners within academic centers. I
think there was a study, I don't know, five or six years ago
where they looked at the distribution in terms of where
nurse practitioners go geographically in terms of urban
versus rural, and there was a predilection for it to
parallel where physicians go. So that would be the second
point. Is there any update on the distribution of APNs and
PAs?

My other question has to do with the slide that's
up here right now, the APN and PA of four percent. I think,
and I'm not sure this is the case, that if you were to break
that pie part out and looked at the ratio of the PAs to
nurse practitioners, there would be a lopping disproportion
of nurse practitioners within that pie. The reason why I'm
saying that is because of them working independently outside
of the relationship of a physician.

And then, lastly, what I was also interested in is
the breakout on Slide 13. What happens if you were to kind
of tease out the outpatient, hospital, ER, and the office,
because the *Health Affairs* had these two wonderful article
series and one had to do with nurse practitioners going away
from primary care and that progression and PAs recently
going into more surgical subspecialties and kind of looking
at what kind of office that those two entities are in. I think that makes a big difference, too, because we've got the primary care distribution, but I'm wondering, if you were to break out office, how does that break out? It doesn't necessarily parallel the chart on primary care versus non-primary care.

And I'm interested in this from a number of reasons, because if we say there are access problems, then you want to kind of see if the access needs are being met by the decision making of the PAs and the nurse practitioners, because if we're recreating the same dynamic that exists within physicians' choices in terms of where they decide to go, and then the nurse practitioners and PAs decide to go in the same route, I'm not sure we're meeting the needs where we need in terms of primary care.

And also this whole notion of office medicine versus office-based practices. And I know that at our hospitals, we had PAs across the board, and actually, there's more PAs now than nurse practitioners in most of the clinical services, even in the ICU. Thank you.

MR. HACKBARTH: So, do we know anything about changes in patterns, location of practice, for PAs and
advanced-practice nurses?

MS. BLONIARZ: So, what I'll say is the share of APNs -- of nurse practitioners providing primary care, I think, is generally up around 75 percent to 80 percent. That is a slight decline over time. Physician assistants are more likely to practice in specialty care. Around two-thirds of physician assistants practice in specialty care. But the changes over time, I would want to get back to you on it, just --

MR. HACKBARTH: Mary, do you know anything --

DR. NAYLOR: [Off microphone.]

MR. HACKBARTH: Mike? Kate? So let me ask a round two question here, and maybe Scott and Craig and Mary can help with this.

I've heard from a colleague who works in a big practice that has long made use of advanced-practice nurses that the economics of how they're used are changing over time, and this organization, which will remain nameless, is in big cities and actually has a unionized nurse workforce, which may be significant. What he told me is that while at one point in time it was feasible economically to use nurses as team members, clinicians who did not have their own panel
of patients, that's becoming increasingly difficult because
the salaries of the nurses have been increasing to a level
where in order to justify the cost, they need to be able to
basically to bring in their own revenue. They've got to be
able to have responsibility for their own patients and
significantly expand the revenue capacity of the
organization.

So if that is true and that is generally the case, that's a pretty significant development for the profession
and it means that it may need to be supported financially by
-- well, let me just stop there. I think it's a significant
development.

Does that ring true to people who use advanced-practice nurses, or Mary, have you heard that?

DR. SAMITT: Well, I think it very much depends on
how the organization is compensated itself, so if in a fee-
for-service-based environment, I think that is absolutely
ture that I think we're beginning to see an analysis at the
level of the advanced practitioner of the revenues minus
their own expenses. However, in a value-based organization
like our own, there's a whole other different phenomenon,
which is, you know, you want to maximize the talent of your
team members and have them work at the top of their license in that type of environment. And in that particular case, you see less of the dynamic of revenue minus cost because it's now the comparison of not revenue versus cost but the relative roles and responsibilities of the different team members. You want the physicians to do truly physician work and the advanced practitioners to do advanced practitioner work.

And so I think it depends on the organization and whether you're more value, Medicare Advantage, global payment-like or whether you're more fee-for-service-like.

MR. HACKBARTH: Although if you're in an organization that is paid on a prepaid basis, wouldn't it be really important if adding advanced practice nurses could increase your primary care capacity? So now as opposed to, you know, having 2,000 per primary care clinician, you'd now have a group of advanced practice nurses that expand your revenue capacity and you don't have just 2,000 coming in for each internist, you also have advanced practice nurses each bringing in revenue for their own panels in essence. They're not practicing as supports; they have their own panels.
DR. SAMITT: I guess philosophically it would work that way. I'm not sure that's the dynamic that we're actually seeing in organizations that are fee-for-service-driven. I don't know if Scott has a different experience.

MR. ARMSTRONG: Yeah, we're entirely capitated, but we're very intentionally moving to a shift in the ratio of more nurse practitioners and PAs per MD than we've been at. And, yeah, the challenge is how do you build the panels, and it's really -- I think where we're going to go is it's around to teams; the panels are associated with not just a single doctor but with a team. And then we'll increase pretty significantly the size of those panels.

DR. NAYLOR: I totally agree with these two perspectives and want to clarify also that nurse practitioners, advanced practice nurses, have a socialization around care coordination and the whole -- so it's not just who -- you know, that they take on panels of patients, but their capacity to really influence care across systems and over time is a unique feature of their preparation.

And so the extent to which we can maximize their contributions, maximize what they bring to the team, is
exceedingly important, and this gets to the point -- I'll wait. I was going to say -- do you want to go to Round 2?

So it gets to your question about what problem are we trying to solve here, and I think the report did an excellent job of highlighting what exists right now, huge variations across states in scope of practice, variations even within states, in which payers and providers are enabling, or not, a group of health professionals to be able to do in terms of their contributions.

Bloomberg News just had a piece on a nurse practitioner who set up a practice in an underserved area and was unable to get a physician collaborator to join, and that was a requirement of the state, and could go a couple of miles away into another state and set up that practice and be able to serve a very underserved population.

So the issues around promoting access to a growing population of Medicare beneficiaries -- and to the extent that the Medicare program itself can help to get to a position and an environment where we optimize the contributions of advanced practice nurses and PAs, to be able to deliver and address the challenging needs of a Medicare population, especially the chronically ill, is
exceedingly important.

MR. HACKBARTH: So let's assume for the sake of discussion that scope of practice laws are beyond the scope at least of what MedPAC is going to recommend. What are the things that would be high on your list of what Medicare can do to achieve the goal you just described?

DR. NAYLOR: So I don't know what's possible here, but I would say to the extent that Medicare pays payers and supports plans, MA plans, to be able to deliver services, I would really wonder whether or not we couldn't create the conditions of participation that say you can't restrict use of people. So if payers are restricting who is able to take on panels, that should be an important part. The Medicare program should do that.

We are supporting a lot of innovations in PPACA, the accountable care organizations, and we heard yesterday about the convoluted path that we must have in order to for nurse practitioners to be able to lead. And yet they could be opening ACOs in markets that are not the same markets where MA plans are and address a whole population in the states that don't have ACOs, et cetera.

So to the extent that we can enable and eliminate
these barriers, I think eliminating the barriers to certification of NPs and PAs, APNs and PAs to be able to determine who is right for home care -- I mean, this is the work of nurses to understand home care -- to eliminate that is to create the best -- I mean, a good solution to making sure that everybody is getting the right kind of assessment for those certifications, et cetera. So there are paths to promoting enhanced access that Medicare has, I think, a great opportunity.

I think everyone here should know there is an opportunity here to really look at the complexity of services and the payment for those services. And when we talk about paying comparable rates for comparable services, it doesn't necessarily mean that we have to pay 100 percent. Maybe it is 85 percent that will get us to -- because we know from evidence that we have the same quality outcomes, 30 years of evidence on looking at least at advanced practice nurses.

So I think those ideas about use of efficient providers, equity in payment for comparable services, these are thing our payment program can really work toward.

MR. HACKBARTH: So I thought you were going to
say, Mary, on the 85 percent issue that at least for certain
levels of codes in visits, the more basic care, you know,
why shouldn't we be paying equal for equal work.

DR. NAYLOR: That's exactly what I am saying.

MR. HACKBARTH: Oh, okay.

DR. NAYLOR: But I'm not saying that it
necessarily has to be 100 percent; in other words, we should
be looking at what are those services and what should we be
paying for those services, and who is competent to deliver
those services getting those payments?

MR. HACKBARTH: Well, any information that you can
bring to bear on Alice's questions about location decisions
and sensitivity of location decisions to payment incentives,
you know, can we address specific shortage, geographic
shortage issues more readily through payment policies
directed at advanced practice nurses, anything along --

DR. NAYLOR: Foster more of the nurse-managed
clinics which exist in these underserved -- exactly, yes.

MR. HACKBARTH: Yeah, if you can help us think
through those things, that would be helpful.

MR. BUTLER: Yeah, so I think we still need to
describe the landscape a little bit more thoroughly to then
get to the payment or the Medicare role. We haven't
highlighted the fact that to train a physician -- to the
extent these are substitutes for physicians, a physician has
a minimum of seven years -- four years of school and three
years of residency. Not only is the cycle time long, but
the total expense is enormous compared to what's in this
pipeline if you were to accelerate it, which would be
cheaper and faster.

We have a College of Health Sciences with a
relatively new PA program that has more applicants per slot
than any program in our university, wildly popular. We have
a very large college of nursing that is one of the five
organizations in the study that Mary referenced, doubling
the size of GME programs.

The pipeline is going to grow rapidly one way or
another, but to get back to the point of these people, I
think today, despite the fact that it looks like there's a
lot of primary care here, they're getting gobbled up by
health systems, they're getting gobbled up by specialists.
The primary care picture is not as clear to me that they're
either going into primary care or going into places where
care is needed that isn't accessible now. And I think we've
been making this point, and I'm only saying I'm seeing that firsthand in the pipeline that's coming out, that we need to find a way to not have these people just kind of -- and we have hired a whole bunch of them ourselves as one system to be more part of the team still, not to be out on their own generating revenue to cover their costs.

So a little bit more on that landscape, and, by the way, they're all getting paid a ton, like the same as primary care physicians, even if they don't generate the same revenue. So they're very valuable.

DR. HALL: Well, just a couple of comments. This is the start of what I think is a very important dialogue.

The national membership organizations that represent physicians and nursing have become hopelessly politicized on this issue, as I'm sure most of you are aware. And I don't think we have any business inter -- or should we get into that, because they're not going to solve the problem.

The flip side of that is that any physician who has worked with advanced practice clinicians in various camps, the relationships are quite cordial, and the synergy can be extraordinary in terms of the benefit of the patient.
So we have this -- maybe it's not surprising, but a funny kind of dichotomy between attitudes and opinions that get expressed publicly.

I should say in full disclosure I have daughter who is a physician assistant, and she's practiced independently since she was about six, as far as I'm concerned.

[Laughter.]

DR. HALL: I think what we can do as an organization is to follow a little more closely the trajectory that we started, and that is, what's the problem we're trying to solve, and I think it's high-quality care for the Medicare population. And to suggest that only one group has the ability to solve all of these problems with the burgeoning population is silly. There's plenty of room in the landscape for a variety of training trajectories and patterns. And as Mary has mentioned, there are areas where there is in my mind no question that the individuals who are drawn to a professional career in nursing and possibly into PA have attitudes and skills that are different. They are much more collaborative. They are sensitized much more to some of the biopsychosocial aspects of care. And so there's
a great merit, just as there's also merit in encouraging primary care physicians who arguably would not necessarily just be a pipeline to referral to specialists.

So I think the prize here is a health system that is highly professionalized but highly compassionate as well, and these are the roles that need to be filled, and then that should start driving whether we -- rather than move right to the issue of how much somebody has paid or all the rest. In a way, I don't think this is as complex a problem as we want to make it right now, but I think we should -- as we carry this analysis further, let's really figure out what MedPAC can do here in terms of our own, if you will, scope of practice.

DR. HOADLEY: So two kinds of thoughts. One is on this question of the 85 percent issue, and I don't know if that's something we ought to look into or not, but it does seem like as a researcher my inclination is to say, okay, this was looked at in 1991, that's a long time ago, what has changed. Have there been changes in scope of practice in that 20-year period? Have there been changes in the actual -- both the legal scope of practice and sort of the actual practice of what these people are doing that would lead one
to reach a different conclusion in 2013 than we did in 1991? So I'd just sort of throw that out. On the broader question that you raise as to how to think about what are the barriers to doing some of the things that we all think need to be done, addressing both the primary care shortage issues but also the better care delivery and the care coordination and the transitions and the team-based care and all that kind of stuff, but particularly in a fee-for-service context, because I think we've already had comments on what is probably going to happen on its own in the managed care context. It seems like there are two kinds of things that can be done. One are things that are not specific to advanced practice nurses or nurse practitioners, so that's things like the codes that have appeared for -- you know, these new codes that were mentioned, transitional care management and things, you know, those are codes that can be used by a doctor or used by a nurse, and if the nurse practitioners are particularly oriented to providing that kind of care, that will then happen. So those are things that might be good moves for the program in general, and that would be -- as a side-effect effect -- better use of
these advanced practice nurses and PAs. And the others are, I think, things where it's specific barriers. And so the two examples I've heard particularly talked about were some of the things that came up yesterday in the ACOs and then the question of home health certification.

Again, I don't necessarily have the answer to what's the right solution there, but I think if we thought about where are there explicit barriers that are addressing the use of these types of practitioners versus the other kinds that are things that we might just do in general because they're good things to do and, in fact, they will also benefit better use of these kinds of clinicians, that may be a helpful framework.

DR. NERENZ: I would be interested in Tom and Craig and perhaps Bill's thoughts about some greater explicit differentiation of tasks within primary care. It seems that over the last, I will call it, two decades we have added a number of expectations and requirements of primary care. We've embedded them in quality programs, things like smoking cessation counseling, depression screening, lifestyle counseling, various things. And a number of these things don't really require the unique
skills that doctors gain during four years of medical school and residency, and they're probably things that good nurse practitioners and PAs can do. And it seemed like in some of our team models, we've probably evolved already to a point that nurse practitioners and PAs sort of step up and do those things, but I don't know that. I'd be curious about it.

But in terms of what you could do with payment policy, presumably in the fee-for-service domain, one can identify codes like you just said for these activities specifically and then create rules by which nurse practitioners and PAs can do those things, which then perhaps get embedded in the scope of practice.

Now, I don't know if what we really want to do is just expand the set of codes in fee-for-service. Maybe we just want to push into bundled payment situations in which these things can happen a little more naturally. But I'm just curious, your thoughts about this, because up to this point, I think we've talked about primary care as one thing and whether folks either do it or don't do it. I'm a little more interested in the tasks within it and how those can be sorted out.
MR. ARMSTRONG: Actually, I'll build on David's comments. My point of view is that -- and it's not just limited to primary care, but the Medicare program is purchasing billions of dollars of services that are provided by doctors that don't need to be provided by doctors. And it's analogous to some of our other payment policy issues where we're paying for services that could be done in a couple of different settings, but it's being done in the more expensive setting, and we're paying the higher rate and we shouldn't.

So I get all the restrictions around licensure and, you know, that kind of thing, but it would just be interesting to me to ask is there some way -- and this is, I think, where you're going -- to identify what are all those services that we pay for that you actually don't need a doctor to perform. And to Mary's point, arguably, some of those services could be done even better by some of these other professionals.

So I just -- that's maybe a different way on a very similar question, but it's -- and I don't know if it's answerable, but I'm sure there are people in this room that know much better than I do what those would look like.
And I would just say in our system that is how we're thinking about this, and we think that we can solve it and build a care system that will be much more cost-effective but also effective in achieving the overall health outcomes that we're trying to achieve.

DR. REDBERG: I think it's a really important topic, particularly as we're addressing the future needs and how to address our growing primary care deficit. But I just think it's important to kind of play it through and think about it, because I wouldn't want -- I mean, I highly value the services of advanced practice nurses. I work with them daily. But I wouldn't want to say, okay, doctors can't do primary care, they can't talk to patients, and we're just going to assign all of that to other health professionals, because I don't think that would be in our best interests. And, you know, some of that is not in payment policy, but some of it is, as we have talked about, because there's a great imbalance between primary care and specialty pay currently, and that, you know, certainly there's large differences in training. I did very intensive medical training for 11 years after college. You know, for a primary care specialty, it would be more like seven years.
But that's very different than someone who's done one or two years, or in PAs, I think perhaps no years after a four-year degree in terms of training. And so it's important to consider what is the best role of those health professionals.

I mean, certainly for a lot of routine things, yes, patients I see in my office, I don't -- they wouldn't have needed to see me as a cardiologist or even a medical doctor. But the point is I have a lot of training in order to make that determination, and you wouldn't want to have missed. You know, so how -- the point is you don't know what you don't know, right? So you don't want to have someone who didn't have such training have missed something that wouldn't have been missed by somebody with more training. And that's really the key.

And where I see a lot of nurses and advanced practice nurses being used now that I'm just not sure is the best use -- and it's not necessarily because they're nurses, but a lot of primary care practices, when the doctor's not available, you get the nurse. And I only notice this because when I'm on service and I got down to admit patients -- I'm a cardiologist -- I see a lot of patients with chest
pain that I would have never, ever sent to the emergency room. They're young people. They have very atypical symptoms. And I ask them why didn't they call their doctor, and they often say they did call their doctor, they got the nurse, and the nurse, you know, as soon as they heard "chest pain," they followed the triage, sent them to the emergency room. And so it generated more, you know, unnecessary visits.

Now, it's not necessarily -- I mean, I'm not saying nurses have to do that, and it could have been, you know, perhaps the covering doctor would have done that, because part of it is when you don't know the patient, you're more likely. But part of it is when you're not that comfortable with those whole chest pain symptoms -- and chest pain is certainly a challenging area anyway, even in the emergency room. But I just think we should kind of think in a sort of bigger picture of sort of where we -- how primary care is best done and what the role is.

And I would just lastly say I'm not that comfortable lumping nurse practitioners and PAs because I think it's a very -- I think nurse practitioners are more highly skilled, more highly trained. PAs, it was
interesting, I didn't know they came from medics, but
certainly now I don't think that's where they're coming
from. And I think some of them might be, as Peter kind of
alluded to, it's a shorter route to a lucrative medical job.
And I'm not saying that's what they're doing, but I just
wouldn't lump them all at this time.
And the last comment I'll make is if we do --
because I always think we should try to look at quality
metrics -- if we had quality metrics for these other health
professionals in comparison, it would be helpful to look at
those, too.

DR. SAMITT: So I think this is an essential,
critical topic for us to focus a lot more energy on. My
personal bias -- there's a lot of discussion about the
supply of physicians nationally. My personal bias is that
we do not have a shortage of supply of physicians, that I
think that if the care delivery model redesigned itself
appropriately, that we have ample number of physicians, and
a big component of that is assuring that we develop
complementary care teams that manage population health --
not just in primary care, by the way, but in nearly every
discipline, that there is an opportunity to really look at
which individual plays what role. But I think it takes a lot of thought to really identify, you know, how do you segment responsibilities. So I do have a series of thoughts, if I may.

One is, you know, are there ways to modify the payment policy to incent and reward the right individuals to do the right work? So we talk about an 85 percent differential for the advanced practitioners. Maybe actually there are some diagnoses that it should be 100 percent for advanced practitioners and 85 percent for physicians, because we really want to rebalance the role and responsibility, and maybe that's something that we should think about.

The second thing is I think we absolutely should remove barriers to certification and the things that no longer make sense, and you even wonder about federalization of certification requirements to address state-based gaps where State A may have one approach and State B may have another, and it really isn't consistent and it is a bit problematic. So I wonder if that's a possibility that we can recommend.

The third thing, which was in response to Glenn's
comment about what problem we're trying to solve, is it's kind of interesting that the HPSA-related bonus in underserved areas is kind of -- has applicability in this particular case as well, which is, you know, do we -- is there an interrelationship here? Do we essentially say that we define underserved areas and we enhance payments for advanced practitioners in those areas to encourage growth of access-related needs in those areas? And, you know, the same challenge pertains as it does to HPSA, which is how do you define "undeserved," which I think has been the problem with HPSA. But if we come up with a good definition of that, the question is: Instead of trying to recruit physicians, do we try to recruit advanced practitioners for some functions? And then the final thing that I would say is I think the worst thing that we could do is to create incentives that enhance a silo-based approach to care. What we don't want is we don't want to change incentives so that advanced practitioners are competing with physicians, that the future is about team-based care. So I think all of our discussions about alternative payment models and ACOs and, you know, fixing SGR and shift to primary care, my sense is
that they will reward the right complement in primary care
if we do all those things right, practices will do the right
thing and will want to create these complementary
relationships between physicians and APs rather than a
competitive relationship if it's just arm's-length payment
from a payer to these various groups of providers.

DR. DEAN: I would echo much of what Craig just
said. I mean, I could not have survived in the location
where I’ve been for all these years had it not been for
these folks, both PAs and nurse practitioners. It just
simply wouldn’t have been possible.

Plus, being married to one, that probably had some
effect, too.

[Laughter.]

DR. DEAN: And in terms of the quality, just on
that side, you know, when nurse-midwives’ outcomes are
compared with obstetricians for the group of people that
they take care of, the midwives inevitably come out better,
just inevitably. So from a quality point of view, I don’t
think there’s a question.

I do quibble -- and I think we can get all hung up
on trying to figure out well, what is the right payment for
each individual. I don’t think MedPAC or Medicare should get caught up in that for all of the reasons that Craig has talked about, and so forth. I think the whole answer is that we need to set up structures and -- I shouldn’t say set up. We need to encourage structures that support a team-based approach because you can’t even make those decisions based on what certificate a person has. I mean, I’ve worked with a whole range of these folks. The certificate that they have on the wall tells me a little bit, but it doesn’t in any way answer how much responsibility am I comfortable with that person taking.

It so much varies with the individual and their experience and their ability to make decisions, and all those things. And I think those decisions can only be made within a team, as to who can really -- who’s the right person to do this. And we need to remove the payment barriers and allow the flexibility for those decisions to be made within that team. And I think that’s the way you’ll get the efficiency and the outcome that we want.

As Bill said, you know, this gets very politicized and there’s a lot of egos that get involved and my profession, unfortunately, is probably overburdened with
that problem. But the whole idea of independent practice is
something that I think is probably an obsolete concept,
basically. I think that we have to move to a -- none of us
are reasonably an independent practice and we need to
recognize that. And again, it gets back to making sure that
we have payment structures that don’t encourage that.

I am a strong believer that these folks have a
tremendous amount to offer. I think the decision exactly
what they do really needs to be done on a local basis and we
need to allow that to happen.

DR. BAICKER: So this is a very productive line of
investigation. I look forward to more of the details. I’d
love to get a sense of whether by focusing at the separately
billed ones we’re looking under the lamppost because we can
see it, but there’s a huge array of other stuff going on
incident to that we just can’t see, or just what share of
the pie we’re talking about.

I’d also love to see more about the relationship
between shortages -- and I know the challenges we discussed
last time in defining shortage areas -- the share of
services delivered by these types of practitioners, and the
state laws. I know it’s going to be very hard to know cause
and effect there. Do people move to areas where they can practice more freely? Or do they change practice laws because of shortages?

But I would love to know the relationship among those to get a sense of the potential scope of increased access that could be gained by expanding state restrictions.

MR. HACKBARTH: Okay, thank you all. I appreciate the good work on this.

DR. DEAN: Glenn, can I make one other comment?

MR. HACKBARTH: Sure.

DR. DEAN: One thing I forgot to mention, or forgot to offer last night. If anybody would like to see a truly functioning critical access hospital, the invitation is open to see how a hospital works with an occupancy of about two. I would love to show off one that I think really meets the letter and the spirit of the law, as far as what critical access hospitals do. So you’re all welcome, including the staff, and anybody in the audience. Whatever.

MR. HACKBARTH: Tom, could you tell us when summer begins and ends in South Dakota?

[Laughter.]

DR. DEAN: We sort of know when it happens.
[Laughter.]

DR. DEAN: The statement in South Dakota is if you don’t like the weather, wait until tomorrow because it will be different.

MR. HACKBARTH: Okay, we will now have our public comment period.

Could I see hands? We have two. Anybody else who's going to get in the queue? It's just helpful for me to know the total number. So four. Anybody else? Okay. We have four.

So please begin by introducing yourself and your organization and limit your comments to two minutes. When the red light comes back on, that's the end of your two minutes.

MR. PRISTER: Thank you. Good morning, Mr. Chairman and Commissioners. My name is Jim Prister and I'm the President and CEO of RML Specialty Hospital, which is a not-for-profit long-term acute-care hospital composed of two freestanding LTCHs in the Chicago area. RML is organized as a partnership with its current partners being Advocate Health Care and Loyola University Medical Center. RML is also the entity that Commissioner Butler described during
your January Commission meeting.

Patients come to RML from approximately 65 referring hospitals. Over 90 percent of all of our patients come directly from intensive care units, and approximately 20 percent of all of our patients are on dialysis. RML was a very active participant in RTI's alpha and beta testing of the post-acute care tool.

The purpose of my comments this morning are to encourage MedPAC to strongly support the need for additional research, not just in the costs and the payments, but also in the outcomes. We also need to look at the payments and the outcomes over a longer period of time, whether it's 90 days, 180 days, or 365 days post-discharge from either the indexed short-term hospital stay or the long-term care setting.

It's interesting to note that there are no Model 3 bundles approved by Medicare for the LTCH setting as of today.

As we all know, there is very limited objective and consistent clinical information pertaining to the Medicare sector and I'm here this morning to share with you some significant innovative developments occurring in the
A study conducted at RML by Dr. Amal Jubran and her colleagues was recently published in *JAMA* on January 22, and it was conducted over the course of eight years and is the largest prolonged mechanical ventilator study ever conducted. The editorial was very interesting because it describes some of the significant benefits of this research, not just on prolonged mechanical ventilation patients, but very much so on the CCI patients that were discussed this morning.

And we have over 800 patients on prolonged mechanical ventilation that are treated at RML at our two locations. More than 60 percent of these patients are weaned, and if we use the *JAMA* study guidelines, 76 percent of these patients are alive at the end of one year. The patients in the study also overwhelmingly stated that if they had to go through this process again, they would not hesitate to do so.

We're currently looking at a bundle through the data use agreement, and given the time, I'd be happy to come back and speak with the Commission staff further about that study.
Thank you.

MR. KALMAN: Good morning. My name is Ed Kalman. I'm with the National Association of Long-Term Care Hospitals, and I'd like to make just two points, if I could, in the time allotted. The first point relates to quality and cost. The second point relates to the choice of ICU use as a sole indicator of the high-complexity cases that you're interested in.

As to the first, RTI has not reported any separate explicit data on cost and outcomes for patients with just ICU use. Their report is for the whole LTCH population. So there is no data before you if you select just ICU cases for this new payment policy as to what the effect will be on their outcomes and cost.

But there has been a recent study that NALTH is very interested in and that we're looking into very closely from the University of Pennsylvania published this December, and that study followed, I believe it's patients with ICU use and ventilator use with 13 days in the ICU over an episode of 180 days. It looked at payment, cost, and outcomes. And the finding, as you would suppose, is -- where there is and is not LTCH use, that's the important
point. And the findings were, where there is LTCH use, payments are higher, but notably, costs are much lower, to the tune of $34,000 per discharge. And in terms of outcomes, SNF use is much lower, which implies more days in the community. And also, the LTCHs are hospitals that maintain patients at a higher level of care.

The number one and two alternatives that you are looking at will substitute acute hospital cost, that is, outlier payments, sooner for LTCH cost. The reason that this study showed better cost as opposed to payments -- very important difference -- is that, hands down, LTCHs cost less on a per diem basis than virtually any acute hospital -- no IME, no GME, no DSH, no overhead for an ICU or operating rooms. They're very low cost on a per diem basis. And also, you've got to be very concerned about quality outcomes.

So we would suggest that as you go on with this research, that you explicitly require a report on cost efficiency and outcomes.

Secondly, my second point, in terms of ICU use, NALTH has looked at this in the past. ICU use in and of itself should not be the sole predictor of CCI patients
because, as pointed out, it is variable. It is a bad --
well, what is an ICU in one hospital is not an ICU case in
another hospital, and moreover, we're creating a higher-paid
incentive to use it.

We looked at this in terms of looking at payment
efficiency over a shorter episode of care than 180 days. It
was a combined LTCH PPS use. And what we found was there's
other predictors, and those include -- and it makes sense --
number of procedures and -- not or -- diagnosis. That's
predictive of a case that saves money if it comes to an
LTCH, on a payment basis as opposed to a cost basis.

So there are other predictors other than just ICU
use that may be -- are not as amenable to gaming that you
should look at. And we really think you should take a good
look at this quality issue.

Lastly, on the chart that bothers me the most,
which is Table No. 3, which shows discharging for payment as
opposed to medical necessity, I want to point out to you
that in the March report, there's a finding -- there's a
difference between low-margin and high-cost LTCHs, with low-
margin LTCHs having four times the high-cost outlier use.
They, hands down -- mathematically, they cannot be
discharging just before the geometric mean length of stay. They are holding the cases longer. They are incurring the losses. And they are producing these better outcomes. So you might also consider that with relation.

But thank you. I see I've exhausted my time.

Thank you very much.

MS. BRASSARD: Hi. I'm Andrea Brassard and I'm recently at the American Nurses Association and I'm formerly from AARP. I'd like to talk about home health and I'd like to talk about "incident to" services.

While I was at AARP, I wrote a Public Policy Institute paper on removing barriers to home health care. In the States like Washington State, there's an increase for our Medicare beneficiaries of nurse practitioners who are having specialized home care practices, and for these providers, the requirement for the home health certification being by a physician is just an extra cost. It would help the overall system, it would help the physicians that have to just sign the papers. There's no point.

And in my paper, I wrote about when Bill Scanlon was on this committee and he said, you know, we should just look at this. It was about ten years ago. And I would
I really encourage the Commission to go back and look at home health and talk to the American Association of Home Care Physicians, many of whom are nurse practitioners and physician assistants, about how it would help the Medicare system.

Then I would like to talk about "incident to" billing. I work full-time in health policy, but to maintain my certification as a nurse practitioner, I need to practice, and I recently had to leave a practice -- it was a wonderful little job Saturday mornings in a family practice. I was there by myself. The requirements, the Medicare regulations for "incident to," a practice cannot bill "incident to" for a nurse practitioner or PA services, three Ns: If there's no physician on site; if it's a new patient, you can't; and if it's a new problem, okay, it's not specific how big the problem is. But, obviously, there was no physician on site, so one Saturday morning, the biller brings her husband in and I say, "It's getting towards the end of the year. Can you give me my number of patients that I've seen under Medicare?" She said, "Oh, no. He is not billing under your number."

And I'm giving you just my anecdotal experience,
but I speak nationally. And whenever I talk to nurse practitioners about the importance of billing under their own numbers, they say, no, the practice won't let me. They bill under the physicians. And recently, a nurse practitioner went to a Medicare fraud continuing education and brought it up to the speaker and the speaker says, "There's nothing we can do about it."

I would encourage the Commission, it is just so widespread. It is so widespread and it's unnecessary. I would -- my personal opinion is just eliminate "incident to," because -- or add a modifier.

Thank you.

MS. BUTTERFIELD: Good afternoon. My name is Kristin Butterfield. I'm with the American Academy of Physician Assistants. I would like to offer just a quick clarification, a suggestion, and then also an agreement with one of the slides.

Just as a point of clarification, the vast majority of the 160-odd PA programs in the country are Master's level programs. They are generally about 28 months in duration and include over 2,000 hours of direct clinical education, and there are just shy of about 90,000 PAs in the
country. That was a question that was posed earlier.

As to my suggestion, I'd actually like to make an exception to the point made on Slide 8 about barriers being imposed upon PAs that might restrict access. The inability of PAs to provide hospice, to certify hospice and certify home health care, to do things like certify and order fecal occults, diabetic shoes, medical nutritional counseling, those types of things do actually restrict the ability of PAs to practice and to restrict access to care in medically underserved areas, communities where there are no physician providers. These PAs cannot do these things and it creates delays of care to these underserved patients.

And, finally, I would like to make a statement of agreement that we do feel that there needs to be greater transparency of the care provided by PAs, both the commenter before me as well as some of you all. In terms of how payment is made to PAs with "incident to" and these other things, there's not a lot of transparency right now as to what volume of medical care is being provided by PAs. So we encourage you all to look at that.

Thank you very much for taking a close look at the role of these non-physician providers. We think it's really
important. PAs, NPs, other advanced-practice nurses are really a key to the American health care system going forward. Thanks very much.

MS. TOWERS: I'm Jan Towers with the American Association of Nurse Practitioners, and I'm not going to come up with a bunch of suggestions for you right now.

First of all, we want to thank you for taking this issue up and helping to address it. Our major goal here is to provide patient care in the best way we possibly can. This means that we would like to see advanced-practice nurses being able to function at the top of their license and at their full scope of preparation, and as you are delving into things, we will be glad to provide more information for you in terms of what we do and how we do it. We do have a lot of the data that you're talking about and we're looking forward to dialoguing with you further.

MR. HACKBARTH: Okay. Thank you all.

We will see Commissioners at the retreat, except for Tom.

[Whereupon, at 12:01 p.m., the meeting was adjourned.]